1 Thursday, 30 May 2013
2 (10.00 am)
3 THE CHAIRMAN: Before we start, ladies and gentlemen, I see
4 Dr McKaigue here and he was due to be followed today by
5 Dr Gannon's evidence. Dr Gannon's evidence has to be
6 postponed. We received a further witness statement from
7 Dr Gannon after 5 o'clock last night, in which she takes
8 serious issue with Mr Lucas of the inquiry. We haven't
9 had an opportunity to speak to Professor Lucas, and what
10 we've arranged, this morning, Mr McAlinden, is that
11 Dr Gannon and Professor Lucas give evidence together on
12 Monday 1 July.
13 MR McALINDEN: Yes.
14 THE CHAIRMAN: That gets us around that hiccup. I don't
15 think Professor Lucas will have taken a full day and it
16 seems to make sense for him and Dr Gannon to give
17 evidence together. That means that today, in a few
18 moments, we'll hear from Dr McKaigue, but before we do
19 that, I want to say something.
20 I heard evidence yesterday, quite specific evidence
21 yesterday, that it was recognised in the
22 Children's Hospital on Thursday 13 April 2000 that there
23 were identified issues about the treatment which Lucy
24 was given in the Erne on Wednesday 12th and Thursday
25 13th April. That evidence came from Dr Chisakuta, who

1 was one of a number of paediatric anaesthetists involved
2 in Lucy's care, and from Dr Caroline Stewart, who was
3 working as a registrar to Dr Hanrahan.
4 Despite what they identified as recognition in the
5 Royal of problems which had been caused in the Erne, the
6 Crawford family appears not to have been told of those
7 problems and there appears, on the evidence as it stands
8 after yesterday, to have been no learning at all in the
9 Royal. Even less is there any evidence of an exchange
10 between the Royal and the Erne which would have helped
11 the Erne learn from what had happened. I don't want to
12 go further into the evidence than that, but I also have
13 to say that yesterday's evidence is capable of a much
14 harsher analysis than what I have just said.
15 I recognise that the evidence may change and that
16 the picture which was painted yesterday may alter, but
17 I encourage the Belfast Trust, the Western Trust and the
18 individuals who have still to give evidence to consider
19 and, if necessary, reconsider their evidence. We
20 already know from previous sessions in this inquiry that
21 people and organisations paint themselves into corners
22 on occasions. For instance, Dr Taylor did that in
23 Adam's case, and I believe from having heard his
24 evidence that he regrets that almost as much as Adam's
25 mother regrets it.

1 It is worthwhile for the trusts and the individuals
2 who are to give evidence to consider if they need to
3 reassess their positions and if they do so then it would
4 be helpful to me and to the inquiry generally if they
5 said so at the start of their evidence. In other words,
6 if they identify at the start of their evidence any
7 departure which they intend to make from their written
8 statements.
9 Yesterday, Mr McAlinden, I have to say was not
10 a good day for the Trust.
11 MR McALINDEN: I take on board the comments, Mr Chairman.
12 THE CHAIRMAN: So I'm ready to hear Dr McKaigue now.
13 Let me emphasise, doctor, what I have just said is
14 not in any way aimed at you as opposed to any of the
15 other individuals who are about to give evidence, but
16 I can't let yesterday's evidence pass without remarking
17 on the evidence, the very stark and clear evidence,
18 which was given by the two doctors yesterday.
19 Are you content for me to move straight into
20 Dr McKaigue's evidence?
21 MR McALINDEN: Yes, thank you.
22 THE CHAIRMAN: Doctor, would you come forward, please?
23 DR JAMES MCKAIGUE (called)
24 Questions from MS ANYADIKE-DANES
25 MS ANYADIKE-DANES: Good morning, doctor. Do you have there

1 by you your CV?
2 A. Yes.
3 Q. Thank you very much. Doctor, you've made a number of
4 statements, not just in relation to this part of the
5 inquiry to Lucy's case, but also in relation to the
6 previous cases of Adam and Claire. You've given
7 evidence in Claire's case; I don't believe you gave
8 evidence in Adam's case.
9 A. No.
10 Q. But in any event, I'm going to ask you if, when I recite
11 what those statements are, if you wish to adopt them as
12 your evidence, subject to anything that you may say now
13 when you give your oral evidence.
14 So if I tell you what they are. You had a PSNI
15 statement dated 16 March 2005. That was in relation to
16 this case, Lucy's case, and the reference for that is
17 115-027-001. Then you had your witness statement in the
18 Adam case, that's witness statement 129/1. You had
19 a statement in the Claire governance part, and we don't
20 need to go into that because you gave your evidence and
21 you adopted that statement in the course of that.
22 But in the Lucy section that we're going to deal
23 with now, you've provided three statements. Each has
24 a series of 302: the first is dated 21 November 2012,
25 then 23 January 2013, and then 26 April 2013; do you

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

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

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

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

1 Q. Thank you. Then under "Teaching", we see:
2 "Trainee anaesthetists on the topic of IV fluids,
3 blood and blood products."
4 If we just stick with the issue of IV fluids, when
5 would you have been doing that teaching?
6 A. That would principally have been in theatres, informal
7 teaching during a case. There would have been some sort
8 of set-piece lectures to maybe a wider group of
9 anaesthetists in the Trust.
10 Q. Sorry?
11 A. A wider group of trainee anaesthetists; this is trainee
12 anaesthetists.
13 Q. When you said "than the Trust", do you mean those who
14 were anaesthetists, but not within the Trust, could also
15 come to these lectures?
16 A. At any one time there might be three, four, five trainee
17 anaesthetists in the Children's Hospital. So while they
18 were there for their three-month attachment I would have
19 taught fluid management then, on the job so to speak,
20 and then there were --
21 Q. This is part of a series of talks that would be
22 available for --
23 A. Yes, I would have given some talks.
24 Q. Can you remember if you always gave talks on IV fluids
25 or, if not, when you started?

1 A. I recall I started before 2000, and I carried on after
2 that for a number of years. It's some years since I've
3 actually given the talks. It's not in my CV there, but
4 I think I also gave maybe one or two talks to medical
5 students as well. But the predominant audience was
6 trainee anaesthetists. Certainly after 2000, 2001
7 possibly.
8 Q. Well, before 2000, when you think you might have given
9 some talks before then, did you give any talks on
10 hyponatraemia?
11 A. Um ...
12 Q. At least if I put it a different way, the use of
13 low-sodium fluids?
14 A. Yes. I may have, I cannot recall the individual talks,
15 but I almost certainly would have talked about
16 hyponatraemia, I'm sure.
17 THE CHAIRMAN: As an aspect of a talk on IV fluids?
18 A. Yes, the IV fluids, including, you know, the
19 administration of blood and blood products.
20 MS ANYADIKE-DANES: I'll come back to some of that when
21 I deal with some substantive issues as we go through
22 some of the issues that arise out of that, but
23 thank you.
24 Then you treated Adam when he was in PICU,
25 post-surgery; is that correct?

1 A. No.
2 Q. Okay. You weren't in PICU when Adam was admitted?
3 A. Not that I can recall, no.
4 Q. Did you sign off on a statement -- let me pull it up for
5 you, 011-014-107A. Have you seen that before?
6 A. Yes.
7 Q. In relation to that, did you sign-off on that?
8 A. There were a number of versions of that statement.
9 Q. There were.
10 A. And I redressed this in some of my witness statements
11 because I remember there were a number of versions going
12 around. So I signed-off on one version.
13 Q. Yes. But any of those versions referred to the need to
14 be carefully monitoring post-operative children who
15 might have a potential for electrolyte imbalance.
16 That's a common theme in all of them. So you were
17 endorsing that, I take it. And:
18 "The now known complications of hyponatraemia will
19 be assessed."
20 That was a common theme in them. And if you go down
21 to:
22 "All anaesthetic staff will be made aware of these
23 particular phenomena and advised to act appropriately."
24 Were you aware that that was an element of what
25 the coroner was going to be told?

1 A. I believe so. Unless the statement I've signed --
2 unless what I've said in my previous witness statement
3 differs significantly from that one.
4 Q. Well, how was that going to happen?
5 A. How was it going to happen?
6 Q. Yes. How were all anaesthetic staff going to be made
7 aware of these particular phenomena and advised to act
8 appropriately?
9 A. For trainees that would have been an intrinsic part of
10 on-the-job anaesthetic training. It would have been
11 second nature to -- if you were an anaesthetist, using
12 this sort of apprenticeship model of training where
13 there's no absolutely defined curriculum, as and when
14 teaching opportunities arose, you would highlight them
15 and make points which were learning points.
16 Q. Did you when you were engaged in your teaching?
17 A. Yes.
18 Q. You referred to Adam's case?
19 A. I may have, I cannot remember. I cannot honestly
20 remember, but I may have.
21 Q. And when you were lead clinician, which was a couple of
22 years after, in fact the following year -- the inquest
23 for which this statement was produced was in the summer
24 of 1996, you became lead clinician, paediatric
25 anaesthesia, in July 1997, so about a year after this.

1 At that stage, were you thinking about how you might
2 incorporate the learning from Adam's case into something
3 more systematic, if I can put it that way, for trainee
4 anaesthetists?
5 A. I wasn't thinking of something formalised or systematic,
6 no.
7 Q. Were you thinking at all about how you might communicate
8 this?
9 A. Rather than specifically communicate the Adam Strain
10 case, the importance and the concept of hyponatraemia
11 and dilutional hyponatraemia with No. 18 Solution.
12 Q. So if you're the lead clinician, you'd be wanting to
13 make good on that statement, that there was training
14 going out to the trainee anaesthetists in relation to
15 what is described there as "the particular phenomena";
16 would that be right?
17 A. Yes.
18 Q. So that means that the trainee anaesthetists coming
19 through your hands, if I can put it that way, should be
20 aware of these issues?
21 A. And my colleagues' hands too.
22 Q. Yes, and your colleagues also.
23 A. Yes.
24 Q. So as from at least when you took over in the summer of
25 1997, they should have been aware -- and probably before

1 then -- if that statement is going to be made good?
2 A. Yes.
3 Q. And then when we come to the case of Claire Roberts.
4 Were you aware of that case?
5 A. Yes.
6 Q. In your witness statement, we don't need to pull it up,
7 but it's 302/1, page 6, you say:
8 "In the case of Claire Roberts, hyponatraemia was
9 a contributory factor to the development of fatal
10 cerebral oedema."
11 So that was recognised by you in that case?
12 A. Yes.
13 Q. Did you think that, well, that's another case of
14 hyponatraemia we've got, maybe we should perhaps
15 redouble our efforts to ensure that people are aware of
16 the implications of the use of low-sodium fluids?
17 A. I personally was aware and I believe I would have
18 communicated, in a general manner, the care that had to
19 be taken with No. 18 Solution.
20 Q. But how is that going to be done in a way that you can
21 be satisfied, as the lead clinician, that these matters
22 are being taken on board? This statement comes in the
23 summer of 1996, Claire's death happens towards the end
24 of that same year and then, in the summer of the
25 following, year you have taken on responsibility with

1 this new role. How are you going to make sure that this
2 lesson in terms of the potential dangers or risks
3 involved in the use of low-sodium fluids is being
4 understood, accepted and properly addressed?
5 A. Well, I have to say that I didn't consider that, so
6 I didn't personally take any steps to ensure that under
7 my role as lead clinician in paediatric anaesthesia.
8 Q. Is there any particular reason why not because you
9 personally would know of two cases within a year that
10 had happened?
11 A. I can't explain why.
12 THE CHAIRMAN: Did the doctor know in 1996 that
13 hyponatraemia was a contributory cause of Claire's
14 death?
15 A. Did I know? Yes, I did.
16 MS ANYADIKE-DANES: Yes, that was in his witness statement,
17 Mr Chairman.
18 And you signed-off on this, so although you hadn't
19 treated Adam, you were aware of the issues because there
20 was communication back and forth that led to this
21 statement --
22 A. Yes.
23 Q. -- which was going to be provided to the coroner? So
24 you were aware of two instances within a year of each
25 other.

1 A. Yes.
2 Q. So then what I was asking you was: well, why didn't you?
3 A. In my job we had lots of demands on our time and I never
4 got the time, really, to reflect on that. That's the
5 only explanation I can offer.
6 Q. What about when you become convenor? You become
7 convenor in February 2000, things have moved on.
8 That is convenor for the paediatric anaesthesia audit
9 group, February 2000 to May 2004, so things have moved
10 on a bit. That is just before Lucy gets admitted.
11 A. Yes.
12 Q. At that time, of course, there are perhaps more
13 publications in relation to the potential risks of
14 low-sodium fluids. Did you think with that, in that
15 forum, it might be something that could be discussed?
16 A. I personally don't recall making that thought.
17 Q. Let me just read you out what you said about how that
18 group operated. It's at 302/1, page 2:
19 "It focused on issues important to us as paediatric
20 anaesthetists, e.g. drawing up guidelines with
21 multidisciplinary input, if appropriate, collating
22 anaesthetic critical incidents and then reviewing them
23 for learning points. A report was produced for each
24 meeting, which was circulated within the group, the
25 Trust audit department and our clinical director, with

1 the intention of sharing information and learning
2 opportunities among other anaesthetists."
3 That would be a good forum for doing that.
4 A. Yes.
5 Q. I mean, did you know that Dr Chisakuta, for example, in
6 1998 thought to include in a talk he was giving at an
7 inaugural lecture for the Western Anaesthetic Society --
8 that he would pick up on the newly-published article by
9 Professor Arieff on the risks of low sodium and he did
10 that in 1998? Were you aware of that?
11 A. I was aware of that paper, yes.
12 Q. The paper. Were you aware that he was going out to
13 Derry to give a talk in relation to that?
14 A. No.
15 Q. When that paper came out, did it not strike you that
16 what was being said there was perhaps something that was
17 worthy of greater dissemination amongst your colleagues
18 and trainees?
19 A. I suppose the issue of hyponatraemia was one -- a very
20 important part of my professional job, to avoid
21 hyponatraemia --
22 Q. Yes.
23 A. -- but there was just so many other things going on that
24 it's not that I positively decided to not do anything
25 about hyponatraemia. On top of my busy clinical job,

1 I must have been distracted by a multitude of other
2 things, so it wasn't a conscious decision to exclude
3 that; it was just the way life was.
4 Q. I understand. In your witness statement at 302/1,
5 page 11 -- and maybe this is worth picking up -- you
6 talk about your practice changing. The question that
7 you're being asked is in relation to Adam and Claire,
8 who you both knew about:
9 "How did the knowledge about them affect your work?"
10 And the answer to that is:
11 "My practice did change in that at some point I no
12 longer used Solution No. 18 as a maintenance fluid and
13 this became Trust policy."
14 Can we just pause there? Am I correct from the way
15 you framed that that you would always have considered it
16 inappropriate to use it as a replacement fluid?
17 A. I believe that I didn't -- I would not have used it as
18 a replacement fluid. I would have been very comfortable
19 with using Hartmann's or saline. So that would have
20 been, from memory, my intuitive practice.
21 Q. So what you're talking about here is a change in your
22 practice when at one stage you would have used it as
23 a maintenance fluid and what you're telling the inquiry
24 here is that your practice changed in relation to that?
25 A. Yes.

1 Q. And you simply stopped using it as a maintenance fluid;
2 can you remember when did you that?
3 A. No, I'm aware that that's a question the inquiry have
4 been asking for some time now and of many different
5 people. I cannot -- there is no particular date or even
6 period in my mind.
7 Q. Maybe I can help you this way: do you know why your
8 practice changed?
9 A. It changed because of the issue of ADH.
10 Q. When did that become something that you recognised and
11 were taking cognisance of?
12 A. Well, I -- after, I suppose, the Adam Strain case,
13 I would have been aware of the issues of ADH.
14 Q. Does that mean after his case, you -- maybe not
15 immediately, but gradually -- changed your use of
16 Solution No. 18? Would that be a fair way of putting
17 it?
18 A. As a maintenance fluid?
19 Q. Yes, as a maintenance fluid.
20 A. I think that would be a fair point to make.
21 Q. When you were doing that, did you discuss that, because
22 that's a change in practice and it's a practice that
23 many others carried on adhering to? Did you discuss
24 that with any of your colleagues?
25 A. I can't remember individual discussions, but it would

1 have been a topic, yes. It was a topic that we would
2 have discussed.
3 Q. And do you think you were alone in that?
4 A. In discussing it with my colleagues?
5 Q. No, alone in responding in that way in changing your
6 practice.
7 A. As a group or as an individual?
8 Q. Well, you said you thought you did it. Were you aware
9 of any of your other colleagues doing it?
10 A. Yes, I -- and I suppose, just to go back, to be clear
11 what you're asking me, is that as a maintenance fluid or
12 as a resuscitation fluid?
13 Q. As a maintenance fluid.
14 A. I'm honestly not sure what my colleagues -- I mean,
15 I would -- in the absence of having factual sight of
16 a lot of anaesthetic records, I'd be loath to speculate
17 on what they were actually doing.
18 Q. Do you think you would have taught your trainees that?
19 A. At some stage I did, but I can't remember when.
20 Q. Would you not have taught them when you started yourself
21 to change your practice?
22 A. Yes.
23 Q. And explained the reason for it?
24 A. Yes, very much so.
25 Q. I know I've asked you this question, but I'm not sure

1 why, if you're actually changing your practice, why
2 that's not something that would get discussed in one or
3 other of these fora that you were telling us before.
4 A. You see, I'm not exactly sure when, you know, from what
5 date or even what year that was happening, so it's hard
6 to -- if I'm not quite sure when it happened, it's hard
7 to know when it didn't appear in one of the meetings.
8 Q. Yes, but what you did say is you thought you might have
9 done it in response to your learning about ADH
10 in relation to Adam Strain.
11 A. Yes.
12 Q. Well, that case happened in -- you may not have really
13 learnt much about it until 1996, but that's quite
14 a while ago.
15 You've mentioned that --
16 THE CHAIRMAN: Sorry, let me just ask one more point on
17 that.
18 You were considering the continued use of
19 Solution No. 18 as a maintenance fluid. You had used it
20 previously as a maintenance fluid and then at some point
21 you stopped doing that.
22 A. Yes.
23 THE CHAIRMAN: Can I take it that when you stopped using it
24 as a maintenance fluid you stopped dead? Having sort of
25 considered to and fro the arguments for and against, if

1 you stopped using it, say, hypothetically on a Monday or
2 Tuesday, I presume that two weeks later you weren't
3 using it again on an occasional basis as a maintenance
4 fluid. When you stopped using it as a maintenance
5 fluid, because you identified some risks involved in it
6 and you were comfortable using Hartmann's or saline,
7 from then on you would not have used Solution No. 18 at
8 all as a maintenance fluid?
9 A. It would be very hard to me to say I never used it,
10 but -- as a maintenance fluid. I'm ... I suppose this
11 period we're talking about spans many, many years in the
12 Children's Hospital where we have complicated patients
13 with maybe electrolyte abnormalities, so it's very hard
14 to say that at a certain date I never used it. But
15 there was this very, very -- at some stage there was
16 a very strong trend to dispense with No. 18 Solution.
17 THE CHAIRMAN: Can you remember, when you were in
18 discussions with your colleagues, whether you were out
19 on a limb or whether they were, at least some of them
20 were with you, even if it wasn't universal?
21 A. No, it would have been as a group.
22 THE CHAIRMAN: Thank you.
23 MS ANYADIKE-DANES: You said earlier, when I started this
24 line of questioning, that you were aware that the
25 inquiry's been trying to put a date to it because

1 a number of your colleagues have been asked. What
2 prompted some of that line of enquiry was that
3 Dr Nesbitt initially wrote a letter to Dr Fulton. Do
4 you know who Dr Nesbitt is?
5 A. Yes, I do.
6 Q. So he was the clinical director at that time at
7 Altnagelvin. He also was a consultant anaesthetist who
8 had seen first-hand Raychel before she collapsed in
9 Altnagelvin and accompanied her to the Children's
10 Hospital. He writes a letter to his medical director
11 having made some investigations in relation to the use
12 of Solution No. 18. If I just take you to that, the
13 letter is to be found at 026-005-006.
14 You can see he says that he has contacted -- have
15 you seen this letter before, by the way?
16 A. I don't think so.
17 Q. Right. You see the date, 14 June. Very proximate to
18 Raychel's death:
19 "I have contacted several hospitals, including the
20 Children's Hospital."
21 And he has made enquiries. He is trying to find out
22 what everybody else does about their perioperative fluid
23 management. He says:
24 "The Children's Hospital anaesthetists have recently
25 changed [recently to June 2001] their practice and have

1 moved away from No. 18 Solution to Hartmann's solution.
2 This change occurred six months ago and followed several
3 deaths involving No. 18."
4 Then he goes on to say that:
5 "The anaesthetists in Craigavon have been trying to
6 change the fluid also to Hartmann's, but they've met
7 resistance in the paediatric wards where the
8 paediatricians wished to follow a medical paediatric
9 protocol."
10 Can you help us with what might have happened?
11 Firstly, was there a change like that so far as you're
12 aware?
13 A. In the Children's Hospital?
14 Q. Yes.
15 A. There definitely was a change, but I'm not sure of the
16 time frame, when it started.
17 Q. But there was a change?
18 A. Yes, because now we no longer use --
19 Q. I know you don't now.
20 A. Now it's very clearly we don't use it, but I'm not sure
21 when that started.
22 Q. He attributes a reason for that shift six months ago, he
23 said:
24 "Following several deaths involving No. 18
25 Solution."

1 Do you recollect that?
2 A. The deaths?
3 Q. Yes.
4 A. Well, Adam Strain, Claire Roberts, and this is
5 in June 2001, and Lucy Crawford.
6 Q. So are you saying that the Children's Hospital was
7 recognising in June 2001 that the use of Solution No. 18
8 was implicated in Claire Roberts' death?
9 A. I would imagine that he -- he mentioned three cases.
10 Q. "Several."
11 A. Seven?
12 Q. "Several."
13 A. Several cases. Um ... Well, I don't know where he got
14 that information from.
15 Q. No, but what I'm asking you is: when you mentioned Adam
16 and Claire, were you saying that because it was
17 recognised in the Children's Hospital in 2001 that
18 Solution No. 18 had been implicated in Claire's death?
19 A. I recognised that it was implicated. I'm not sure, you
20 know, what the ... um, the hospital itself, the
21 corporate hospital, had recognised.
22 Q. Did you make that known to the hospital that you thought
23 the use of a low-sodium fluid, Solution No. 18, was
24 implicated in her death?
25 A. No, I didn't.

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

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

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

1 normal maintenance rates, which was standard practice in
2 paediatrics.
3 Q. Exactly, so something that was standard practice could,
4 in certain instances, end up being implicated in
5 a child's death. That's exactly the point.
6 A. As an anaesthetist, I felt that all the time in Claire's
7 case I was, if you like, looking at what paediatricians
8 were doing. Where I came from with Adam was -- Adam had
9 received a large volume of No. 18 Solution, a large
10 volume, whereas Claire hadn't, and there were other --
11 there was SIADH, which was contributing to the
12 hyponatraemia.
13 Q. Yes.
14 A. So Claire's case and Adam's case were entirely
15 different.
16 Q. But if you just stay with Claire's case, you have said
17 Solution No. 18 was implicated. So it wasn't a neutral
18 issue; it played a role. Implicated. That's why I'm
19 asking you. Once you form that view, even if you formed
20 it just as an anaesthetist and wondered whether the
21 paediatricians had an answer to it, once you'd formed
22 that view, why didn't you take that to the Trust or at
23 least raise it in one of the fora that were available to
24 you to do so because, if you were right, it might have
25 significant implications?

1 A. Well, my answer to that is I didn't do it and I have no
2 explanation for that.
3 THE CHAIRMAN: Let's go back. The note that was prepared
4 for the coroner talked about managing electrolyte
5 imbalances after major surgery, right?
6 A. Yes.
7 THE CHAIRMAN: So we've already had a debate about "major
8 surgery", but let's move on to Claire's case. Claire
9 didn't have major surgery. In fact, Claire didn't have
10 any surgery, right? And Solution No. 18, the use of
11 Solution No. 18 and monitoring electrolytes, has been
12 identified at least to the coroner as a point that he's
13 reassured the Children's Hospital will be alert to in
14 future when monitoring children who have had serious
15 surgery or major surgery.
16 A. Yes.
17 THE CHAIRMAN: A few months later, Claire comes in, she's
18 had no surgery at all, she dies in a very short time,
19 and you take a lesson from that that even though she
20 didn't have an excessive rate of Solution No. 18, you
21 regard hyponatraemia and Solution No. 18 as
22 a contributory cause to her death. That's what you
23 identify as a paediatric anaesthetist. So did you speak
24 to any of your paediatric colleagues to say, "Look, this
25 actually could be something that we should be worried

1 about"?
2 A. No, I didn't.
3 THE CHAIRMAN: Well, can you explain why? Sorry, was it
4 something to be worried about that a child who didn't
5 have any surgery, who got a normal rate of fluid, but
6 the fluid she received was Solution No. 18, then died?
7 Was that aspect of her death something to worry about?
8 A. Whenever I was thinking about Claire, what was very much
9 in my mind were the other disease processes which were
10 causing cerebral oedema, and among them was SIADH. So
11 there were no particular warnings about SIADH and No. 18
12 Solution.
13 THE CHAIRMAN: But surely that's the point. The fact that
14 a girl who had something else wrong with her or may have
15 had something else wrong with her dies with
16 hyponatraemia as a contributory cause. That must lead
17 to you questioning the continued use of Solution No. 18
18 in a non-surgery case.
19 A. I can only say that SIADH was relatively common, No. 18
20 Solution was very common, and this would not have been
21 the first instance that -- well, I'm speculating. But
22 it would have been quite a common combination. Sick
23 children would have had SIADH and would have received
24 No. 18 Solution. It still seemed to be normal practice.
25 That was my ...

1 THE CHAIRMAN: But it's going to stay normal practice until
2 someone says it shouldn't be normal practice. The
3 reason we got on to this is because this letter written
4 in June 2001 talks about:
5 "... several deaths as a result of which the Royal
6 stopped using Solution No. 18."
7 I think Ms Anyadike-Danes was saying to you that, in
8 Adam's death, Solution No. 18 was implicated in that,
9 particularly with the excessive volume which Adam
10 received, and when she asked you whose the deaths were,
11 you suggested Adam, Claire and Lucy; okay? So you have
12 just told us about Claire.
13 In June 2001, was Lucy's death identified in the
14 Children's Hospital as related to Solution No. 18?
15 A. With respect to Lucy, I didn't know that. My answer to
16 that question was sort of partly informed with the
17 knowledge I have now. But at the time I didn't know
18 that fluids played a role in Lucy's death.
19 MS ANYADIKE-DANES: Sorry, just before we exactly get on to
20 that, that statement which had been up just a little
21 while ago that you approved in 1996, C5 as it's called,
22 shown to the coroner, that refers to an article by
23 Professor Arieff and his colleagues, in particular Ayus,
24 who was working on this area of hyponatraemia, and you
25 must have known that because it's actually referred to

1 in all the versions of the statements.
2 A. Yes.
3 Q. And that is 1992. The title of that article is:
4 "Hyponatraemia and death or permanent brain damage
5 in healthy children."
6 That is what that article is about; it's not
7 necessarily about children post-operatively. It's about
8 the risks of the use of low-sodium fluids, and the
9 problem is you can't actually tell which child is going
10 to respond in a particular way, and you have just
11 highlighted that yourself. A number of children may
12 develop a syndrome of inappropriate antidiuretic
13 hormone, SIADH, they may also be given low-sodium
14 fluids --
15 A. Yes.
16 Q. -- but they don't necessarily go on to develop a fatal
17 cerebral oedema. But some do, and you'd recognised that
18 Claire was one of those. For some reason -- maybe in
19 response to some of the underlying factors that you were
20 thinking about -- she developed SIADH, which means that
21 she was going to inappropriately retain water. She was
22 also being given low-sodium fluids, and because she was
23 inappropriately retaining it and -- one presumes she
24 carried on retaining the water, coupled with the fact
25 that she was being given low-sodium fluids, admittedly

1 at a normal maintenance rate or close to normal
2 maintenance rate. The combination of those factors for
3 matter, you have just recognised, was fatal because
4 you have -- sorry, if I may just finish? Maybe I can
5 correct myself.
6 What you recognised is that the low sodium was
7 implicated in her death in some way; that is what you
8 said, yes?
9 A. Yes.
10 MR McALINDEN: Just before the witness answers this
11 question, I have refrained from interrupting at this
12 stage until now, but I think the line of questioning
13 that this witness is now facing is really going back
14 into a previous case. The line of questioning which he
15 expected to face in relation to the line of questions
16 that were submitted this morning, very early this
17 morning, and indeed the details contained in his Salmon
18 letter, do not deal with this aspect of the case.
19 If he's going to be asked in detail about the cases
20 of Claire Roberts and Adam Strain, it's my submission
21 that he should have time to refresh himself in relation
22 to the contents of his detailed witness statements that
23 were made in relation to Adam Strain and in relation to
24 Claire Roberts because the questioning that he is now
25 being subjected to really has been dealt with by him in

1 those earlier statements in quite significant detail.
2 In relation to his knowledge of Claire Roberts and
3 in relation to his consideration of the factors that
4 play in Claire Roberts, in witness statement WS156/1 at
5 page 31 -- it's question 33, sub-paragraph (c) -- he
6 deals --
7 THE CHAIRMAN: Sorry, page what?
8 MR McALINDEN: 156/1, page 31, question 33(c). He deals
9 with it in detail with the various factors that were in
10 play in Claire's case and his attribution of -- well,
11 his opinion in relation to the causal significance of
12 those factors. So if this line of questioning is going
13 to go over this whole issue in relation to his state of
14 knowledge in relation to Solution No. 18 at the time of
15 Claire's death and thereafter, it would be my submission
16 that, at this stage, he should be given some time to
17 consider the contents of his earlier statements, which
18 obviously would not have been at the forefront of his
19 mind coming into the witness box to answer questions
20 in relation to Lucy Crawford.
21 MS ANYADIKE-DANES: I understand that, Mr Chairman, but in
22 fairness the second line of the line says:
23 "Knowledge of hyponatraemia and use of Solution
24 No. 18."
25 But it may well be that he wasn't expecting that

1 I would ask him that in relation to going back to 1996.
2 MR McALINDEN: When a witness receives a Salmon letter, it's
3 a very serious matter and I'm sure that when the witness
4 received the Salmon letter, his concentration would have
5 been primarily aimed at the issues that have been
6 contained in that letter. And certainly the issues that
7 have been raised this morning for the last hour appear
8 nowhere in the Salmon letter that he received.
9 THE CHAIRMAN: Let me say this. There's a difference,
10 Mr McAlinden, as you must very well know. I don't think
11 there's a single witness in this inquiry to date who has
12 been questioned only about the points in their Salmon
13 letter. So to suggest that questioning should be
14 restricted to points in a Salmon letter is entirely
15 without foundation.
16 MR McALINDEN: I'm not suggesting that.
17 THE CHAIRMAN: So far as this evidence is concerned, this
18 segment of the inquiry has been opened and yesterday's
19 witnesses were questioned on the basis of Dr Nesbitt's
20 letter. Dr Nesbitt's letter says that the Royal's
21 position was that there had been several deaths as
22 a result of Solution No. 18. And Dr McKaigue has
23 identified three deaths which are in some way connected
24 to the use of Solution No. 18. So he was being asked
25 about Claire and he has said that he recognised that

1 Solution No. 18 was implicated in the sense that
2 Solution No. 18 was a contributory element, perhaps not
3 the primary element. And I understand that and I'm
4 content now to move on to his position or his knowledge
5 about Lucy. If he needs to go back to his earlier
6 statements, that can easily be arranged. They're to
7 hand. Okay?
8 MS ANYADIKE-DANES: Thank you very much, Mr Chairman.
9 A. If I could just make one point about the Arieff paper --
10 Q. Of course.
11 A. -- the 1992 Arieff paper? It never mentioned SIADH
12 in that paper.
13 Q. No, I wasn't going to claim that it did do that. The
14 chairman was talking about healthy children who can
15 nonetheless succumb and die, partly as a result of the
16 low-sodium solution that's administered to them.
17 If I then move on, and I'm dealing really with what
18 could have given rise to the statement that Dr Nesbitt
19 feels was made to him by the Trust, and his statement,
20 at least in that letter -- we'll come on to what he says
21 when he makes his statement to the police -- but in that
22 letter he says that he's being told that, six months
23 before Raychel's admission and death, the Children's
24 Hospital had changed their practice and what had
25 prompted them to do that was that there had been several

1 deaths in relation to the use of Solution No. 18.
2 That's where we were, and I was asking you whether you
3 knew about that. Although you didn't know what the
4 source of his knowledge was, helping us with which
5 deaths that they might be, you had identified Adam,
6 Claire, and I think you said Lucy, but I'm not sure
7 whether you did say Lucy.
8 A. I did say Lucy, but this is obviously important to my
9 evidence today.
10 Q. Yes.
11 A. In answering that question, I'm drawing on knowledge
12 which is in the public domain now but not what --
13 I think I qualified it finally by saying I personally
14 did not know --
15 Q. You did do that.
16 A. I didn't answer your question correctly, and then again
17 I suppose I wasn't really in a position to speak for the
18 Royal. I could only speak for myself.
19 Q. Can you help me with this though? Even though you
20 wouldn't be in a position to know that Lucy would be
21 in that list, you knew about Adam and you knew about
22 Claire, but you wouldn't know about Lucy. But so far as
23 you're aware, did the Royal know that Lucy had died with
24 Solution No. 18 being implicated in her death, if I can
25 put it that way?

1 A. I don't know.
2 THE CHAIRMAN: What concerns me is that -- I don't know if
3 you've had a chance to see or hear what Dr Chisakuta
4 said yesterday. Dr Nesbitt's recollection is that -- in
5 fact, it was Dr Nesbitt who wrote this letter fairly
6 contemporaneously. He said: it was Dr Chisakuta who
7 told me there had been several deaths. Dr Chisakuta
8 said yesterday he didn't know about Adam's case and he
9 didn't know about Claire's case. So if he was talking
10 about "several deaths", who was he talking about?
11 A. I don't know.
12 THE CHAIRMAN: Thank you.
13 MS ANYADIKE-DANES: Well, who could he have been trying to
14 speak to? He's going round phoning hospitals to try and
15 find an answer to the question. He's not actually
16 trying to find out how many deaths happened in the
17 Children's Hospital; he's trying to find out what is the
18 Children's Hospital's practice in relation to
19 perioperative fluid management. That is what he's
20 actually trying to find out, in common with that same
21 question he's putting to other hospitals. He's trying
22 to see whether they were out of sync with people or not
23 and then what they're going to do about it, whatever
24 might be the answer to that. As it happens, the
25 information he gets from the Children's Hospital is the

1 very one I have put to you. So if he was trying to find
2 out that question, who's the appropriate person to have
3 contacted in the Children's Hospital?
4 A. I suppose from a generic point of view, you might go to
5 maybe the senior person. On the other hand, you might
6 go to a colleague maybe who you've a good, say,
7 friendship with, or on a personal level you might ring
8 up somebody. It's really impossible for me to answer
9 that.
10 Q. Let's leave the person you might know personally. If
11 you were trying to make contact with the person who has
12 the position that's likely to be able to help me with
13 what is the Children's Hospital's perioperative fluid
14 management regime or practice, what's the title of the
15 person you're going to ask that of in your view?
16 A. Knowing the way anaesthetics works, titles may not
17 necessarily mean an awful lot. It's more the
18 individuals.
19 Q. So you wouldn't be going to whoever was the lead
20 clinician in paediatric anaesthesia?
21 A. No. In my opinion, no.
22 Q. The most senior consultant in paediatric anaesthesia?
23 A. The most senior consultant would be an obvious choice.
24 Q. And who was the most senior consultant in 2001?
25 A. Dr Crean.

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

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

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

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

1 six months, the prescribing practice for No. 18 Solution
2 had changed in the Children's Hospital. Paediatric
3 directorate or, you know, the bulk of the consultants
4 in the Children's Hospital must have been aware of that
5 in some way.
6 Q. If the paediatric directorate --
7 THE CHAIRMAN: Sorry. Mr McAlinden, could we check
8 something? We're going on something of an assumption
9 here. Could I ask that, at some point over the next few
10 days, the figures for the following six months be
11 provided? I just want to make sure that the purchase
12 level stayed as low as this graph suggested it
13 plummetted to.
14 MR McALINDEN: I have directed that enquiries be made not
15 only in relation to that issue but also in relation to
16 whether there is any increase in the use of alternative
17 fluids. I have also directed that all correspondence to
18 and from the company that was supplying all the fluids,
19 which was Galen Pharmaceuticals be checked to ascertain
20 whether there was any detailed correspondence during
21 this period which may highlight the rationale behind the
22 change in the supply of various types of fluid to the
23 Children's Hospital.
24 THE CHAIRMAN: Thank you very much. I just want to make
25 sure we're not working on an assumption which turns out

1 to be false. Thank you.
2 MS ANYADIKE-DANES: I think we had asked similar questions
3 ourselves because we also wanted to see what happened in
4 the preceding period to make sure we didn't have an
5 aberrant year, for example.
6 It is an assumption, so it may well be one that gets
7 corrected with more direct evidence. But from your
8 point of view as a senior clinician in the Children's
9 Hospital, if a decision was being made -- and you said
10 you thought, to have this kind of effect, it would be
11 one that would be made by the paediatric directorate --
12 what's the forum, what's the mechanism by which
13 a decision like that would be made?
14 A. There was a directorate structure. I was not
15 particularly familiar with it, but there would have been
16 some sort of directorate structure that's headed up by
17 a clinical director and then a business manager and
18 senior nurses. So there was some sort of structure
19 there. They would meet regularly and they would have
20 lots of business to do. So I would imagine this would
21 have to be signed-off by somebody or authorised by
22 somebody because it's a major, major change in practice.
23 Q. So --
24 A. No. 18 Solution was deeply embedded in paediatric
25 practice. For that to happen, there's enormous shift in

1 culture and attitudes.
2 Q. So if there was a decision like that or signed off,
3 you'd expect there would be some sort of meeting, some
4 sort of minute or something that recorded this change?
5 A. I would expect so.
6 Q. Thank you very much indeed. Then if we go on to things
7 more directly concerning Lucy's time at the
8 Children's Hospital. In your police statement of
9 16 March 2005 you say that you were the duty consultant.
10 A. Yes.
11 Q. Dr Chisakuta gave some evidence as to how the rotation
12 works. Can you explain what that term "duty consultant"
13 means and how the system of consultant cover works for
14 PICU?
15 A. Yes. The paediatric intensive care unit has to be
16 covered 24 hours a day, 365 days of the year. That is
17 managed and planned with a rota. As you can see from my
18 management responsibilities, I was the anaesthetic rota
19 organiser for three years. I gave it up for an interval
20 of a few years and two other colleagues took it on, and
21 then I think, since 2006 up until now, I am the current
22 rota organiser, so I have a lot of experience with
23 rotas.
24 During the daytime, PICU would always have
25 a consultant on. In other words, elective operating

1 lists would be cancelled to give PICU priority because
2 of the emergency nature of the work. So it had the
3 highest -- along with the emergency theatre, it had the
4 highest priority in the hospital for anaesthetic cover.
5 Night cover was from 6 o'clock in the evening until
6 9 o'clock the next day. There was a rota made out for
7 that.
8 Q. The night cover, were you physically -- whoever was
9 doing it, were they physically present in the hospital?
10 A. No, they weren't.
11 Q. So you were on call at home?
12 A. You were on call at home, yes.
13 Q. I understand.
14 A. So on the particular night that Lucy was transferred
15 from Enniskillen, I was on call at home.
16 Q. And present in PICU at that time, so this would be the
17 early hours of the morning, who would be actually
18 present in PICU at that time?
19 A. There would always be a resident paediatrician.
20 Q. At what level in the early hours of the morning?
21 A. It would vary. It would be a very experienced SHO up to
22 a very experienced senior registrar.
23 Q. Okay. So that's from the paediatric discipline?
24 A. Yes.
25 Q. Would there be an anaesthetist?

1 A. No, the anaesthetist -- the trainee anaesthetists did
2 not have specific duties in ICU. The nursing staff and
3 the resident paediatrician could call on them in an
4 emergency or, if there was some particular anaesthetic
5 advice or issue required, they might give the
6 anaesthetist, the trainee anaesthetist, a call to
7 troubleshoot some problem with equipment or ventilators
8 or monitoring.
9 Q. What you go on to say is that -- this is in your
10 statement. In fairness to you I will pull it up,
11 115-027-001. You say that you recall receiving
12 a telephone call from the Erne Hospital about Lucy. The
13 telephone call was from Dr O'Donohoe. You agreed to
14 Lucy being transferred to the Children's Hospital.
15 Is that the first contact that you had had about the
16 prospect of Lucy being transferred?
17 A. The telephone call from Dr O'Donohoe?
18 Q. Yes.
19 A. I think it was. There are two ways -- there's two
20 possible ways. The registrar may have rung me about the
21 case and then said, "Dr O'Donohoe is going to ring you",
22 or else Dr O'Donohoe may have been given my number by
23 the registrar and he rang me directly.
24 Q. I don't know if you were here for Dr Stewart's evidence
25 yesterday --

1 A. Yes.
2 Q. Dr Stewart -- it's not just in her evidence, it's in her
3 PSNI statement. The reference for it is 115-022-001.
4 She says that:
5 "[She] was on call in the early hours of that
6 morning and that she accepted by telephone her transfer
7 from the Erne Hospital around 6 o'clock in the morning."
8 In her evidence she said that what would happen
9 is -- and what did happen is -- that she received
10 a phone call and she contacted you. I believe that was
11 her evidence, to tell you about that, and she gave you
12 some brief details about it.
13 So if that's correct and you've said that sometimes
14 it does happen like that, does that mean when
15 Dr O'Donohoe called you, that wasn't the first you were
16 hearing about Lucy and you were aware that there was
17 a child in a very sick condition that you were going to
18 hear about, if I can put it that way?
19 A. If that premise was the actual case, I personally don't
20 remember the call from Dr Stewart. It's the call from
21 Dr O'Donohoe is the call I remember, but I'm not
22 disputing -- what she describes there is very standard
23 routine practice.
24 Q. Yes. You say that you didn't make a note of the call
25 and that you don't actually remember it with certainty,

1 but you think -- and this is in your second statement at
2 302/1, page 7:
3 "I believe it was a critically-ill child who had
4 developed seizures, may have had fixed and dilated
5 pupils, and an anaesthetist was planning to intubate the
6 child or had already done so. I believed I would have
7 advised the administration of mannitol if this had not
8 already been given."
9 What would you have been wanting to know about the
10 child before she came?
11 A. I got all the information I needed from that phone call
12 because the scenario was an emergency one.
13 Q. Yes.
14 A. And it was happening in real time, so things had to be
15 done quickly, and I prioritised the -- I had to satisfy
16 myself that appropriate steps were being taken to
17 prevent any further deterioration in the child. So
18 that's what was the general discussion about her
19 management.
20 Q. In fairness to you in your earlier -- I think you see it
21 there in the PSNI statement, you say that:
22 "It was [your] recollection that there was a general
23 discussion about treatment and the type of fluid she
24 received, which [you] thought was a dextrose-based
25 solution, but [you] don't remember whether he told [you]

1 about volumes."
2 The dextrose-based solution, what would that have
3 connoted to you? If he had said that, would that have
4 meant Solution No. 18 or something else?
5 A. It could have been dextrose 5 per cent, it could have
6 been saline 0.45 per cent, dextrose 2.5 per cent.
7 Q. Why were you wanting to suggest that the child be given
8 mannitol?
9 A. In the scenario that I believed I was dealing with,
10 a child who had a seizure and now had fixed dilated
11 pupils, in my experience that means that the brain is at
12 risk from cerebral oedema and, as a generic response to
13 treating brain oedema, I wanted to ensure that the child
14 received mannitol promptly to reduce the swelling inside
15 the brain.
16 Q. The information that the inquiry received about the use
17 of mannitol is that it's an osmotic diuretic and it's
18 a solution which is designed to provoke a rapid
19 excretion of free water through the kidneys when given
20 intravenously and it's part of the emergency treatment
21 of cerebral oedema and raised intracranial pressure;
22 would you agree with that?
23 A. Yes.
24 Q. So you were thinking we might be dealing with cerebral
25 oedema here?

1 A. Yes.
2 Q. And there's a number of ways in which you could be
3 dealing with cerebral oedema.
4 A. Yes.
5 Q. One of the ways in which you could be dealing with
6 cerebral oedema is something to do with her fluids --
7 A. Yes.
8 Q. -- but you wouldn't necessarily know that at that stage.
9 A. Yes.
10 Q. When you went on to answer questions from us in relation
11 to your second witness statement, you said:
12 "My priority during this telephone call [this is at
13 302/1, page 7] would have been to ensure that all
14 available measures were being taken to treat a potential
15 brain injury by protecting the brain if possible from
16 any further insult. This approach applied to any
17 scenario in which there was actual or potential brain
18 injury."
19 If that's what you were trying to do, if she had
20 a cerebral oedema and that is what was causing the
21 raised intracranial pressure, that was what had caused
22 the fit and what had led to her fixed and dilated
23 pupils, if that's what you were dealing with --
24 A. Well --
25 Q. You might not have known her pupils were fixed and

1 dilated.
2 A. I think I recall they may have been fixed and dilated --
3 Q. Yes.
4 A. -- and the other sentinel event was the seizure. So
5 something caused the seizure. That could have led to
6 cerebral oedema in its own right.
7 Q. What I was asking you is: you've got cerebral oedema was
8 a potential. You've got a phone call, you're trying to
9 work out a number of different things that might be
10 happening and give some guidance before the child is
11 brought to the Children's Hospital to, so far as
12 possible, protect the child's brain before you and your
13 colleagues have an opportunity to see what's happening
14 and see what can be done to reverse the situation, if
15 that is possible.
16 So if that's where you're at and you've got cerebral
17 oedema as a potential issue for you, do you not want to
18 know, just as part of the routine things you might want
19 to know, "What is she on in terms of her fluids?" You
20 know she's on some fluids and if those fluids were
21 low-sodium fluids and you were thinking along the lines
22 of a potential cerebral oedema, that would not be
23 helpful or might not be helpful.
24 A. I suppose -- going back to the seizure, I was concerned
25 about the child -- something precipitated the seizure,

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

1 period of time?
2 A. That's what I think I did.
3 Q. Yes, but is not a very basic thing to ask: what are her
4 fluids?
5 MR McALINDEN: Mr Chairman --
6 THE CHAIRMAN: We're outside the remit here,
7 Ms Anyadike-Danes.
8 MR McALINDEN: I would submit it's clearly a clinical issue.
9 THE CHAIRMAN: It's a clinical issue. This isn't the
10 aftermath of Lucy's death. You're asking the doctor
11 about the treatment that he might have directed to give
12 to Lucy before her death, and that's outside the remit.
13 MS ANYADIKE-DANES: Yes, it is put in that way. What I was
14 actually trying to establish --
15 THE CHAIRMAN: I'm sorry. The questioning was significantly
16 outside the remit, I'm afraid.
17 MS ANYADIKE-DANES: Yes, Mr Chairman, I understand that. If
18 I may just explain what I was trying to establish.
19 If he knew what the fluids were, then that becomes
20 an issue as to what the Royal might have known and when
21 they received her notes and how they treated her, what
22 the Royal might have been concluding about what was
23 wrong with her. Because that's the aftermath.
24 THE CHAIRMAN: I'm afraid that is markedly different from
25 the question you asked.

1 MS ANYADIKE-DANES: That's why I have apologised for the way
2 I framed the question.
3 What I'm trying to find out, doctor, and one of the
4 reasons for putting it that way is because you couldn't
5 clearly remember, so I was approaching it, badly, from
6 trying to see, even if you can't actually remember, what
7 might you have wanted to do to try and get a handle on
8 the likelihood of you knowing what her fluid regime was
9 or any prospect of knowing that? So that is why I was
10 phrasing it as to, "What would you have wanted to
11 know?", and I apologise for doing it rather badly.
12 But in any event, can you help us with this: so far
13 as you're concerned, is it possible that you were told
14 what her fluid regime was?
15 A. It is possible, yes.
16 Q. Thank you. And if you had been told what her fluid
17 regime was, is that part of what would start to work
18 with you, and when you communicated it to your
19 colleagues, as to what the problem might be?
20 A. Yes.
21 Q. Thank you. You knew that Lucy, at that time, was being
22 treated or being assisted by an anaesthetist --
23 A. Yes.
24 Q. -- and you were talking to her consultant paediatrician?
25 A. Yes.

1 Q. You're an anaesthetist. Did it ever occur to you or do
2 you think it would have been a prudent step, even
3 subsequently, for any of the anaesthetists who were
4 treating her when she actually arrived to talk to that
5 anaesthetist?
6 A. By telephone?
7 Q. Yes.
8 A. Not necessarily, no.
9 Q. Well, the reason I ask that is because some of the
10 clinicians who saw Lucy have been unclear about elements
11 of her treatment at the Erne and the significance of
12 some of that treatment. And you have there an
13 anaesthetist who, of the disciplines that were treating
14 her, one of the disciplines that knows about fluids and
15 fluid regime and their impact. And that is why I was
16 asking you if there was any concern about what the fluid
17 regime had been or any lack of clarity about it
18 in relation to her notes, whether it wouldn't have been
19 appropriate to have contacted the anaesthetists at the
20 Erne.
21 A. It wouldn't have been inappropriate, if I can answer it
22 that way.
23 Q. Would that not have been a simple thing to do?
24 A. Yes, it could have been considered.
25 Q. Did you know that the anaesthetists had actually

1 contacted the Children's Hospital?
2 A. Yes, I did, yes.
3 Q. So if he's doing that and, according to the note, and
4 although he doesn't remember that part of it, he's not
5 going to differ from Dr McLoughlin who records it, he
6 contacted the Royal or the Children's Hospital to tell
7 them the results of the second serum sodium test that
8 had been done. So if he's being prepared to engage, if
9 I can put it that way, with the Children's Hospital
10 in relation to some element of what had happened to Lucy
11 at the Erne, would that not have been appropriate to
12 have taken that opportunity to have found out more about
13 what happened there?
14 A. It was certainly an opportunity.
15 Q. Do you think it should have been taken?
16 A. It would depend what particular knowledge deficit you
17 were trying to address. Yes, if there was a knowledge
18 deficit, if there were questions to be asked and you
19 come up against a brick wall, then yes, it would be
20 entirely reasonable to contact the anaesthetist.
21 Q. Let me put it this way: you were there when Lucy
22 arrived --
23 A. Yes.
24 Q. -- and you spoke to Dr O'Donohoe?
25 A. Yes.

1 Q. And he had with him her transfer letter?
2 A. Yes.
3 Q. And there was also a transfer form. Well, let me show
4 it to you just in case. The transfer form can be found
5 at 061-015-040 and if we pull up alongside it
6 061-016-041. That's a Western Health and Social
7 Services Board standard patient transfer form and that's
8 what was completed for Lucy. Do you recognise that?
9 A. I cannot ... I have possibly vague memories of seeing
10 the list of blood pressure readings and heart rates and
11 saturations at the time.
12 Q. Well, this is a form that goes to you, or does this
13 go -- who else would it go to?
14 A. It would go to the clinical team, the clinical team.
15 Q. And you, at that stage, were the lead consultant in
16 anaesthesia at PICU when she came in. In fact, you were
17 the only consultant in anaesthesia in PICU when she came
18 in.
19 A. Yes. So yes -- and as I say, I have a faint memory that
20 I recall noting that the observations had been done
21 in the ambulance. I think the patient had deteriorated,
22 I think, and during the journey -- I recall that. When
23 she arrived with me, I had concerns about her clinical
24 condition. She was unstable.
25 Q. What do you mean by that, Dr McKaigue?

1 A. What do you mean, concerns about her --
2 Q. No, you said you regarded her as being unstable. What
3 does that mean? Clinically I mean.
4 A. She -- her blood pressure and heart rate were giving me
5 cause for concern. That's what I mean.
6 Q. When you saw her and had an opportunity to observe her,
7 what was your view at that time as to the chances of
8 being able to reverse her condition?
9 A. I felt they were very, very bleak.
10 Q. Did you think realistically there was any prospect of
11 doing that?
12 A. Realistically, no.
13 Q. Thank you. So you got that, but maybe the document that
14 you'd have paid even more attention to is the transfer
15 letter. If we pull up the two pages of that,
16 061-014-038 and 039 next to it. What is the information
17 that you would have wanted to have on the transfer
18 letter?
19 THE CHAIRMAN: Instead of going through what's on the
20 transfer letter, is there information which wasn't on
21 the transfer letter that you would have expected to have
22 seen?
23 A. I'm not even so sure I actually read that transfer
24 letter at the time. I had a very --
25 THE CHAIRMAN: What, because you had Dr O'Donohoe with you?

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

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

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

1 wanted some explanation for why that was her fluid
2 regime?
3 A. Well, I would have wanted to really sit down and go
4 through all the information I had and try and work out
5 what's going on here, a sequence of events,
6 a differential diagnosis, and then look for supporting
7 information. So it wouldn't have been a quick reaction
8 or a quick decision; it would have required some
9 thought.
10 Q. Yes. Well, in terms of --
11 A. And I would have also, while not necessarily doing that
12 myself, then other members of the team could have been
13 doing that.
14 Q. Dr Crean's evidence to the coroner, which we don't need
15 to pull up, but for reference purposes is 013-021-074
16 was:
17 "It would have been important to have had the fluid
18 management record from the Erne Hospital. Lucy had been
19 seen in another hospital and as much information as
20 possible was essential."
21 Then in his witness statement to the inquiry, which
22 we also don't need to pull up, but is 292/1, page 3:
23 "It was and still is usual practice to receive
24 a copy of a patient's notes from the referring hospital
25 when a patient is being transferred. A copy of the

1 notes can usually be faxed to PICU."
2 Would you agree with that?
3 A. Yes. The relevant section from -- the relevant section
4 from the patient notes, because some of these patients,
5 would be impossible to, you know, meet that requirement.
6 THE CHAIRMAN: You mean because they have a long,
7 complicated history?
8 A. Yes.
9 THE CHAIRMAN: In a case such as Lucy's, which almost had no
10 history at all, then in those circumstances it should be
11 very simple to provide the notes or copy notes,
12 shouldn't it?
13 A. Yes.
14 MS ANYADIKE-DANES: Would you have expected to have got the
15 notes not just from the ward but also from the intensive
16 care unit? So the most recent notes from her stay
17 in the Erne.
18 A. Yes, that's also correct.
19 Q. And do you say that because it's just logical, it makes
20 sense, or because that was pretty much established
21 practice, that's what people did when they transferred
22 very sick patients?
23 A. Well, it's logical and it makes sense. It's always nice
24 to know, as an anaesthetist, what the other anaesthetist
25 has been doing vis-a-vis drugs and the size of the tube

1 and what position the tube has been taped in and the
2 chest X-ray of the tube in place. So these are the
3 ideals.
4 Q. Going back to 2000 when this happened, in your
5 experience how common was it to receive a child like
6 Lucy who came with absolutely no notes at all?
7 A. I would have to say that sometimes ... I mean, I would
8 say the norm was usually adequate, we usually were
9 reasonably satisfied with the documentation that
10 arrived. If we hadn't, we would have contacted the
11 hospital.
12 Q. Yes.
13 A. But I can't say that there were never any situations
14 where documentation was lacking because that's the
15 system we work in. There are always transfer materials
16 which is just not really adequate.
17 Q. But you, I think, were being contacted in the relatively
18 early morning. She leaves at 6 o'clock, she gets to
19 you -- not you personally, but to PICU -- at about 7.45
20 or thereabouts, 8 o'clock. In your view, given that
21 sort of time lag, would you have expected the relevant
22 portions of her notes to have, if they didn't accompany
23 her, to be faxed over?
24 A. Yes.
25 Q. Thank you. So then, I think from how you answered my

1 questions and the chairman's, it doesn't seem that you
2 had very much time to really have a discussion with
3 Dr O'Donohoe as to what had happened in relation to
4 Lucy?
5 A. No.
6 Q. Would that be fair?
7 A. Yes.
8 Q. If you had had more time, would you have wanted to
9 discuss what had happened at the Erne in relation to
10 Lucy?
11 A. Yes, that would have been part of the information
12 gathering exercise, to hear particular consultants'
13 views. It's just more knowledge, more information.
14 MS ANYADIKE-DANES: Yes. Mr Chairman, I'm being asked if we
15 could have a break.
16 THE CHAIRMAN: Yes. Let me take one point before we break.
17 Did I understand you to say that you were here
18 yesterday?
19 A. I was here yesterday, yes.
20 THE CHAIRMAN: At the end of Dr Stewart's evidence, she was
21 asked about what the point was of transferring Lucy from
22 the Erne to the Royal.
23 A. Yes.
24 THE CHAIRMAN: You have said that, realistically, she didn't
25 have any prospects of surviving.

1 A. Yes.
2 THE CHAIRMAN: In your eyes, what was the point of
3 transferring her from the Erne?
4 A. Well, whenever a child collapses -- a sudden collapse is
5 an extremely distressing thing for the parents and for
6 the staff. If there's still life -- so there's
7 a collapse and most doctors will recognise a sudden
8 collapse producing fixed dilated pupils is a very bad
9 prognosis, so in their heart of hearts they know that
10 there's nothing more that can be done locally for the
11 child.
12 But it's a very big decision for somebody to take,
13 being mindful of the fact that they don't necessarily
14 know all the information. So for somebody to say,
15 "There you go, sudden collapse, fixed dilated pupils,
16 let's take the patient, let's extubate the patient", and
17 let them die from the parents' point of view. That's
18 a very big step to take. Because always at the back of
19 your mind you're going to ask yourself, "Have I always
20 absolutely got this right?" It's not a thing that
21 should be rushed into.
22 We're then moving into the situation where, with
23 Lucy, she was effectively brainstem dead, but she was
24 extremely unstable because the autonomic nervous system
25 is impaired so heart rate and blood pressure become very

1 unstable, so you then have to step in and support the
2 circulation. To do that in a very small child you need
3 advanced paediatric anaesthetic skills, and the only
4 place you get those is in Belfast. So if you want to
5 give adrenaline or dopamine through a central line to
6 a collapsed child, that's best done in Belfast.
7 From the parents' point of view, the whole thing has
8 been devastating and they almost -- it helps that they
9 have time to come to terms with what has happened, they
10 have time to be counselled and come to terms. Once we
11 get the patient to Belfast, we have to -- before you can
12 actually do brainstem death testing, you have to really
13 understand what exactly has happened before you can do
14 brainstem death testing, and that requires a diagnostic
15 element and CT scans and further experience from other
16 specialists. And then, finally, if brainstem tests are
17 done and the patient is declared brainstem dead, there
18 is the issue of organ donation, potential organ
19 donation, so again that is all best managed in Belfast.
20 That is why all these patients come to Belfast.
21 THE CHAIRMAN: Is there also another element, which
22 Dr Stewart said, which is the transfer helps to find out
23 why the child has died in the first place?
24 A. Yes, I think I mentioned that.
25 THE CHAIRMAN: Sorry, that's understanding what happened?

1 A. Yes.
2 THE CHAIRMAN: Thank you.
3 MS ANYADIKE-DANES: In fact, the way that I had posed it to
4 Dr Stewart was on the one hand it's a possibility that
5 there could be some treatment that could reverse, in
6 some part, the condition. On the other hand, there's
7 a recognition that that's unlikely and, if you're going
8 to be in that course, then the child needs to be
9 stabilised, brainstem death tests need to be carried
10 out, CT scans performed and so on, all to do the very
11 thing that you had suggested.
12 So I had put to her, which did she think was more
13 likely. Did she think that a child in that condition
14 would be being moved or transferred for the former or
15 the latter? And she was thinking in those circumstances
16 it was really the latter.
17 A. The latter being?
18 Q. That you recognise that the child is probably
19 irretrievable, but nonetheless there are procedures that
20 have to be carried out, investigations that have to be
21 done, so that you can bring the child to a condition
22 whereby you can carry out the brainstem tests and
23 certify what has to be certified and so forth. My
24 understanding of your evidence is that you suspected it
25 was more the latter reason, that a child like Lucy would

1 be being transferred.
2 A. Yes.
3 Q. Just finally, the question that I went on to put to her
4 is that if you've recognised that from the transferring
5 hospital -- because she's at a hospital now as
6 a consultant where she transfers children -- what is it
7 that you are telling the parents about the purpose of
8 the trip to the Children's Hospital?
9 A. Your question is what I think the referring hospital
10 should be telling the parents?
11 Q. Yes, in those circumstances.
12 A. I think you have to be honest with them about the
13 prognosis, but you can't really take away a child's
14 hope -- sorry, a parent's hope.
15 MS ANYADIKE-DANES: Thank you very much.
16 THE CHAIRMAN: We'll take a 15-minute break, doctor. 12.15.
17 Thank you.
18 (12.00 pm)
19 (A short break)
20 (12.15 pm)
21 MS ANYADIKE-DANES: Dr McKaigue, you said just when I was
22 asking you some questions a little while ago that you
23 really didn't see Lucy for very long, you were called
24 away, and you handed over to Dr Chisakuta.
25 A. Yes.

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

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

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

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

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

1 answer to question 2, he says:
2 "It was not clear to me that I was the responsible
3 consultant and I may have believed that I was only
4 involved in a consultative role."
5 And he doesn't recall formally assuming
6 responsibility. That issue of formally assuming
7 responsibility is one which I think the chairman just
8 alluded to earlier, which is an issue that arose in
9 Claire's case as between Dr Webb and Dr Steen.
10 Dr Webb's position was: I was providing specialist
11 input and advice and care; I had not assumed
12 responsibility for that child. And ultimately Dr Steen
13 conceded that, that it had not been transferred, and she
14 accepted, almost using Dr Hanrahan's words, in
15 the transcript of 15 October 2012 at page 94:
16 "Until it's formally taken over and there's a formal
17 transfer and Dr Webb and I discuss it, I remain the
18 named consultant."
19 She was on the flimsy.
20 Then when we asked the inquiry's expert Dr MacFaul
21 about that, still in Claire's case, in his report,
22 238-002-106, paragraph 441:
23 "A consultant takes responsibility for all patients
24 admitted under their care, either by planned or acute
25 admission and then responsibility for continuing care of

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

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

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

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

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

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

1 treatment which Lucy had received in the Erne was
2 problematic.
3 When you spoke to anybody on that day, later on on
4 the Thursday, did you, in whatever terms you heard that,
5 did you hear that?
6 A. No.
7 THE CHAIRMAN: Right.
8 MS ANYADIKE-DANES: You're right, you did make an entry,
9 it's timed at 13.40, 061-018-064. It comes immediately
10 after quite a lengthy entry by Dr Hanrahan, who Dr Crean
11 specifically asked to come and examine her from
12 a neurological point of view, if I can put it that way.
13 That, in turn, follows quite a long summary of her
14 condition as she arrived, which is entered by
15 Dr McLoughlin. She also enters the sodium results of
16 127 that weren't on that transfer letter.
17 By this time, 1.40, the notes from the Erne have
18 been faxed and they're there, so what's available, if
19 you're looking to try and see for yourself a little bit
20 more about her, there's those entries since she's been
21 admitted, and then there are her Erne notes and the
22 transfer letter itself, of course.
23 So if you're looking ahead of where you've made your
24 entry, what did you understand from those notes as to
25 what had happened to Lucy?

1 A. Well, I don't recall seeing the Erne notes. I would
2 have read through Dr Hanrahan's note and I would have --
3 I noted that the sodium was 127. That was one of the
4 first entries, I think, in her ...
5 Q. Dr Hanrahan or Dr McLoughlin?
6 A. No, the telephone result.
7 Q. That's the telephone result at 9 o'clock by
8 Dr McLoughlin; you'd have noted that?
9 A. I believe I would have read through the notes which
10 began by -- which were begun by Dr McLoughlin.
11 Q. We can pull that up just to familiarise yourself with
12 them. It's 061-018-058. Those notes, you mean,
13 starting like that?
14 A. Yes.
15 Q. And she goes on. We can pull these up side by side so
16 that you have an opportunity to look through them
17 quickly. 061-018-059. In fact, you will see there, if
18 you were looking at that, the final line is:
19 "Erne notes requested for further information."
20 So if you read that, would you want to know, "Have
21 we got them yet, what do they show?"
22 A. Whenever I was reading the notes, I would have been
23 scanning them quite quickly. I suspect I was by that
24 stage ... I can't say that I took on board every point
25 in the note.

1 Q. No, but you would see -- if you'd scanned just from
2 there forward, you would see that you didn't have the
3 Erne notes at that section. And since you had earlier,
4 when I was asking you, expressed agreement with Dr Crean
5 that you would want to see those notes, that that would
6 be important. If you're trying to see what had happened
7 to Lucy as you come now to make your entry, don't you
8 wonder, "Where are the notes from the referring
9 hospital? I don't see them".
10 A. I may well have wondered that. All I can say is I don't
11 recall seeing the Erne notes. And at that stage, I was
12 really -- my intention at that stage was to document my
13 own note and I can't say that I read through in a lot of
14 detail and gave a lot of thought to those entries.
15 Q. But aren't you interested to know why Lucy arrived
16 in that condition?
17 A. I would have been interested, but there was no ...
18 I don't think anybody had the answers at that stage.
19 Q. No, but I'm trying to see what you might have read so
20 that you could have tried to get some of your own
21 answers or at least ask anybody what their answers were.
22 A. Well, I didn't read through the notes with any great
23 detail or particular thought, that would be my
24 recollection. My frame of mind then, I had sort of been
25 involved in another resuscitation and I suppose there

1 were other -- possibly other things on my mind. But
2 I did not get into, you know, a sort of detailed
3 analysis of these notes.
4 Q. A little bit further on in Dr Hanrahan's note,
5 061-018-063, I think you said you did look at
6 Dr Hanrahan's note, his summary right at the top:
7 "Assuming the paralysis has worn off and she has
8 been given no sedation, findings would suggest she shows
9 no sign now of brainstem function."
10 You would have known, because you believed you were
11 told during that first phone call before she even
12 arrived that her pupils were fixed and dilated and
13 they're certainly recorded as fixed and dilated when she
14 arrives in the Children's Hospital so that they have
15 been that way for some number of hours. And what
16 Dr Hanrahan is recording, in his view, is that assuming
17 that her presentation is not affected by medication,
18 she's showing no sign of brainstem function.
19 Then if you look halfway down the page, he has some
20 differential diagnoses, he's not sure, is it infectious,
21 is it haemorrhagic shock, is there something metabolic
22 going on? Then he says:
23 "Cerebral oedema for other cause."
24 And then:
25 "No cause is clinically evident as yet."

1 So what he's indicating there on those notes is he's
2 not entirely sure what's happening, although I think
3 it would seem that he thought that there was cerebral
4 oedema. So those are questions he's posing. Did that
5 not prompt you to want to ask him, almost from
6 a professional point of view, "Where do we think we
7 stand now with this child?"
8 A. Well, I don't recall ever seeing Dr Hanrahan. It was my
9 intention at that stage to make my note in the chart.
10 I had read his notes, there was a list of differential
11 diagnoses.
12 Q. Yes.
13 A. And I thought that there were investigations in process
14 and there may not have been any answers just at that
15 point in time.
16 Q. If I can put it this way: you having finished your shift
17 at 9 o'clock and you have a bit of outstanding business
18 to do, which is you need to write up your note which you
19 couldn't do contemporaneously; did you regard yourself
20 as playing no further role in either Lucy's care or any
21 investigations to find out what had happened?
22 A. At that point in time, yes.
23 Q. So that's it. When you go off shift, then you don't
24 have a role any more or contribute to any discussion as
25 to what might have happened to her?

1 A. You would still have an interest in a patient. You
2 would still want to find out what's happening with
3 a patient or what the cause of the collapse was.
4 Q. And what did you do about that interest that you still
5 had?
6 A. Well, in Lucy's case I didn't pursue it at that time
7 there.
8 Q. When did you?
9 A. The only other time whenever she was in was whenever
10 I had spoken with Dr Chisakuta and found out that she
11 had died.
12 Q. When was that?
13 A. That was, looking back on it, on the Friday.
14 Q. So you had an interest and you then spoke to
15 Dr Chisakuta the following day?
16 A. Well, the following -- I had handed over my care and
17 I think I may have spoken with Dr Chisakuta on the
18 Friday and had found out that she had died and that her
19 death had been referred to the coroner.
20 Q. Since what your interest was was finding out what had
21 happened, was there any discussion between you as to
22 what had happened in his view?
23 A. No, I can't recall the conversation I had with
24 Dr Chisakuta. I just had the -- I knew that she had
25 died and that her case had been referred to the coroner.

1 My impression was that it was not a coroner's case.
2 Q. It wasn't a coroner's case?
3 A. That was the impression I got.
4 Q. Impression from whom?
5 A. Dr Chisakuta.
6 Q. Dr Chisakuta didn't think it was a coroner's case?
7 A. After having a conversation with Dr Chisakuta, I had the
8 impression it wasn't a coroner's case.
9 Q. And why was that?
10 A. Well, I can't remember the conversation. I just had
11 that impression that it was not a coroner's case.
12 THE CHAIRMAN: Sorry, do you know if by that stage the
13 exchange had taken place, which led to it not being
14 a coroner's case?
15 A. No.
16 THE CHAIRMAN: It depends when you spoke to Dr Chisakuta
17 that day because Dr Chisakuta agreed effectively that
18 Lucy's death should be raised with the coroner and
19 learned later that day that there was to be a hospital
20 post-mortem rather than a coroner's post-mortem. So the
21 impression that you got from him may depend on whether
22 you spoke to him after the first stage or the second
23 stage.
24 A. I can't remember that.
25 MS ANYADIKE-DANES: Did you have a view as to whether hers

1 was a case that ought to be reported to the coroner?
2 A. I didn't know anything, I had very limited input into
3 Lucy's care and I had very limited knowledge arising
4 from that, so I did not -- would not have been able to
5 make a judgment on whether she was referred to
6 the coroner.
7 Q. Well, you knew that she had died relatively suddenly
8 in the scheme of things.
9 A. Yes.
10 Q. And if matters had not progressed from the entry that
11 Dr Hanrahan wrote, which precedes yours, which is, "No
12 cause is clinically evident yet"; he has differential
13 diagnoses, but he hasn't got a clear clinical cause. If
14 that had stayed like that, in your view, is that a case
15 that should therefore be reported to the coroner?
16 A. Yes, if you don't know the cause of death then you have
17 to report that case to the coroner.
18 Q. Thank you. So at some stage you learn from Dr Chisakuta
19 that there's not going to be an inquest?
20 A. Yes.
21 Q. Do you learn that there's going to be a hospital
22 post-mortem?
23 A. I can't remember if there was going to be a hospital
24 post-mortem or not.
25 Q. Dr Stewart, who was Dr Hanrahan's registrar, was tasked

1 to complete the autopsy request form. In her evidence
2 to the PSNI, her statement to them, at 115-022-002,
3 says:
4 "I stated on the autopsy form that the clinical
5 diagnosis was dehydration and hyponatraemia, cerebral
6 oedema, acute coning and brain death. This was the
7 working pathogenesis agreed by Dr Hanrahan and the
8 anaesthetists in the absence of a definitive
9 aetiological diagnosis."
10 Then she goes on in her witness statement for the
11 inquiry, 282/1, page 12, because we asked her who she
12 meant by "the anaesthetists", and she says:
13 "The anaesthetists involved in looking after Lucy
14 were Dr McKaigue, Dr Crean and Dr Chisakuta. There may
15 have been others working in PICU who I cannot remember."
16 She indicates, therefore, that you were part of
17 a group who assisted in formulating the working
18 pathogenesis that she would include on that autopsy
19 request form. Can you remember anything like that?
20 A. No.
21 Q. Could it have happened and you just don't remember it?
22 A. I don't think so, because I did not have any, really,
23 knowledge of what was going on with Lucy.
24 THE CHAIRMAN: In essence, doctor, do I understand you to be
25 saying, "I had some initial involvement in Lucy's case,

1 but substantively it was handled by my colleagues rather
2 than by me"?
3 A. Yes.
4 THE CHAIRMAN: And that explains why you don't remember
5 contributing to later discussions about the cause of
6 death or whether it's to be referred to the coroner or
7 referred back to the coroner?
8 A. No.
9 THE CHAIRMAN: Thank you.
10 MS ANYADIKE-DANES: Can you help us with how she could have
11 put you in that category? If we look at the top of
12 this, you can see the question that was put to her:
13 "I stated on the autopsy form that the clinical
14 diagnosis was dehydration and hyponatraemia, cerebral
15 oedema, acute coning and brain death. This was the
16 working pathogenesis agreed by Dr Hanrahan and the
17 anaesthetists."
18 Then the question she's asked is:
19 "Identify the anaesthetists who agreed this working
20 pathogenesis."
21 And then she says:
22 "The anaesthetists involved in looking after Lucy
23 were ..."
24 And she names you there. It may be that she's not
25 answered the question, she's just listed you as the

1 anaesthetist who, as far as she was concerned, were
2 involved in looking after Lucy or she may mean by that
3 you were one of those who assisted in formulating the
4 working pathogenesis. But in any event, are you saying
5 that you don't remember doing that and you don't think
6 it's likely that you did?
7 A. Yes.
8 Q. Did you get to see Lucy's notes in more detail at any
9 stage since or have you at any stage since?
10 A. Well, I've seen her notes on the inquiry website.
11 Q. Yes. Have you seen her notes at any stage after you had
12 your discussion with Dr Chisakuta? Or was the last time
13 you saw her notes before you saw them on the website
14 when you made your own entry?
15 A. The last time I saw her notes was whenever I made my
16 entry.
17 Q. And you didn't see them again until you saw them on the
18 inquiry website; is that correct?
19 A. Yes.
20 THE CHAIRMAN: Would you not have seen them when you were
21 asked to make a police statement? Would you not have
22 checked them at the time you were asked to make a police
23 statement just to refresh your memory? You gave your
24 police statement in March 2005, which was almost five
25 years after the event. I'm not trying to trip you up,

1 but I would have thought that before you made a police
2 statement that you might have looked over the notes.
3 A. That's a point, yes. I hadn't thought of that.
4 THE CHAIRMAN: In any event, that's after what actually
5 happened to Lucy has been revealed.
6 A. Yes.
7 THE CHAIRMAN: And after the documentary has been broadcast.
8 Thank you.
9 MS ANYADIKE-DANES: Even if you didn't see them at any time
10 after your direct involvement with her and the entry in
11 her notes, did you know what the clinicians thought were
12 the clinical problems, if I can put it that way?
13 A. No.
14 Q. Let's just be clear. If we look at the relevant page of
15 the autopsy request form, it's 061-022-075. Up at the
16 top is what has been identified as the clinical
17 problems. I think Dr Stewart conceded that she wasn't
18 actually putting them in the order of importance; she
19 was putting them in the order in which they would have
20 occurred, if I can put it that way. So the child starts
21 off with vomiting and diarrhoea, she becomes dehydrated,
22 then I think she conceded there's probably a gap there.
23 Something else happens, as a result of which she becomes
24 hyponatraemic. She then has a seizure and becomes
25 unresponsive, leading to brainstem death. Had you had

1 any discussion or formed any view about those clinical
2 problems in relation to Lucy?
3 A. What was the question? The question being?
4 Q. Had you had any discussion with anyone about those being
5 the clinical problems? Did you yourself have any view
6 as to the extent to which those were the clinical
7 problems involved with Lucy?
8 A. At what time -- what time is this?
9 Q. At the time you last made your entry and were discussing
10 with Dr Chisakuta. You make your entry on the Thursday,
11 you have a discussion with him the following day. That
12 seems to be, from what you said, more or less it so far
13 as your involvement with Lucy. So I'm asking you, at
14 that stage, had there been any discussion that you were
15 aware of as to these being the clinical problems or did
16 you yourself form a view that these might be the
17 clinical problems?
18 A. I didn't have a discussion with anybody about those
19 clinical problems and I hadn't formulated in my own --
20 I knew there was a number of clinical problems, but
21 I hadn't formulated anything or constructed anything out
22 of what I knew her clinical problems were.
23 Q. Did you have any thought that she had suffered vomiting
24 and diarrhoea?
25 A. Yes, I had a thought, yes.

1 Q. Because you pointed out the 127 serum sodium result, so
2 had you any thought that maybe as a result of that
3 vomiting and diarrhoea she had become dehydrated?
4 A. The dehydration, yes, would have been a feature of
5 vomiting and diarrhoea.
6 Q. Yes. Even if you hadn't looked at it at the time he
7 handed you the transfer letter, it at least says that,
8 "Slow capillary refill greater than 2 seconds".
9 A. Yes.
10 Q. So there's some suggestion of dehydration and she's on
11 IV fluids. Had you any thought then, when you saw the
12 result of 127, she's become a bit hyponatraemic?
13 A. I can't remember my thoughts, crystal clear thoughts
14 at the time, but the hyponatraemia was in keeping with
15 diarrhoea.
16 Q. Yes. And a serum sodium level of 127 is to be
17 hyponatraemic.
18 A. Yes.
19 Q. We'll get into an issue as to the degrees of
20 hyponatraemia and its implications and consequences, but
21 that is to be hyponatraemic.
22 A. Yes.
23 Q. And if you'd even the most cursory glance at the
24 information that she came with, or even Dr McLoughlin's
25 notes, would have let you know that she was 137 when she

1 was admitted, so she's dropped 10 millimoles.
2 A. Yes.
3 Q. And you had thought when you first received the
4 telephone call that you might be dealing with a child
5 who had cerebral oedema.
6 A. Yes.
7 Q. So if you had wanted to know what had happened to Lucy,
8 which you told the chairman you did want to know, you
9 had some pointers there that might have started at least
10 some enquiry with your colleagues who were treating her
11 as to what they made of these things. Dr Chisakuta most
12 obviously because you'd transferred your management to
13 him and he had been looking after her on the 14th.
14 A. I don't recall the conversation I had with Dr Chisakuta.
15 All I can recall is what I had learned from it, that her
16 death had been reported to the coroner and that -- I was
17 under the impression that there wasn't an inquest, so I
18 had -- I didn't ... I don't recall raising these issues
19 with Dr Chisakuta. I can't remember the conversation.
20 Q. Wouldn't that be even more the reason because that would
21 mean that you're not going to find out, whatever was
22 Lucy's problem, through an inquest? What I'm really
23 trying to explore with you is why just at the level of
24 professional interest or curiosity, almost, you weren't
25 asking Dr Chisakuta, who looked after her that second

1 day when she then died, exchanging a view with him as to
2 what he thought was the problem.
3 A. Well, I don't recall doing that.
4 Q. In your first witness statement for the inquiry, 302/1,
5 page 9, you say:
6 "There were discussions between myself and my
7 anaesthetic colleagues about Lucy's death, but I cannot
8 recall discussions about her cause of death."
9 If we pause there for the minute, the question
10 of course is:
11 "Was Lucy's death and/or the cause of her death the
12 subject of discussions between you and your medical
13 colleagues in the Children's Hospital?"
14 If we just pause there. Your answer is:
15 "There were discussions."
16 So in answer to the first bit:
17 "Yes, there were, but [you] can't recall any
18 discussions about her cause of death."
19 So what are the discussions you think you did have
20 with your discussions and who are the colleagues?
21 A. I have no recollection of the discussions with
22 Dr Chisakuta. With Dr Crean -- this is like discussions
23 going on possibly for, you know, over the years and
24 following since the inquiry was set up. So there would
25 have been discussions with Dr Crean then.

1 Dr Chisakuta -- I had a conversation with
2 Dr Chisakuta and I was told that Lucy had died and her
3 death had been referred to the coroner. That was the
4 conversation I had with Dr Chisakuta.
5 Q. What it says below, it says, "See 11(i)":
6 "I had discussions with Dr Crean and Dr Chisakuta.
7 I was aware that Lucy had hyponatraemia, she died, and
8 that would of itself have been mentioned."
9 What do you mean there exactly?
10 A. Well, that, I think, referred to discussions with
11 Dr Crean.
12 Q. Are these still discussions that you say happened much
13 later on, not at the time?
14 A. Yes.
15 THE CHAIRMAN: Can I ask you this: long before the inquiry
16 was set up, there was a belated inquest into Lucy's
17 death; isn't that right? In fact, it was one of the
18 points of the documentary in October 2004 that Lucy's
19 death had been missed, to put it neutrally, and that it
20 was only after Raychel's inquest that Stanley Millar and
21 the Western Council had picked up a similarity between
22 the cases. When that happened and when Lucy's death was
23 then made the subject of a coroner's hearing, that must
24 have been an embarrassment within the Royal, I suggest.
25 A. I just didn't catch the last bit of that.

1 THE CHAIRMAN: I suggested that must have been an
2 embarrassment within the Children's Hospital because the
3 outcome of the inquest was to change fundamentally the
4 reasons which had been given from the
5 Children's Hospital for Lucy's death. There surely must
6 have been significant discussions in the run-up to
7 Lucy's inquest about how things had gone wrong in the
8 Royal, not in the sense of the treatment of Lucy, but in
9 the sense of not recognising or making known the real
10 cause of her death.
11 A. I am not aware of discussions with that theme, the
12 second theme. But the first theme, I said that I became
13 aware from Dr Crean there were issues around Lucy's
14 fluid management, and I think that was in the run-up to
15 the inquest.
16 THE CHAIRMAN: Well, maybe you'll correct me. It seems to
17 me from the outside that it should have been a cause of
18 some embarrassment to the Children's Hospital when
19 the coroner did call an inquest into Lucy's death and he
20 will have seen the death certificate, which
21 Ms Anyadike-Danes is going to go on to in a few moments,
22 and the information which was available to the Royal in
23 2000 to suggest what Dr Chisakuta and Dr Stewart told me
24 yesterday, namely that there were big issues about fluid
25 management. Was that not an embarrassment within the

1 Children's Hospital in 2002/2003?
2 A. From outside looking in, yes. Inside, I don't recall
3 that being discussed as an embarrassment.
4 THE CHAIRMAN: Did somebody even say, "How on earth did we
5 miss that"?
6 A. Not that I'm aware of.
7 MS ANYADIKE-DANES: Do you think it was missed? It was
8 there to be seen but was missed.
9 A. I'm -- speaking retrospectively?
10 Q. Yes.
11 A. I think I have the benefit of the inquest and all the
12 expert reports to --
13 Q. No, please don't use that benefit.
14 Since you have looked at Lucy's notes, which you say
15 you have had access to because they're on the website,
16 so you have seen the notes that came from the Erne, you
17 did read some part of the notes before your own that
18 were recorded in PICU and you'll have seen the notes
19 subsequent to your own. In the light of all of that,
20 do you not think that there are issues there that could
21 have pointed to the concerns about Lucy's fluid
22 management that seemed to have been missed?
23 A. My thoughts on the fluid balance chart are that it's
24 difficult to say how much fluid Lucy actually got.
25 I mean, I haven't gone -- I haven't studied it in a lot

1 of detail, but I've picked up from experts that that was
2 part of the problem, the record keeping was unclear.
3 Q. Dr McKaigue, you don't have to pick up from the experts
4 the fact that it is recorded in her notes that she
5 received 100 ml an hour of No. 18 Solution. I mean, you
6 don't need an expert report to tell you that. That much
7 of it is clear. She was getting that rate from about
8 10.30 or 11 o'clock at night and, by 3 o'clock, she has
9 had a fatal collapse. You, as a consultant paediatric
10 anaesthetist, could work out what her appropriate
11 maintenance rate of fluid should be and, if she was
12 a bit dehydrated, which there are indications of on her
13 notes, then you could work out, given a certain level of
14 dehydration -- possibly mild, maybe moderate -- what the
15 replacement should be. And having worked that out, you
16 could compare that with what is recorded on her notes.
17 You don't need an expert to tell you that; that is
18 exactly what you would have had to be doing if you had
19 not been called away and her notes had accompanied her.
20 You'd have to be interpreting those notes and
21 formulating a plan.
22 A. I thought I was commenting on events after --
23 Q. No, what I was inviting you to do is to consider whether
24 or not the problem with Lucy in terms of her fluid
25 management regime at the Erne was missed at PICU.

1 That's what I was inviting you to consider.
2 So I was taking you to some of the elements that
3 were in her notes and asking you whether there wasn't
4 enough there for the four consultants who saw her one
5 way or the other to have figured out there was a problem
6 with her fluid management?
7 THE CHAIRMAN: Sorry, I've contributed to this line of
8 questioning and I think it's probably not productive
9 because the reality of yesterday's evidence is that it
10 wasn't missed at all.
11 The fact is, on yesterday's clear evidence to this
12 inquiry, the fluid management problems were not missed
13 within the Royal. They were identified and a decision
14 was taken to keep quiet about them.
15 Let's move on. To be fair to Dr McKaigue, his role
16 in that was, if he had a role at all, is significantly
17 less than the role of the other doctors.
18 MS ANYADIKE-DANES: Yes, Mr Chairman.
19 THE CHAIRMAN: That's why I started this morning by asking
20 for the Belfast Trust, as successor to the Royal Trust,
21 to consider the evidence it was going to present to the
22 inquiry.
23 MS ANYADIKE-DANES: I would like to show you the medical
24 certificate that was issued. This is the medical
25 certificate that was ultimately issued for Lucy. As

1 you know, she hadn't had an inquest, she had a hospital
2 post-mortem, and after that this certificate was
3 produced. Can you help us with whether you think it
4 makes sense?
5 A. On the face of it, dehydration -- and this is -- I'm
6 interpreting this now with the knowledge I've acquired
7 subsequent to Lucy's death.
8 Q. Sorry? Are you meaning that you needed knowledge
9 subsequent to Lucy's death to know whether there is any
10 difficulty in having dehydration cause cerebral oedema?
11 A. Well, as I said previously, I knew of specific diagnoses
12 in Lucy's case, but I hadn't formulated -- I didn't know
13 enough about her to formulate something.
14 Q. That's not the question. If you look at that death
15 certificate:
16 "Cause of death [first line]: cerebral oedema due to
17 (or as a consequence of) dehydration."
18 Does that make sense to you?
19 A. Dehydration as a direct -- cerebral oedema as a direct
20 cause of dehydration?
21 Q. It's actually the other way round. It says dehydration
22 causes the cerebral oedema.
23 A. Well, it doesn't -- on the face of it, it doesn't
24 directly cause --
25 Q. Yes, it doesn't. So just put like that, it doesn't make

1 sense.
2 A. But indirectly it could.
3 Q. And how would that be?
4 A. Well, through treating the dehydration.
5 Q. Isn't that what would cause it then? Because it's not
6 a natural consequence of treating dehydration that you
7 end up with cerebral oedema; if you over-rehydrate you
8 could.
9 THE CHAIRMAN: It's Dr Stewart's point yesterday afternoon,
10 isn't it, that you heard?
11 A. Yes.
12 THE CHAIRMAN: It's the rehydration of Lucy which caused the
13 cerebral oedema; right?
14 A. Yes.
15 THE CHAIRMAN: She had gastroenteritis, that made her
16 dehydrated. She had to be rehydrated. As a result of
17 the way in which the rehydration was carried out, she
18 developed cerebral oedema. And what's missing from that
19 death certificate is the fact that the cerebral oedema
20 comes from the rehydration; the rehydration is a result
21 of clinical intervention; and it is that clinical
22 intervention and that rehydration which is missing from
23 the death certificate.
24 And as Ms Anyadike-Danes asked yesterday afternoon,
25 and Dr Stewart said yesterday afternoon, if that

1 appeared on the death certificate, it becomes
2 a requirement to report it to the coroner because the
3 death follows clinical intervention. I'm summarising
4 what Dr Stewart said late yesterday afternoon. In
5 a sense, what I'm asking you is whether you disagree
6 with what Dr Stewart said or whether you have anything
7 to add to it?
8 A. Well, I agree that -- I suppose what ... Am I being
9 asked could you, under any circumstances, write a death
10 certificate like this?
11 THE CHAIRMAN: Yes.
12 A. Only if you accept that dehydration indirectly could
13 cause cerebral oedema.
14 THE CHAIRMAN: Right. And so you can write that death
15 certificate if you leave out the step which turns
16 dehydration into cerebral oedema?
17 A. Yes.
18 THE CHAIRMAN: But that's not how you write death
19 certificates, is it?
20 A. Well, there's no space to write rehydration.
21 THE CHAIRMAN: Well, there is. Line (b), "cerebral oedema
22 due to rehydration".
23 A. But rehydration is not a disease, it's a treatment.
24 THE CHAIRMAN: Right. So if you're saying it's indirect --
25 okay. We have the death certificate which was

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

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

1 A. There must be something.
2 THE CHAIRMAN: You're unhappy about this, doctor, are you?
3 A. Well, it's ...
4 THE CHAIRMAN: When you were saying about rehydration a few
5 moments ago, you said you can't put on rehydration
6 because it's not a condition, it's the act of
7 re-hydrating.
8 A. Yes.
9 THE CHAIRMAN: The way that that has been addressed by
10 the coroner is that it's to address the hyponatraemia,
11 to include the hyponatraemia, which is what was omitted
12 from the death certificate in the Royal.
13 A. And gastroenteritis then has been put to line 2.
14 THE CHAIRMAN: Yes, because that's -- the sequence is,
15 I think Lucy gets gastroenteritis, she becomes
16 dehydrated, which is why her GP refers her to the Erne,
17 she then begins to receive fluid -- which is described
18 here as "excess dilute fluid" -- it leads to acute
19 dilutional hyponatraemia, which leads to cerebral
20 oedema.
21 A. Yes, but you would need four lines, would you not, on
22 the death certificate? You'd need 1(a), 1(b), 1(c) and
23 1(d) for that sequence, would you not?
24 THE CHAIRMAN: I'm not sure how much we want to spend on
25 this, but I'm not sure you are ... What's omitted from

1 the Royal's death certificate is the critical line of
2 hyponatraemia. What brought about the cerebral oedema
3 was hyponatraemia; that's the one thing which is missing
4 from the certificate.
5 A. Yes. Is it missing because -- I mean, I ...
6 MS ANYADIKE-DANES: Mr Chairman, I think we can help on this
7 because, in fact, Professor Lucas has addressed it.
8 It's 252-003-014. Before I go to that, I should say,
9 first of all, he looks at the death certificate as it
10 stands as you have just been considering it.
11 He says it is illogical: dehydration is not going to
12 directly cause brain swelling. Then he looks at these
13 different formulations. At the bottom is the coroner's
14 one, which the chairman was taking you to. And you can
15 see that you don't need an extra line because
16 gastroenteritis goes into 2. If we bring back the death
17 certificate next to this, there you are, you see there's
18 1 and 2 in the box for cause of death. You must have
19 seen these sort of things before. There's 1; 1 is
20 composed of 1(a), (b), (c). Then there's 2:
21 "Other significant conditions contributing to the
22 death, but not related to the disease or condition
23 causing it."
24 What the coroner has done with his formulation is
25 he's got cerebral oedema as the disease or condition

1 directly leading to the cause of death. That's at (a).
2 Then:
3 "Due to (or as a consequence of) (b) acute
4 dilutional hyponatraemia."
5 That's on the second line. Third line:
6 "(c), excess dilute fluid [and], 2,
7 gastroenteritis."
8 So if you wanted to convey the accurate information
9 on the cause of death as it was thought to be, it could
10 be done, not that that is a death certificate that you
11 should have been sending in like that, but it could be
12 done. Sending it in like that without having reported
13 to the coroner.
14 A. I have seen Professor Lucas' report. He's formulated
15 a different death certificate, hasn't he?
16 Q. I was taking you to an explanation as to how
17 the coroner's formulation is to show you that the
18 information that the chairman was putting to you can be
19 inserted on the death certificate form because there are
20 enough, to use your expression, lines on it.
21 In any event, this line of enquiry, if I can put it
22 that way, only started because I was asking for your
23 observation as to whether, in your view, it made sense
24 to have cerebral oedema being caused by or due to
25 dehydration, and I think you've answered that to say not

1 unless you're talking about the response to the
2 dehydration.
3 THE CHAIRMAN: Indirectly, I think was --
4 MS ANYADIKE-DANES: I took that's what you indirectly meant:
5 the treatment of the dehydration could lead to cerebral
6 oedema.
7 A. Would it be possible to see Professor Lucas' ...
8 THE CHAIRMAN: If you take down the right-hand side of the
9 screen and give us 252-003-015. Is that what you're
10 referring to?
11 A. Mm-hm.
12 MS ANYADIKE-DANES: In fact, he has been able to get the
13 rehydration for the dehydration point that the chairman
14 was putting to you all on 1(b), and then you can put
15 your gastroenteritis, if you want to, on line (c). So
16 you don't need an extra line once again.
17 A. The guidelines that were present at the time, 2000, only
18 allowed you to put one disease on the line. Now,
19 I think there are new guidelines out there or
20 clarification of the existing guidelines which allow you
21 to put more than one cause on the line.
22 Q. Then let me approach it a different way so that we don't
23 get ourselves too bogged down in the technicality of it.
24 If you had formed the view that the problem for Lucy
25 was the way in which they had responded to the

1 dehydration, they had in fact over rehydrated her, and,
2 as a result of that, she had developed cerebral oedema,
3 which proved to be fatal, if you had reached that view,
4 what in your view do you do as a result of that?
5 A. You refer that death to the coroner.
6 Q. Thank you.
7 THE CHAIRMAN: But on the death certificate -- do you put
8 cerebral oedema and then, next line, hyponatraemia?
9 A. Under the cerebral oedema, hyponatraemia, and what would
10 the third cause be?
11 THE CHAIRMAN: Well, whatever the third cause is, the
12 critical thing which is missing surely from this death
13 certificate, which was signed on 4 May 2000, was the
14 hyponatraemia? I mean, whatever you put on the third
15 and fourth lines and so on, is the critical issue,
16 doctor, not the omission from the death certificate of
17 hyponatraemia?
18 A. If you had that understanding that hyponatraemia had
19 caused the cerebral oedema, which you then --
20 THE CHAIRMAN: If you had that understanding, then if that
21 was the understanding, then that would go on to the
22 death certificate?
23 A. Yes.
24 THE CHAIRMAN: Okay. Let's move on. Look, it's 1.30. I'm
25 hoping that if we can sit on a little longer, we can

1 finish Dr McKaigue and finish for the day. Is that
2 okay? Thank you.
3 MS ANYADIKE-DANES: You completed the PICU coding form;
4 is that correct?
5 A. Yes.
6 Q. We can pull it up. It's 319-019-002. What is this
7 supposed to indicate? What's the purpose of this form?
8 A. I have given evidence to the inquiry before about the
9 purpose of this form. It was in my transcript when
10 I gave evidence in Claire Roberts and --
11 THE CHAIRMAN: Yes.
12 A. -- without following it chapter and verse from before,
13 this is essentially --
14 MS ANYADIKE-DANES: What I think you said, if I help you,
15 because I'm conscious you don't have that in front of
16 you. You say:
17 "The form have a very specific purpose and that was
18 to improve the depth of clinical coding. This was
19 achieved by recording information about the reason for
20 a patient's admission to PICU and then to document
21 various interventions, investigations and complications
22 to indicate the severity of their underlying clinical
23 condition and that that form could then be used by
24 management within the Trust to better understand the
25 type of patients we were treating."

1 And:

2 "Ultimately I believe that the goal was to make

3 available to the Trust hard information which could be

4 used, if necessary, in some sort of benchmarking

5 exercise when funding was being allocated."

6 So you want to look at the kind of cases you're

7 dealing with them and the incidences of them; would that

8 be a fair way of summarising that?

9 A. Yes.

10 Q. So if you wanted to do that, you have put down the

11 interventions in relation to Lucy, if I can put it that

12 way, and some of her conditions, so a seizure was

13 a condition, she had respiratory arrest, she developed

14 cerebral oedema, brainstem coning, but she was

15 intubated, ventilated, she had a central line, an

16 arterial line, CT scan, and she developed hyponatraemia.

17 So if you were doing that -- not you personally, but

18 if that was being done systematically with paediatric

19 deaths, that would allow you to see the incidence of

20 hyponatraemia.

21 A. Yes.

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

23 one purpose of it.

24 A. Yes.

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

1 filled in accurately so they can have that benefit. And

2 you have put hyponatraemia there. It's dated

3 13 April 2000. Why did you put hyponatraemia there?

4 A. Because I knew the patient had hyponatraemia.

5 Q. In order to complete a list like that to identify what

6 had happened, the interventions, and the results, if I

7 can put it that way, what do you have access to?

8 A. You have access to her -- to find out all the relevant

9 information about the patient, you have access to the

10 chart and whatever other members of staff tell you.

11 Q. So you'd have to be looking at all her notes to make

12 sure you had captured properly the information to make

13 of it best use for the purpose that I have just read out

14 that you gave to us?

15 A. Yes, but this was filled out, I would imagine, at the

16 time I was -- either shortly before ... Before I made

17 my retrospective note or in conjunction with that. So

18 a lot of this --

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

20 your retrospective --

21 THE CHAIRMAN: Or at the same time?

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

23 MS ANYADIKE-DANES: What happens if more things are involved

24 with the patient? Do you not then go on and add on to

25 your coding form?

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

2 Q. So you'd got hyponatraemia by the time you were making

3 your retrospective note at 1.40 on the Thursday, her day

4 of admission?

5 A. Yes.

6 Q. So you had looked at her notes?

7 A. Yes, I knew she had hyponatraemia.

8 Q. Apart from looking at her notes?

9 A. Not apart from looking at her notes.

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

11 A. Yes.

12 Q. In your witness statement, though, for the inquiry,

13 302/1, page 9:

14 "I personally did not give consideration to the

15 cause of Lucy's death."

16 And then at 302/2, page 3:

17 "At that time I was not [and I think at that time is

18 when you were completing this] in a position to form

19 a view as to the sequence of events leading to Lucy's

20 clinical deterioration and ultimately her death."

21 So what's the procedure then? You start off one of

22 these forms putting in what you can from matters that

23 have emerged up until that time?

24 A. Yes.

25 Q. And then somebody else puts in some more?

1 A. That was the intention of the form.

2 Q. And so should any more have been added to this form

3 after Lucy died or to reflect what happened on the next

4 day?

5 A. Yes, because I -- I mean, a similar type of form was

6 filled out by me in Claire's case.

7 Q. Yes.

8 A. And from memory, I think there was brainstem death

9 testing. That form -- it's not an exact thing and it's

10 not meant to be totally exact. There was no, if you

11 like, strict protocol to guide you on completing this

12 form. So my view of what I thought was important may

13 differ from somebody else's in the absence of a set of

14 rules.

15 Q. Sorry, pause there. Why isn't there one? Because is

16 not the benefit of it that these things would be

17 standardised so you're comparing like with like when

18 you're interrogating the system to look at the incidence

19 of any given condition or any particular intervention?

20 A. The form from -- my recollection of the form was that it

21 was meant to be very simple, straightforward, easy to

22 use, free text, to try and capture in as quick and

23 efficient a way as possible more information about the

24 patient. It was meant to be easy to use and we didn't

25 have any -- apart from the aspirational point of view,

1 we didn't have any detailed guidelines that you
2 followed, a set of rules, a Highway Code to dictate what
3 went on the form.
4 Q. That's why I was asking you that. Why didn't you have
5 those?
6 A. We weren't that sophisticated.
7 Q. Why was it you who was completing this form?
8 A. Because I was the consultant on, whenever she first
9 arrived, I initiated the form, but I wouldn't have been
10 responsible for completing it. I initiated it up until
11 13.30.
12 Q. Sorry, does that mean as soon as she arrived, you start
13 putting an entry on?
14 A. No, no.
15 THE CHAIRMAN: You were the person initially responsible
16 when she arrived in the hospital?
17 A. Yes.
18 THE CHAIRMAN: Can I ask you this: since 2000, has the
19 practice for completing these forms changed?
20 A. Yes, insofar as we don't use it any more. We don't use
21 it any more.
22 THE CHAIRMAN: Is there an alternative system in place? If
23 I'm taking you down a side track, tell me to stop.
24 A. We have another database called PICANet, which is
25 a national database, and it's got very strict protocols

1 and guidelines, and the whole point of it is, yes, you
2 can compare how you're doing with 24 other paediatric
3 hospitals or whatever. This was amateur-ish.
4 THE CHAIRMAN: PICANet is P-I-C-A-N-E-T?
5 A. Yes, I think that's the name of the thing, PICANet.
6 MS ANYADIKE-DANES: How long did this go on for, this use of
7 this system, so far as you are aware?
8 A. I think it was maybe on its last legs.
9 Q. And just finally, because you'd indicated that there was
10 an intention to perhaps put further information on. For
11 example, her brainstem death tests; would those have
12 gone on this?
13 A. Yes.
14 Q. And who would be responsible for adding to that?
15 A. The consultant who did the brainstem death tests.
16 Q. So is that how it works, it's whoever perform the
17 intervention adds on to the form as opposed to, for
18 example, her consultant?
19 A. Yes. The way I would have understood it to work would
20 have been, if I was on, on a particular day, and new
21 problems came to light or new investigations were
22 planned or had been done, I would update that form, so
23 if a patient had an MRI scan two weeks later, then on
24 the particular date I would record that because that's
25 all more of the same.

1 THE CHAIRMAN: Okay, thank you.
2 MS ANYADIKE-DANES: Can I then move to the audit meeting?
3 Sorry, just before I do that, I think I understood from
4 your evidence that you didn't actually know that there
5 had been a hospital post-mortem.
6 A. No.
7 Q. When we were dealing with Claire's case, Claire also had
8 a hospital post-mortem, brain-only though, and there was
9 quite a bit of evidence then that after the hospital
10 post-mortem and perhaps some time before the autopsy
11 report is finalised, as part of clinicopathological
12 correlation, there are meetings between the pathologists
13 and the clinicians. Dr Herron and Dr Mirakhur gave
14 quite detailed evidence as to how that is, how the
15 consultant is notified about it, it's
16 a multidisciplinary meeting and there's sometimes
17 a fairly robust exchange of views as to exactly what
18 happened in terms of the patient's cause of death.
19 Is that something that you remember? I don't mean
20 remember in relation to any given child, but a system
21 that you remember.
22 A. I wasn't actually very aware of that. I didn't think
23 that clinicians walked over to the pathology department
24 and took part in meetings like that. There aren't very
25 many post-mortems, hospital post-mortems, done in

1 children. So it may well have gone on, but just through
2 the very small volume I wasn't aware of it. I don't
3 dispute what they're saying.
4 I would imagine there are a lot more adult
5 post-mortems done, so the same procedure would be
6 operating there. But I don't have any -- I never was at
7 one myself and I don't really -- wasn't really aware
8 that other clinicians had been to that.
9 Q. But in any event, you don't recollect that there was any
10 meeting of that sort after the autopsy to try and get
11 a better idea as to Lucy's cause of death? You're not
12 aware of that?
13 A. No.
14 Q. Then let's move to the audit meeting. The audit meeting
15 takes place on 10 August. There's an attendance sheet
16 for it. If we can pull up, it starts at 319-023-003.
17 There you are. On that, you can see your signature is
18 there and your name is there, "consultant anaesthetist",
19 on the left-hand side, about halfway down. Dr Taylor is
20 up at the top. Do you recall that, that you signed
21 that?
22 A. Yes.
23 Q. The purpose of those, in your witness statement to the
24 inquiry, 302/2, page 2:
25 "My recollection of the purpose of the presentation

1 and discussion of mortalities at audit meetings in 2000
2 was to use the forum as an opportunity to present the
3 events surrounding the death of patients in the
4 Children's Hospital primarily to a wider body of doctors
5 [multidisciplinary] and, further, at that time, there
6 was a push within audit circles to establish audit as
7 a multi-professional process -- nurses and professions
8 allied to medicine -- before the presentation."
9 You go on to say:
10 "The presenter would have had to collate and
11 organise in a logical way the different strands
12 pertaining to the case. The death was not only being
13 reviewed by the presenter, but also by peers and other
14 disciplines who could bring a different perspective to
15 aspects of the case and implicit in this process was the
16 opportunity to learn and reflect from listening to the
17 presentation and ensuing discussion."
18 So that, from what you could tell, is what was going
19 to happen in relation to the five cases that were up for
20 discussion at the audit meeting in August. Lucy's was
21 one of five. What, so far as you can recall, is the
22 result of a meeting like that?
23 A. The result meaning something official, or ...
24 Q. What's supposed to be the outcome? You say it is a
25 forum, there's an exchange of views, it's

1 multidisciplinary, so it's very helpful from that point
2 of view because you bring the different specialisms to
3 it. And the intention is that there should be learning.
4 So if in the course of that it's identified that
5 there is a form of treatment that has been detrimental,
6 what happens as a result of that if something like
7 that is identified?
8 A. One would hope that individuals would take note of that.
9 Q. But is there no --
10 THE CHAIRMAN: I suppose that depends on the extent of the
11 lesson to be learned? It might be something which can
12 be resolved at the meeting or it might be something more
13 important, which becomes formalised?
14 A. Yes.
15 THE CHAIRMAN: Right. But in Lucy's case, on yesterday's
16 evidence, there was a recognition that something had
17 gone wrong and would I be naive to think that if that
18 was recognised even before she died that that should
19 then be discussed and form part of the discussion in the
20 audit meeting in August?
21 A. Yes. If it was recognised, that would be the intention
22 of having audit as part of the commentary to the
23 presentation -- highlight to the meeting that here was
24 a problem.
25 THE CHAIRMAN: And the presentation involves somebody

1 outlining what had happened in respect of each of the
2 children who was being discussed at the audit meeting;
3 isn't that right?
4 A. Yes.
5 THE CHAIRMAN: So is it not the case that, on any analysis
6 of what happened with Lucy, it would have been apparent
7 that there were questions to be asked about the
8 treatment she received in the Erne?
9 A. Questions could very well have been asked, yes.
10 THE CHAIRMAN: And if questions are to be asked about what
11 happened in the Erne, how is that taken forward from an
12 audit meeting?
13 A. The audit meeting -- there was a ... If there were
14 learning points, important learning points to be made,
15 then I would imagine there must have been a mechanism to
16 deal with those. In terms of -- I mean, whether, say,
17 individuals or particular interests maybe said that they
18 would take that away with them and look at it, but
19 I don't know if there was a formal system to document
20 and record those things.
21 THE CHAIRMAN: Well, you see, doctor, in a sense this one
22 was or seems to me on the state of the evidence that
23 I have now -- and it may change over the next few
24 weeks -- but on the evidence that I have now this was
25 almost easy for the Royal because nobody's pointing the

1 finger at the Royal for the way in which Lucy was
2 treated; the finger's pointing at the Erne for the way
3 in which Lucy was treated. So when the audit meeting
4 took place in the Royal in August, nobody had to blame
5 anybody else who was in the room who worked for the
6 Royal for what had gone wrong. But if there was any
7 discussion or analysis of what happened in Lucy's case,
8 surely it must be recognised that the Erne has questions
9 to answer or lessons to learn, to put it more
10 positively?
11 A. Yes.
12 THE CHAIRMAN: How does the Erne learn those lessons? If
13 the Royal thinks that the Erne has lessons to learn, how
14 does the Royal tell the Erne what those lessons are?
15 A. I don't know what way things were done historically.
16 I don't know of any reporting mechanism.
17 MS ANYADIKE-DANES: Was there any discussion that that might
18 be a helpful thing to develop? Because the
19 Children's Hospital, because it was the kind of hospital
20 it was, the only one with a paediatric intensive care
21 unit, it's a regional centre and so on, it's likely to
22 receive children who have been referred from hospitals
23 where there have perhaps been issues in relation to
24 their care, and so you will see them and you are the
25 experts, if I can put it that way, there in PICU. Does

1 that not put the Children's Hospital in a very good
2 position to disseminate some of that learning?
3 A. If I can address that in 2013, it's a complete sea
4 change.
5 THE CHAIRMAN: Okay, tell me about 2013 and then we'll go
6 back to 2000.
7 A. In 2013, incident reporting is mandatory. That's my
8 understanding. The Trust have got guidelines on
9 incident reporting and they define what it is and there
10 is an online computerised database where you report the
11 incident and it takes about five minutes to fill that
12 out. That then is sent initially to a local -- somebody
13 reasonably local. If it wasn't theatre or intensive
14 care, there's a local reporter. It goes also to a sort
15 of governance, the governance structures in the hospital
16 as well. I'm not -- I mean, I'm sort of telling you in
17 a sort of conversation what I think happens next, I'm
18 not -- I don't want this to be definitive. But
19 essentially, the initial assessor decides how much
20 weight or how serious it is and then obviously,
21 hand-in-hand with that, they then look at trying to
22 prevent things. Is there learning to be had from this?
23 And it's actually an increasing part of our lives to
24 actually participate in this.
25 THE CHAIRMAN: Okay. Let's go back to 2000. Let's not just

1 confine it to Lucy or to hyponatraemia, but occasionally
2 you must have had children coming into the Royal who had
3 been inadequately treated elsewhere; would that be
4 right?
5 A. There would be sub-optimal treatment, yes.
6 THE CHAIRMAN: If that is recognised in the Royal, how then
7 do the doctors or nurses in Craigavon or Daisy Hill or
8 the Erne get told that this is the mistake you made in
9 our eyes and this is how you avoid it?
10 A. In 2000?
11 THE CHAIRMAN: Yes.
12 A. That would have been, I think, a telephone call.
13 MS ANYADIKE-DANES: Would that happen?
14 A. I believe so, yes.
15 Q. Would you have regarded Lucy's as a case where, if the
16 clinicians -- maybe not you because you've said
17 you weren't that familiar with her case in order to form
18 those sorts of views, but the chairman heard yesterday
19 from Dr Chisakuta and Dr Stewart that in their view
20 those who were more directly involved with her treatment
21 did regard there to be a real concern over her fluid
22 management in the Erne. So assuming that to be the
23 case, is that the sort of instance which you think would
24 have warranted a telephone conversation with her
25 clinicians at the Erne?

1 A. I have to say yes.
2 Q. Thank you. Are you aware of that actually happening?
3 A. Did it happen?
4 Q. Yes.
5 A. To the Erne?
6 Q. Yes.
7 A. No.
8 Q. You know that it didn't?
9 A. I have no knowledge that it did, no. I have no
10 knowledge that it didn't happen.
11 THE CHAIRMAN: Can I ask you one more thing about that? Who
12 makes the call? Or is that agreed at the meeting?
13 A. At what the meeting is that?
14 THE CHAIRMAN: The audit meeting. Sorry, whether it's the
15 audit meeting or even without it going to an audit
16 meeting --
17 A. That would have to be the person really who is in
18 possession of the information and can talk knowledgeably
19 on things.
20 THE CHAIRMAN: And if the call is made to the Erne or
21 Daisy Hill or whoever, is it to the medical director, to
22 the consultant involved, or who does it go to?
23 A. My understanding is it would be the clinicians.
24 THE CHAIRMAN: Thank you.
25 MS ANYADIKE-DANES: So from your point of view -- I had

1 given you an incorrect reference and I apologise for
2 that, I told you that the reference came from your
3 second witness statement; in fact, it was your third,
4 302/3, page 3, and I apologise for that. That's where
5 you set out how an audit meeting would have taken place,
6 or at least, in your view, it would involve if I can put
7 it that way. If we pull that up, 302/3, page 3.
8 It's right at the top where you say that. Then to
9 follow up the point that you've been making, you see
10 that, the discussions around each presentation, the
11 contribution, questions being asked if more information
12 is required. And then you have got:
13 "Suggestions were made to improve shortcomings if an
14 attendee felt that was warranted."
15 There was an audit meeting for Lucy. Is there one
16 for every child that dies?
17 A. Yes.
18 Q. So from what you now know of Lucy's case, what, in your
19 view, are the things that you would have expected to --
20 sorry, I beg your pardon, I should re-frame that. When
21 I say, "From what you now know of Lucy's case", what
22 you have seen from her notes, so I'm not talking about
23 what the inquiry's experts have said, but were there to
24 be seen on her notes. What you have expected to have
25 been the things to have been discussed at the audit

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

1 were administered.
2 Q. So a clearer identification of the fluids that were
3 administered?
4 A. Yes.
5 Q. Both the volume and the type?
6 A. The type of fluid.
7 Q. Anything else?
8 A. And then obviously you're correlating that with
9 a formulation for her cause of death because you then
10 want to be able to say that the fluids were
11 inappropriate.
12 Q. Yes. And so insofar as the chairman has heard from --
13 let's stick with Dr Chisakuta, who was the consultant
14 who actually was involved directly in her treatment at
15 that level. If he's of the view that that treatment was
16 inappropriate so there's a point to be taken up with
17 "Let's have better recording of what's actually being
18 administered and prescribed", is there not another point
19 that that was -- if it's thought to be, that was
20 inappropriate and there would be a discussion around the
21 appropriateness or not of that fluid regime. Is that
22 right?
23 A. Yes.
24 Q. And that takes you to, if the consensus is it was
25 inappropriate, you have learning there, and from what

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

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

1 Q. Is there not a thing called the Sick Child Liaison
2 Group?
3 A. Yes, there is, yes.
4 Q. Dr Taylor was involved in that, wasn't he?
5 A. Yes.
6 Q. Did you participate in that?
7 A. No.
8 Q. Is there a reason?
9 A. No. No, there's no particular reason whatsoever. I was
10 participating in this one here.
11 Q. In his witness statement for Adam at 008/1, page 9, he
12 said he founded that group:
13 "Paediatric anaesthetic and Accident & Emergency
14 consultants, they met two to three times a year at the
15 Antrim Area Hospital, and the purpose was to improve the
16 quality of care to critically-ill infants and children
17 being transferred to the paediatric ICU mainly by better
18 communication."
19 And he says he chaired those meetings and that he
20 kept his clinical director at the time, Dr Hicks, in the
21 loop and informed of discussions. That's a forum, isn't
22 it?
23 A. Yes.
24 Q. And depending on when it was actually established, that
25 might have been something when some of these cases could

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

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

1 MS ANYADIKE-DANES: Thank you.
2 THE CHAIRMAN: Mr Quinn, any questions?
3 MR QUINN: No questions.
4 THE CHAIRMAN: Any questions from the floor? Mr McAlinden?
5 Doctor, thank you very much for coming again to help
6 us. Unless you have anything more to add, your evidence
7 is complete and you're free to leave. Thank you very
8 much.
9 (The witness withdrew)
10 Housekeeping discussion
11 Ladies and gentlemen, just two bits of housekeeping
12 before we finish.
13 The first is that, Mr Uberoi -- if you can hobble to
14 your feet. In terms of the issue which has been raised
15 on behalf of Dr Taylor about the extended role of
16 Professor Kirkham, what I'm arranging to do today is to
17 circulate the letter which came from your solicitor,
18 I think it's ...
19 MR UBEROI: It's 3 May, sir.
20 THE CHAIRMAN: Thank you. We'll circulate that to the other
21 parties in this segment of the inquiry and in the other
22 segments and, at some point next week, when people have
23 had chance to consider their position, we'll raise it
24 in the chamber.
25 MR UBEROI: Thank you, sir.

1 THE CHAIRMAN: Secondly, Mr Simpson, about the Raychel
2 governance. I know it's Mr Lavery; I think you might
3 not be here for Raychel governance.
4 Mr Lavery, we've expressed our concerns and the
5 Western Trust has responded about the role of
6 Miss Brown. I have reservations about it, but we can't
7 delay any further. So what we're going to do is we're
8 going to issue the request for witness statements
9 between today and tomorrow in Raychel governance.
10 I remain concerned that Miss Brown appears to be the
11 only point of contact, but what you will see, as they
12 come out, is those statements are tighter and shorter
13 than previous requests for information. That's partly
14 because we've already touched on some of these issues,
15 sometimes quite extensively in the hearings before
16 Easter. So what I'm very anxious to emphasise today
17 is that we need these statements back as soon as
18 possible. The fact that they are shorter and more
19 restricted will facilitate that.
20 Also, could I ask you one more thing: sometimes
21 previously DLS has waited until they've got a batch of
22 statements and then returned a group rather than return
23 them in ones and twos. On this occasion, as soon as
24 they reach DLS, we would like them to be forwarded to
25 us. I have to do a week's hearing in Raychel governance

1 starting on 2 July and, in order to achieve that, I need
2 the statements back as soon as possible; okay?
3 MR LAVERY: Certainly that message will be forwarded. I
4 should say, Mr Chairman, there is a letter of 21 May
5 which the DLS wrote about the point about Miss Brown's
6 involvement. You made some comments the other day
7 in the chamber, but there was never any substantive
8 reply to that letter.
9 THE CHAIRMAN: If it needs to be followed up beyond today,
10 I will, but --
11 MR LAVERY: There was an issue, Mr Chairman, which arose
12 previously on 12 February. There was another letter in
13 which the inquiry had questioned the roles of both Miss
14 Brown and Dr Nesbitt.
15 THE CHAIRMAN: Part of my concern is this: Miss Brown is an
16 interested party in Raychel governance and I think it
17 puts her in a slightly invidious position for her to be
18 the point of contact for other witness statements and
19 also to be -- for the provision of information to other
20 people who are going to provide witness statements while
21 she is also an interested party. That's been avoided
22 in the Royal and there have been very helpful exchanges
23 involving the Royal, where there are two other ladies
24 who are points of contact. If that's what I'm being
25 told from the Western Trust I can't coerce any other

1 person to be appointed but I think it is an unattractive
2 position for Miss Brown to be in, even from her own
3 perspective, never mind mine.
4 MR LAVERY: I hear your comments, Mr Chairman.
5 THE CHAIRMAN: It's Dr O'Donoghue tomorrow morning?
6 MS ANYADIKE-DANES: Yes, it is.
7 THE CHAIRMAN: And then followed by Dr Auterson?
8 MS ANYADIKE-DANES: Yes.
9 THE CHAIRMAN: So we'll start at 10 o'clock tomorrow
10 morning. Thank you.
11 (2.17 pm)
12 (The hearing adjourned until 10.00 am the following day)
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1 I N D E X
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