1 Thursday, 13 June 2013
2 (10.00 am)
3 (Delay in proceedings)
4 (10.20 am)
5 THE CHAIRMAN: Mr Simpson?
6 MR SIMPSON: Mr Chairman, my understanding of the situation
7 yesterday was that it was indicated by Dr Kelly that he
8 raised the issue of the inquest, what the position was
9 in two meetings, the first on 15 November 2001, and the
10 second on 12 April 2002. I should make it clear that
11 consonant with the stance that the Trust has taken
12 in relation to legal professional privilege, without any
13 way being taken to waive privilege, I can indicate from
14 the bar, as senior counsel for the Trust, that having
15 read the scrutiny committee meeting minutes of both of
16 those dates, there is no support for the proposition
17 that Dr Kelly mentioned the inquest in the meeting of
18 15 November 2001. There is support for that proposition
19 in relation to the meeting of 12 April 2002 insofar as
20 the inquest is referred to, but there is no
21 identification of the person who raised the issue.
22 THE CHAIRMAN: Thank you very much. Mr Green?
23 MR GREEN: Sir, I'm happy for it to be left there for now,
24 although I may wish to revisit it once Dr Kelly has
25 finished giving his evidence and I'm able to discuss

1 matters again with him and take instructions. So I'm
2 grateful to my learned friend for dealing with it
3 in that way for now.
4 THE CHAIRMAN: Thank you very much.
5 MR GREEN: Thank you.
6 DR JAMES KELLY (continued)
7 Questions from MR WOLFE (continued)
8 MR WOLFE: Good morning, doctor. Could I, at the request of
9 one of my learned friends, just go back to two points
10 that arose yesterday. First of all, if we could have up
11 on the screen, please, 036A-046-098. You'll recall,
12 doctor, that that is the letter that you sent to
13 Dr McConnell, 15 May 2000.
14 A. That is correct.
15 Q. The point I wanted to bring you to is in the penultimate
16 paragraph, number 2:
17 "The child, some hours later, was thought to have
18 sustained some form of seizure. The description,
19 however, is more in keeping with the child going to
20 decorticate rigid."
21 Do you see that?
22 A. I do indeed.
23 Q. You told us yesterday that in order to prepare that
24 letter, which you drafted yourself, you spoke to Mr Fee;
25 is that correct?

1 A. That's correct, yes.
2 Q. And the description given of the state of the child,
3 what was the source of information for that?
4 A. I presume -- you'll have to ask Mr Fee exactly where he
5 got that information from, but that was what was being
6 conveyed to me by Mr Fee. He wouldn't have used
7 a phrase like "decorticate rigid". He is describing the
8 situation to me as the information's come through to
9 him.
10 Q. So he's describing a physical state of the child based
11 on information which you're not familiar with, but
12 possibly the nurse is, possibly the doctor is?
13 A. Yes. If it's helpful to the inquiry, my understanding
14 of that would be that most of us would be fully aware of
15 what a typical grand mal epileptic seizure is, and this
16 was not entirely in keeping with that. Therefore the
17 discussion was what kind of event or seizure had
18 occurred, and that would have led to a description that
19 might be in keeping with decorticate rigidity rather
20 than decerebrate rigidity.
21 Q. And what in terms does decorticate rigidity mean?
22 A. It tends to mean that the arms and the legs are moved in
23 a certain way, in a stiffness, in a pose.
24 Q. And that would be consistent with what?
25 A. Brain injury.

1 Q. And are you communicating your understanding that that
2 was the state of the child or the impression that you
3 were given of the state of the child at or about the
4 time when the nurses first arrived?
5 A. I can't state with certainty about timings here. All
6 I'm describing is the information being conveyed to me
7 suggested that this was not a simple seizure, it was
8 something more complicated, and that information was
9 being conveyed presumably from members of the clinical
10 team through to Mr Fee and Dr Anderson.
11 Q. Was it a description that was conveyed to Dr Quinn,
12 ultimately?
13 A. Pass. I have no idea.
14 Q. You didn't convey it?
15 A. I didn't convey that, no.
16 Q. Very well. A second point which arises through one of
17 my learned friends is this: if we could have up on the
18 screen 033-102-296. This is Mr Fee's briefing letter to
19 Dr Quinn, 21 April 2000. In terms of the construction
20 of this letter, had you any input into it?
21 A. I don't believe I had any direct input into this letter
22 as I was on annual leave at that time. I think I was
23 copied into it on my return.
24 Q. Had you any input at all into what should be the terms
25 of reference for the expert who was to be Dr Quinn?

1 A. Well, I would -- I can't recall specifically, but
2 I would imagine on that first day, on the Friday, the
3 14th, any discussion I would have had with Mr Fee would
4 have indicated some key areas like this to be covered.
5 But I didn't have a sit-down discussion with him and
6 say, "This is what needs to be in the remit, Dr Quinn",
7 because at this stage I didn't know that Dr Quinn was to
8 be engaged. I returned from leave to find Dr Quinn had
9 been engaged and therefore this had moved on, so to
10 speak. So I had no input to this letter, no input to
11 that aspect of terms of reference, but it would have
12 been shared with me when I arrived back, and it didn't
13 strike me as anything that would give me concern or
14 anything I particularly wanted to change immediately.
15 Q. The letter refers to an initial review of events. Do
16 you know whether that was in a sense a deliberate phrase
17 because the Trust had it in mind that there was to be,
18 if you like, an initial or preliminary review of events
19 with a view to something else happening?
20 A. Chairman, it's impossible for me to comment on somebody
21 else's letter that --
22 Q. That's why I asked the question in the way I did. Was
23 it the Trust's view that this was to be an initial
24 review of events?
25 A. I'm struggling here to understand where the question's

1 going or what ...
2 THE CHAIRMAN: Since you had had some discussions before you
3 went on leave and you saw this letter when you came back
4 after leave and nothing in it had jarred with you, the
5 second paragraph asks for Dr Quinn's opinion, which
6 would help Dr Anderson and Mr Fee on their initial
7 review of events. What Mr Wolfe was asking you is: what
8 was meant by the reference to "an initial review of
9 events"?
10 A. I don't actually know. I'm perceiving the review is
11 ongoing, the initial review might have been Dr Anderson,
12 Mr Fee, sitting down, reviewing the notes and the
13 initial information, and then moving on Dr Quinn to add
14 to that initial review. That's the way I would
15 interpret it. Nothing more than that.
16 MR WOLFE: Can I take a look at what Mr Fee says about this
17 at WS291/2 at page 10.
18 MR COUNSELL: I wonder if I could assist with the reference?
19 It's a wrong reference. It should be WS287/1, page 10.
20 MR WOLFE: I'm obliged, thank you.
21 We can bring up the preface to the question if you
22 want, but it's in this context of this briefing letter
23 to Dr Quinn. Mr Fee is asked:
24 "If you drafted the briefing letter, were you
25 provided with any assistance in doing so? I believe

1 that I discussed the contents with Dr Kelly, medical
2 director, and Dr Anderson."
3 That's (b) at the top of the page.
4 A. Well, all I can say, chairman, it's clear to me that he
5 couldn't have at that point in time.
6 Q. And why is that?
7 A. I was on annual leave, I wasn't there.
8 THE CHAIRMAN: But there had been some preliminary
9 discussion about the role of Dr Quinn or a doctor before
10 you went on leave.
11 A. Yes. So on the Friday when we had a conversation, there
12 may have been discussions that he has incorporated
13 in the letter, but I wasn't involved in any sit down
14 with Mr Fee, preparing a letter or a briefing at that
15 stage.
16 MR WOLFE: Before getting on our way properly this morning,
17 could I ask you about an entry in a note made by
18 Mr Mills? 030-008-015. Under item 3 -- I should
19 orientate you by saying this is a meeting with Mr Mills
20 on 15 June, at the top of the page. And under item
21 number 3, you can see a note:
22 "M Quinn, 21st. EF and JK."
23 So that's an indication that yourself and Mr Fee are
24 going to have this meeting on 21 June. Fair enough?
25 A. That's correct.

1 Q. And then it says:
2 "L Crawford. Fluid near miss."
3 Do you see that?
4 A. I do indeed.
5 Q. And the writing fades. The best I can do with it is,
6 "And not direct cause", and then it says, "Belfast".
7 Can you help us with --
8 A. Well, I'm presuming that, following Mr Fee's
9 conversations with Dr Quinn earlier in May that are fed
10 back to myself and ongoing feedback I'm receiving from
11 Mr Fee in terms of how the review is proceeding, that's
12 an interpretation of where he's at, that the fluids is a
13 crucial area, has been looked at and a near miss in
14 terms of the fluids weren't right, weren't prescribed
15 correctly, the volumes weren't right, but Dr Quinn was
16 indicating that they did not appear to be the direct
17 cause of the problem. So that's where the near miss
18 comes.
19 I don't understand and can't help you with the
20 phrase "Belfast". It doesn't look like it belongs with
21 the sentence. It looks like it's raised up and written
22 at a different time, but that's just the way reading
23 it -- why does the text look different? I can't think
24 of any reason that that belongs in there. It's almost
25 like it's appended for something else. It doesn't seem

1 to flow with the line.
2 Q. Okay. It's not a suggestion that this information has
3 come from Belfast as opposed to your initial suggestion
4 that it's come from --
5 A. I'm pretty sure it's got nothing to do with Belfast.
6 Q. Okay.
7 A. But I presume you'll ask Mr Mills. It's his note.
8 Q. Could I take up where we left off yesterday? We left
9 off yesterday by examining the aftermath, if you like,
10 of the review report. What I want to address with you
11 this morning is the concerns directed towards you in
12 Dr MacFaul's report. In terms, he says, you failed to
13 take steps to ensure that the review was effectively
14 carried out, and then there are a number of criticisms
15 that he would advance.
16 He says that you failed to take steps to ensure that
17 the review obtained the views of clinicians at the Royal
18 Belfast Hospital, that you failed to identify a need to
19 seek expert paediatric opinion after the review report
20 which you had received failed to determine the cause of
21 death. He says that you failed to note and act upon the
22 omission of the review team to interview the doctors who
23 had cared for Lucy.
24 Dealing with those matters in turn, doctor, I think
25 you accepted yesterday that perhaps, with the benefit of

1 hindsight, the review was not effectively conducted?
2 A. I agreed and have it in my witness statement and in
3 other statements as well, I would say to the inquiry
4 that at that time there was not only no template, but
5 reviews of this nature were extremely rare, and, as
6 I said yesterday and repeat again, to me it came across
7 as an extensive review where the details were looked at
8 and the conclusions, in terms of prescribing and the
9 recording, were identified. I would still say to the
10 inquiry that at that time that appeared to be a good or
11 a reasonable review. I'm fully accepting that, looking
12 back, there were things that could have been done
13 better. I didn't identify them at the time and I tried
14 to provide to the inquiry an explanation yesterday in
15 terms of -- I was hearing of the ongoing discussions
16 with the clinical team and I therefore made an
17 assumption in terms of the cross-checking with clinical
18 personnel that has clearly proven to be incorrect.
19 Q. So that was a communications issue? You assumed that
20 something was being done when in fact it wasn't done.
21 A. And I think that assumption was reasonable, based on
22 what I was hearing back from the review team.
23 Q. And could I suggest to you that upon reading the review
24 report, if you read it conscientiously, you would have
25 identified from it the fact that clinicians were not

1 troubled to comment upon the fluid regime because there
2 was simply no evidence that they were, either in witness
3 statements -- and they provided witness statements which
4 you would have read -- or, for that matter, anywhere
5 else, because there was no document which showed that
6 they were interviewed?
7 A. And I fully accept that that nuance I didn't pick up
8 at the time. I would again contest that other clinical
9 directors, medical directors at the time would equally
10 not have picked it up as clearly as you're stating
11 there.
12 Q. Well, applying the common-sense test or the
13 reasonableness test that we talked about yesterday, you
14 should also have identified the absence of contact with
15 the family in terms of sourcing evidence from them.
16 A. I think that wasn't something that I would have expected
17 at that time. It was a common approach to reviews
18 in the years around that time to not directly involve
19 the family and, chairman, we have discussed this
20 yesterday. We all understand how much better it would
21 be to have done that at the time and that there were
22 sources of evidence that could have added value to this
23 report. I fully accept that, but it wasn't the
24 reasonable or the practice at the time.
25 Q. Would it have been a reasonable or common sense practice

1 at the time to seek the views of the clinicians at the
2 Royal, because it should have been obvious to you that
3 they weren't identified and sourced for evidence?
4 A. I genuinely think it wouldn't have been expected in
5 terms of reviews of this nature. Yes, I agree,
6 complicated reviews can benefit from input from all of
7 the participants in the pathway of the patient,
8 et cetera, and so, yes, it could be a more robust review
9 as a result. But again, applying your test of
10 reasonableness of what was happening at the time, if the
11 events and the seminal event or the key event all
12 occurred in the local hospital then you would expect it
13 to be reviewed at that nature and there wouldn't be
14 direct involvement with the Belfast clinicians.
15 I equally accept what counsel and the chairman
16 clearly impressed on me yesterday that there was more
17 evidence that could have been gained, but that is
18 genuinely with the benefit of hindsight. I don't think
19 that would have been that obvious at the time.
20 Q. Well, it should have been obvious, doctor, that the
21 convention of receiving a discharge letter from the
22 Royal Hospital, the receiving hospital, hadn't been
23 complied with in this case.
24 A. And I would say to you at that time it was common for
25 discharge letters, particularly on deceased patients, to

1 arrive many, many months afterwards. And I would say
2 that you would find that was still the case up to more
3 recent years, that if a death occurred in another
4 hospital you might not receive a discharge letter for
5 many, many months. And often it didn't come back to the
6 referring hospital, it went directly to the primary care
7 practitioner, who would be on the notes. That would
8 have been practice up until the last number of years.
9 So the issue of a discharge letter coming from the Royal
10 would not have entered into the thinking of anybody
11 looking at this report at that point in time.
12 Q. I'll come back in a moment to deal with whether
13 a further report or further expert should have been
14 obtained to look further into this, but I want to put
15 into the balance, doctor, a report that has been
16 submitted on your behalf from a Dr Durkin at
17 162-002-008, the second paragraph on the page. It says:
18 "Although Dr Kelly may have requested a more
19 thorough case review by Dr Quinn, it would not be
20 reasonable to conclude that Dr Kelly failed to identify
21 that Dr Quinn's report was flawed because the report
22 failed to identify hyponatraemia as a probable cause of
23 death."
24 So in the context of your interaction with the
25 review report, Dr Durkin seems to be saying that he

1 can't find a basis for criticising you in terms of the
2 overall conduct of the investigation. But he does make
3 the point there that you may have requested a more
4 thorough review. What do you say about that?
5 A. Well, again, that's obvious in hindsight that that could
6 potentially have been possible. But I would also go --
7 I didn't have the various agencies that are mentioned
8 at the bottom there to assist me with seeking a more
9 thorough review, the NPSA, the National Clinical
10 Assessment Authority, are all organisations that were up
11 and running in 2001 to provide support to clinical
12 people in England and Wales for this type of work. So
13 we were very immature in Northern Ireland at the time
14 and I'm sure, when the inquiry moves to the department,
15 that will be a focus as to where we were with things.
16 But I take the point, I do take the point that, yes,
17 you could have involved other people, other personnel,
18 and tried to get a more extensive review. But at the
19 time it seemed to be a reasonable review to me.
20 Q. Could we move over the page, please, to 009. Under
21 paragraph 6 it says of you:
22 "It is my opinion that Dr Kelly made reasonable
23 efforts to investigate the cause of death of
24 Lucy Crawford and that he did not fail to adequately
25 investigate the death."

1 He goes on to say:
2 "It is my opinion, however, that from the
3 documentation provided there appeared to be more enquiry
4 into the capability of the paediatric medical team
5 following the report as opposed to whether or not it
6 provided sufficient detail to provide for a root-cause
7 analysis of the death of Lucy Crawford."
8 So he is saying, in terms of the balance of the
9 approach that followed this initial review, there was
10 more emphasis on the Dr O'Donohoe competence end of the
11 problem rather than trying to actively identify the
12 cause of Lucy's death.
13 A. It might assist the inquiry if I give a little minute or
14 two of context to it. You, chairman, and counsel,
15 talked yesterday about Dr Asghar's letter in June. That
16 included a significant amount of issues in terms of
17 competence, not just in the Lucy Crawford case, and
18 conduct in terms of harassment and bullying. He
19 followed that up with other letters and the result was
20 that I had effectively four streams of work ongoing:
21 stream 1 was the one this inquiry is most interested in,
22 the Lucy Crawford review; stream 2 was the competency of
23 Dr O'Donohoe in a wider sense; stream 3 was harassment
24 and bullying; and stream 4 was not fulfilling his
25 contract and attending sessions and other things.

1 I therefore had a very big agenda in terms of the
2 competency, et cetera, and performance of Dr O'Donohoe
3 to move forward at the same time. I was taking that
4 forward and the papers, et cetera, therefore would
5 appear that I'm giving an awful lot of weight to that
6 end of moving the situation forward.
7 It's very important to recognise the complexity of
8 all that while a review is coming to an end, but what
9 that subsequently led to was me going, "There is
10 an issue here, not just arising out of Lucy Crawford,
11 but arising out of all of the other areas of complaint
12 of Dr Asghar and others that patient safety, children's
13 safety, may be at risk". So, as a medical director,
14 that naturally became a dominant focus of mine. It
15 wasn't to lose sight of one of the strands of
16 investigation in Lucy Crawford, but it's to explain to
17 the inquiry why a phrase like that exists.
18 The GMC would have got all of that information
19 in relation to those aspects of investigating
20 Dr O'Donohoe that are predominantly redacted in the
21 papers before the inquiry. I hope that's helpful,
22 chairman.
23 Q. Yes. Could we just look at a number of other aspects of
24 Dr Durkin's report which I'd ask to your comment on.
25 In the paragraph in the middle of the page it says:

1 "From the documentation provided, Mr Fee was tasked
2 with the leadership of the investigation into the death
3 of Lucy Crawford."
4 Is that right?
5 A. Well, I believed it was a joint leadership. Now,
6 obviously you've heard already in oral evidence that
7 Dr Anderson feels he was playing a lesser role, but
8 I believed it was a joint -- Mr Fee, I presume this
9 afternoon, will answer that more fully.
10 Q. The paragraph moves on to say:
11 "The report [that is presumably Dr Quinn's report]
12 was shared with Dr Kelly, who had the opportunity to
13 discuss the report with Dr Quinn."
14 That's not correct, is it?
15 A. Well, I discussed the verbal report with Dr Quinn in the
16 room.
17 Q. No, you received the verbal report from Dr Quinn in the
18 room.
19 A. And we discussed it in the room, so in that sense we
20 were discussing his report. We went to receive his
21 report, we received a report, we discussed it and he put
22 it in writing afterwards. So I did believe I was
23 receiving a report in that sense on the day.
24 Q. You didn't discuss his written report with him?
25 A. No, I did not go back and discuss what I received a week

1 later and ring Dr Quinn and query anything.
2 Q. Moving on down the page under section 7, Dr Durkin
3 refers to the actions taken in the context of the
4 Royal College. He then goes on to say:
5 "It is recorded that he made a written update to the
6 Western Health and Social Services Board following
7 receipt of the report in May 2000."
8 This is incorrect also, isn't it?
9 A. I think he's referring back to the letter during the
10 review, I suspect.
11 Q. Yes. By which stage --
12 A. I was giving a written update on the process rather than
13 the end of the review, yes, I think. I suspect. That
14 would have to be clarified with Dr Durkin.
15 Q. By which stage Mr Fee had merely had a preliminary
16 conversation with Dr Quinn on 2 May and the report
17 which --
18 A. Chairman, I have to be careful here because this is me
19 speculating what way Dr Durkin arrived at that
20 conclusion.
21 Q. Yes. I simply want to invite you to comment on whether
22 it's correct or not. There was no report to hand by
23 this time for you to send to the Western Board.
24 A. The report went to the Western Board after that, you're
25 correct.

1 Q. If we could have over the page, please. Maybe this page
2 and the previous page up together. Towards the bottom
3 of the left-hand page, it goes on to say:
4 "It is recorded that he discussed the findings of
5 the report with senior members of the clinical team at
6 Altnagelvin Hospital."
7 Is that correct?
8 A. Can you direct me to where we are?
9 Q. I beg your pardon. The left-hand page just where
10 we were talking about the Western Board and
11 the suggestion that you made a written update to the
12 board in respect of the report in May 2000, which
13 doesn't appear to be correct. Then it says:
14 "It is recorded that he [that is you] discussed the
15 findings of the report with senior members of the
16 clinical team at Altnagelvin Hospital."
17 A. I think he's referring to senior clinical members of the
18 Western Board, the doctor, nurse, Bill McConnell -- I'm
19 presuming that -- and Martin Bradley.
20 Q. How can one presume that from that? It's two different
21 things.
22 A. I agree.
23 Q. Is it correct that you discussed the findings --
24 A. No, I did not discuss the findings of the review in 2000
25 with the clinical members of Altnagelvin. I didn't have

1 a forum for doing it.
2 Q. But the top of the page then, on the right-hand side, it
3 says:
4 "It is apparent that he shared the findings of
5 published materials on this matter with staff at
6 Altnagelvin Hospital."
7 A. Can you draw me to where we are?
8 Q. The second paragraph. It's highlighted for you now.
9 A. So the findings ... I'm not sure which --
10 Q. "It is apparent that he [that is you] shared the
11 findings of published materials on this matter [that is
12 presumably the subject matter of --
13 A. Dr Stewart's report. We seem to have moved on to --
14 we're now after Dr Stewart's and the Royal College of
15 Paediatricians and Child Health involvement. So we are
16 at that stage now, and it is apparent, based on that,
17 that I've shared that with staff at Altnagelvin. I've
18 shared it with the staff in the Erne Hospital, the
19 paediatric staff. That's who I have shared with it. So
20 that's incorrect. In terms of discussions with any
21 staff at Altnagelvin Hospital, that was with the medical
22 director, Raymond Fulton, and I'm sure that's recorded.
23 Q. You had an informal meeting with him on --
24 A. Correct.
25 Q. -- on the edges of the medical directors' group meeting.

1 Are you telling us that these references to discussing
2 these matters with Altnagelvin Hospital are incorrect?
3 A. That's incorrect.
4 Q. Can you help us, doctor, on how he could have reached
5 such factually inaccurate views?
6 A. I can't.
7 MR GREEN: That's a matter, with respect, for Dr Durkin.
8 THE CHAIRMAN: Yes, but either Dr Durkin has made the
9 mistake or else he has been provided with incorrect
10 information. This is a fairly significant report,
11 Mr Green, isn't it? This is the basis of the GMC
12 deciding to take no action.
13 MR GREEN: I agree it is plainly a significant report and
14 the conclusion is plainly significant. I don't cavil or
15 baulk at that proposition at all, but I wonder, in the
16 interests of fairness, if a particular document could be
17 pulled up? It's 067b-067-158. You see it's headed on
18 Altnagelvin notepaper. And then if you go down to the
19 fourth bullet point, you see that it says:
20 "On 18 June 2001, the Trust's then medical director,
21 Dr Raymond Fulton, met with Dr Ian Carson, deputy CMO
22 and medical directors from other Northern Ireland
23 trusts."
24 I mention that as a starting point because then
25 if we follow that through, and that's a document

1 actually dated 18 June 2001, if we move forward to
2 a document dated 21 June 2001, the reference is
3 036A-055-141, then there's a letter from Dr Kelly to his
4 colleagues at the Erne Hospital, which doesn't
5 explicitly make reference to a meeting in Altnagelvin,
6 but if one follows it back to the only reference that
7 I've been able to identify in the documentation about
8 a medical directors' meeting in the recent days before
9 that letter was written, it takes one back to 18 June.
10 THE CHAIRMAN: 15 June, I think, is it?
11 MR GREEN: 15 June at the top. The actual document, if you
12 wheel through to the end of several pages, is 18 June.
13 You will see in parentheses there's a reference to
14 "the article in the BMJ (see enclosure)". I just want
15 to be careful that I've got my own reference right on
16 this point. But the next document in the sequence then
17 appears to be that very document that's referred to in
18 brackets, and that's at 036A-056-142. You will see that
19 that's an article about this subject and, at the bottom,
20 there is a reference to BMJ, volume 322, 31 March 2001
21 it's dated. I don't know if that assists my learned
22 friend, but I thought it right in fairness that if he's
23 going down this line, I should draw the inquiry's
24 attention to those three documents.
25 MR WOLFE: I'm not sure how it assists the question that

1 I asked, doctor. The question is limited to whether you
2 can help us to explain how the author of that report,
3 Dr Durkin, came to think that you had discussed a report
4 with clinicians in Altnagelvin and went on to share with
5 them academic articles. Altnagelvin as opposed to your
6 own trust. That seems to be --
7 A. I'm assuming Dr Durkin has looked at the paper, the
8 Insight article there, seen this reference to this
9 meeting. I referenced this same meeting and it's
10 immediately followed by my alert letter to all of the
11 paediatricians, et cetera, in the Erne Hospital. He has
12 over interpreted that that in some way I've sent the same
13 thing to Altnagelvin. But I have had a discussion with
14 Dr Fulton, one of the clinical team at Altnagelvin, and
15 discussed this issue. I'm aware of the actions he's
16 taken locally and, together, we raised this issue with
17 the CMO.
18 Q. Yes.
19 A. So that would be my understanding of how the GMC could
20 have got that line.
21 Q. Right. And in what way did you raise it with the CMO?
22 A. I was at the meeting.
23 Q. Is this the June 2001 meeting?
24 A. Yes. So the June 2001 meeting was a meeting of the
25 medical directors across the Province. I can't recall

1 how many were present. Members of the CMO office would
2 have been chairing that meeting and, during the coffee
3 break of that meeting, I went to my colleague, as it
4 were, Dr Fulton from Altnagelvin, and said, "How are
5 you? How are things?", and he said, "Fine, but we've
6 just recently had a tragic death", and he described some
7 details but only short details of what had happened
8 in the Raychel Ferguson case. The name wasn't
9 mentioned. And I shared with him that I'd just come
10 back from a meeting fairly recently with Moira Stewart.
11 I'd shared with him some very brief details of the
12 Lucy Crawford case. I'd shared with him the complexity
13 of it and that there may have been some fluid issues
14 involved in that and that we had been advised by the
15 Royal that they no longer used this Solution No. 18 that
16 was -- and they had seemed to change practice or
17 guidelines.
18 So we had this discussion and out of that discussion
19 we both went, "There's something odd about this,
20 we haven't come across this before and here we are with
21 a problem". So I said to Dr Fulton, "I wonder, has
22 anybody else heard of this problem", and we went and had
23 a discussion with another group of medical directors.
24 And in my witness statement I, to the best of my
25 ability, tried to recall who was present and might have

1 participated in that meeting. So I hope that's helpful
2 to the inquiry, the names.
3 We began to hear of occasional reports, near misses,
4 that seemed to relate to No. 18 Solution. One of the
5 medical directors, I can't remember which, said that he
6 had attended a conference recently where there had been
7 a paper or abstract presented on this issue. So that's
8 the context. That was again still all during a coffee
9 break. Dr Fulton and myself had a further conversation
10 and said, "If the Royal's changed its guidelines, maybe
11 there's something we need to think about regionally
12 here", and Raymond Fulton asked me, "Should we raise it
13 at this meeting?", and I said, "Most definitely. Let's
14 raise it". But it wasn't a matter of raising it; it was
15 raise it and ask for them to look at a regional guidance
16 on this issue, "There's something in this".
17 So that's the context, that's my recollection of
18 what happened. I didn't personally raise it myself
19 because I had to get back, I was on duty, so I had to
20 leave the meeting before the end of it and, as I said
21 when I was asked yesterday, this is not a meeting that
22 discusses clinical incidents or adverse incident
23 reporting, this is a meeting on strategic agenda items,
24 so to speak.
25 Q. Yes.

1 A. So this was brought up by Dr Fulton under any other
2 business, after I'd gone.
3 Q. After you'd gone?
4 A. I checked with Dr Fulton again over the summer that it
5 had been raised, he assured me it had, and I also
6 checked with the Western Board later that they had taken
7 action on it.
8 Q. And it was the discussion at this meeting that prompted
9 you to write the letter internally, which my learned
10 friend has identified?
11 A. That's right. It's the combination of the two, of the
12 meeting with Dr Stewart, the change in practice that
13 seemed to be evident in the Royal and hearing that
14 there's something emerging. It wasn't clear enough, but
15 it was enough to set an alarm bell off in my head that
16 there's something in fluids here that I need to put
17 something out quickly on whilst the department looks at
18 whether that's needed or not. I was also conscious that
19 we, in a small peripheral hospital, might be behind best
20 practice in the centre.
21 Q. Okay. Let me ask you, first of all, about the change in
22 practice at the Royal. You have told us that that fact
23 emerged during your discussions with Dr Moira Stewart
24 initially.
25 A. Yes.

1 Q. Did she explain the change in practice to you?
2 A. I think, again, this has to be seen in the context of
3 a much longer conversation of an hour or two, discussing
4 four cases, not one case.
5 Q. If we could move quickly to that and deal with that.
6 A. Yes. So the phrasing that led up to that was to do with
7 electrolyte changes and Moira Stewart indicating to me
8 that there's significant ongoing debate in relation to
9 fluid management in terms of rehydration. So that's the
10 context of what was happening.
11 Q. Doctor, just to be clear, we're going to come to the
12 Moira Stewart meeting in some detail. I want to deal
13 slightly out of chronology, but because it's convenient
14 to deal with it now, deal, if you would, please, with
15 your understanding of the change in practice in the
16 Royal.
17 A. So Dr Stewart, out of that aspect of there's a change in
18 debate, said, "We no longer use No. 18 Solution".
19 I obviously expressed surprise, as it was still in
20 existing guidelines, it wasn't removed from all
21 guidelines. I was surprised. And the message she said
22 to me was, "We've had some problems with it in the
23 past". That was it. No identification of cases of what
24 happened, no identification of any deaths, no
25 identification of where the cases might have come from,

1 et cetera. That was what I understood she was saying to
2 me.
3 Q. Yes. Could I just interject there, doctor, to put it in
4 context? This meeting was happening on 31 May 2001;
5 isn't that correct?
6 A. That's correct.
7 Q. And the death of Lucy Crawford had happened some
8 14 months or so earlier; isn't that right?
9 A. Yes.
10 Q. Can you tell us whether, when she talked about the
11 reasons for the change in practice, whether the death of
12 Lucy Crawford was discussed in that context?
13 A. Oh no, not at all. It was nothing to do with the case
14 we were discussing; it was clearly to do with other
15 events.
16 Q. Right. And did she tell you what those other events
17 were to the best of your recollection?
18 A. No, it was literally, as I said, like a passing comment,
19 "We've had problems before with this fluid". It wasn't
20 about deaths that I perceived at the time and that had
21 led them to change their practice. That's how
22 I interpreted that conversation.
23 Q. Very well.
24 A. And I interpreted it as more than that because I used
25 the phrase to Dr Fulton in our conversation, that it led

1 to change in guidelines, which may not actually have
2 been correct. It may have been a simple change in
3 practice.
4 Q. Let me then move to your conversation with Dr Fulton and
5 unpack that a little bit more. Was he aware of the
6 change in practice at the Royal?
7 A. I don't know the answer to that question. My impression
8 was he was aware things had changed, but I don't know
9 the extent to what that meant when he was talking to me.
10 It would be fair to say that, as that conversation
11 proceeded, we were both alarmed that there had been
12 a change in practice that we didn't seem to be aware of.
13 I think it would be fair to say Dr Fulton and myself
14 were quite annoyed at that time.
15 Q. And did you, doctor, see any correlation between what
16 you were being told at that discussion with Dr Fulton
17 and the death of Lucy Crawford?
18 A. I saw the correlation in terms that the fluids were
19 a more complicated issue than we had realised, that
20 there was some new problem or appeared to be a new
21 problem emerging with this No. 18 Solution and I was
22 aware that this was the solution that had been given to
23 Lucy Crawford. So therefore it may have been a factor,
24 so in that sense, yes. But the discussion that occurred
25 with Dr Fulton and all those other medical directors was

1 very much in relation to acute surgical cases receiving
2 fluid, and one of the medical directors -- I don't
3 recall which one -- specifically said, "This is to do
4 with the stress at the time of surgery and the fluid
5 thereafter". So that was why it didn't immediately
6 accord with Lucy Crawford directly; they seemed to be
7 very different types of cases.
8 Q. Let me leave that issue now behind us.
9 THE CHAIRMAN: Sorry, just before you do. You just said to
10 me that you and Dr Fulton were annoyed about a change
11 in the Royal which hadn't been communicated elsewhere;
12 is that right?
13 A. That was in that moment of conversation we were quite
14 cross.
15 THE CHAIRMAN: Dr Carson told me a few days ago in this era
16 there just wasn't the sending out of information from
17 the Royal to the district hospitals or exchanging
18 between different hospitals about lessons learnt.
19 A. And I would respond to that and go, "Well, we're
20 surprised, we're annoyed at that time that something as
21 fundamental as that was not shared with us". Because
22 that's -- our perception was it would have been.
23 THE CHAIRMAN: Did you have a different experience from the
24 one that Dr Carson has suggested? Did you have
25 experience in the Erne of receiving information or

1 advice from the Royal to the various district hospitals?
2 A. I would be unable to recall any specific example,
3 chairman. But I would have expected a change as
4 fundamental as that, that was arising out of problems,
5 that would have been shared. That's the conversation we
6 had on the day, so we had an expectation that something
7 as fundamental as that would be shared wider, through
8 some pathway.
9 MR WOLFE: Let me move back, doctor --
10 MR QUINN: It occurred to me that this is a very important
11 issue for any recommendations arising out of this
12 inquiry. It occurs to me that perhaps this should be
13 followed up a little more tightly and the witness asked,
14 for example, were there any serious issues that were
15 subject to the exchange of information between the
16 various hospitals, albeit the two teaching hospitals,
17 Altnagelvin -- or three -- Antrim and Belfast, the
18 Royal. Can he think of any specific issues that were
19 raised by way of exchange of information?
20 A. All I can comment is, not many paediatricians, they
21 wouldn't automatically come to me. I wouldn't have
22 expected it to come to me if it was a fluid issue.
23 I would expected it come to the paediatric departments
24 directly. So --
25 MR QUINN: I wasn't meaning just a fluid issue; I meant

1 a general issue, so we can then tie down whether or not
2 there was any exchange of information then or whether
3 we were just missing out on the fluid exchanges.
4 A. I can't immediately recall anything that I could share
5 with you. So that would have to be asked through the
6 paediatric departments of the Province.
7 THE CHAIRMAN: Well, how long were you medical director for,
8 doctor?
9 A. Three years.
10 THE CHAIRMAN: Do you remember, at any time in those three
11 years, receiving any information from the Royal or, for
12 that matter, from any other hospital about something
13 which went wrong here and we should all be alert to it?
14 A. I don't remember in the terms of being alert to, that
15 method. I can't recall, chairman, off the top of my
16 head.
17 THE CHAIRMAN: In more recent years, do you have any
18 experience of information reaching you from the Royal?
19 A. In more recent years, it would have gone through the
20 department, and that would have been the conduit to get
21 it out. There is a mechanism for doing that.
22 THE CHAIRMAN: Can you give me an example, apart from the
23 hyponatraemia guidelines, of something that has come out
24 from the department?
25 A. That's come from Belfast? I can't off the top of my

1 head, sir. Put on the spot, I can't. If something
2 comes up, I'll ...
3 THE CHAIRMAN: Or even if something comes up after your
4 evidence, if you could tell us.
5 A. I certainly will, chairman.
6 MR WOLFE: Let me conclude with the review report and your
7 involvement in that. When we asked Dr Anderson the
8 other day about what happened to the report after it
9 left his desk, or after it left Mr Fee's desk, and went
10 to senior management, he responded that he received no
11 feedback, he had no further involvement with the report.
12 I want to just identify from you, what, if any, formal
13 response did the senior management team make to the
14 report?
15 A. In terms of -- can we clarify which report we're
16 talking?
17 Q. The review report --
18 A. Okay.
19 Q. -- which Mr Fee --
20 A. In 2000, the report went to Mr Mills. Mr Mills shared
21 it with the chairman of the Trust. Mr Mills shared it
22 with Dr McConnell and the chief executive of the -- or
23 general manager of the Western Trust, Mr Frawley at that
24 time, so it was discussed in those terms --
25 Q. Can we just stop it there? I think if we build too much

1 into your answer -- and you can certainly go back and
2 add to it, but I just want to stop you there. Apart
3 from disseminating the report outwards, was there
4 a formal senior management response to it? In other
5 words, can we point to a document which says: we have
6 considered this report and this is our view as a senior
7 management team?
8 A. No. That would not have been a process that happened at
9 that time, that senior management team sat down,
10 deliberated over a document and then had an action to
11 sign it off. It would happen now, but it didn't happen
12 then.
13 Q. Right. We're not talking very many years ago, doctor.
14 This report comes into the senior management team and
15 discussion of it is not formally recorded?
16 A. Yes. Counsel, I would say that we are talking
17 effectively a generation ago in terms of governance and
18 the way health systems work. So it is radically
19 different, even if we're talking 12 or 13 years ago from
20 today.
21 Q. Very well.
22 A. You're right, it was not signed-off by a meeting of
23 senior managers.
24 Q. Right. The report contains certain recommendations.
25 A. Yes.

1 Q. As medical director, was it incumbent upon you to set up
2 some sort of audit process, whether formal or informal,
3 to determine that those recommendations were put into
4 effect?
5 A. Well, I had to be confident that the directorate was
6 addressing them, but there was no audit trail or audit
7 process wrapped round reports, I guess, at that time --
8 Q. That's why I used the phrase "formal or informal" --
9 THE CHAIRMAN: I don't understand what that means:
10 "I had to be confident that the directorate was
11 addressing them."
12 What does that mean?
13 A. It means that -- in conversation with the directorate,
14 asking them: are you dealing with these recommendations?
15 And as I stated yesterday, I specifically spoke -- to
16 satisfy myself before the review was finalised I spoke
17 to the clinical director, the lead for paediatrics in
18 terms of medicine, the lead for paediatrics in terms of
19 nursing, to make sure they were fully aware and that my
20 expectation is that these would be addressed. That's
21 what I mean by satisfying myself that there was
22 a reasonable approach by the directorate to these. But
23 I didn't -- going back to your point, counsel, I did not
24 set up an audit on it.
25 MR WOLFE: That's why I used the phrase "formal or

1 informal".
2 A. There was no formal audit --
3 Q. Let's put the word audit in the bin and just ask in
4 plain man's language: was there any system of
5 communication at all by which you would check and
6 satisfy yourself, for example, that the directorate was
7 sitting down with its staff to go through the report and
8 understand the lessons that could be derived from it?
9 A. At that time, there was no system as you're describing.
10 Q. In other words, somebody failed to pick up the phone and
11 say, "Have you carried out that meeting yet?"
12 A. Correct.
13 Q. And that is a simple thing that could have been done,
14 but simply wasn't done?
15 A. I agree.
16 Q. And the same with the communication with the parents,
17 which we discussed at length yesterday?
18 A. And we agreed yesterday on that as well.
19 Q. Is this just an example of an inefficient organisation
20 or does it run deeper than that, doctor? Is there
21 something --
22 A. I think --
23 Q. If I can put the question in this way, doctor: should
24 the public infer from this failure to deal with those
25 two important recommendations that there was

1 a reluctance to talk out loud about the treatment and
2 death of this child?
3 A. Well, I don't think the public should infer that. It
4 certainly was not my impression at the time and I think
5 it was common at the time for this to be done in that
6 fashion. Completely different now, but even within
7 a couple of years after that, as I stated yesterday, the
8 work that was ongoing under clinical governance for
9 adverse incidents, clinical reporting, that led to all
10 of those coming through the hospital council to a formal
11 report and an action sign-off. So very quickly, in the
12 subsequent years, the process changed.
13 Q. Dr MacFaul, as well as making those points that I've
14 just put to you, suggests that really, in order to
15 conduct this review process properly, the final report
16 should have gone to Dr Quinn together with all of the
17 appendices to enquire from him whether any of that
18 changed his views in relation to the conclusions that he
19 had reached. Should that have been done?
20 A. I understand. I had never heard of that happening
21 before on previous reviews. But again, I wouldn't have
22 had a lot of experience of previous reviews whereby the
23 whole report at the end is sent to a participant in it
24 to ask if they are content with the overall report.
25 Q. You've told us that it was your impression or your

1 expectation, I should say, that an inquest would occur.
2 A. Yes.
3 Q. You should have, according to Dr MacFaul, brought to the
4 attention of the coroner that this review had been
5 conducted and the conclusions that were reached.
6 A. And I'm surprised at Dr MacFaul stating that. It
7 certainly wasn't convention at the time. If a death has
8 been reported to the coroner and an inquest is expected,
9 the coroner makes contact and seeks access to the
10 information as and when he is setting up the inquest.
11 So I'd not come across this. I didn't come across it
12 even in recent years that stuff was sent to the coroner
13 in advance of him scheduling the inquest. So I am
14 surprised at him stating it like that.
15 Q. I know it was ultimately a false belief in the sense
16 that an inquest wasn't being arranged, but your position
17 is that if an inquest is being arranged then there's no
18 further duty to bring information with regard to the
19 death to the attention of the coroner in advance of the
20 hearing?
21 A. That would have been my understanding at the time.
22 THE CHAIRMAN: So you don't volunteer anything which is
23 relevant to the coroner if he doesn't specifically know
24 about it and ask for it?
25 A. Well, as I said, my understanding of the time is you

1 didn't send documents off to the coroner. I'm not aware
2 of it being done by anybody else.
3 MR WOLFE: In fairness, doctor, the inquiry has a report
4 from its other expert, apart from Dr MacFaul, who
5 suggests, just as you suggest, that once the coroner is
6 seized of the, if you like, the death in the sense of
7 arranging an inquest, there's no immediate requirement
8 to follow-up to the coroner with new information as it
9 emerges. But certainly by the time this inquest was
10 finally arranged, doctor, in 2004, do you know whether
11 the reports from the Royal College, for example, and the
12 report of the review were brought to his attention?
13 A. I'm unable to answer that. I was not in the medical
14 director's post for the previous six months or so, so
15 I wasn't involved in that aspect. The inquest
16 preparation and management of all that would lie with
17 the Trust legal team, so as soon as there as an inquest
18 has been established, the Trust's team deal with all
19 that and they link with the coroner. It's not done
20 through anybody else.
21 MR GREEN: May I interject, sir, just to help and give you
22 a reference if you would like to note it? I'm not going
23 to read out the underlying material because it is really
24 a matter for a submission rather than an interjection on
25 the evidence. It just seems convenient to deal with it

1 in this way.
2 Bridget Dolan, as you know, has prepared a report to
3 this inquiry, which is on the website. She deals, at
4 paragraphs 4.35 and 4.36, with the extent of the
5 statutory and common law duties of disclosure to
6 a coroner, both in Northern Ireland and England and
7 Wales. I simply stand up at this point to give you the
8 reference so that you can insert it if you wish in
9 a convenient place in your note and look it up at your
10 leisure if you think that's going to assist you in due
11 course.
12 THE CHAIRMAN: Thank you, Mr Green.
13 MR WOLFE: Dr MacFaul also makes the point, doctor, that:
14 "In light of the failure of this review to identify
15 with any degree of certainty the underlying cause of
16 Lucy's demise, a further review ought to have been
17 conducted."
18 Was that something that was the subject of
19 conversation among the senior management team?
20 A. Not in such an explicit fashion as you're making it.
21 I would say to you that, following the review, we were
22 acutely aware that there were a number of potential
23 mechanisms but no clear-cut cause of death. So in terms
24 of discussions, for example between myself and Mr Mills,
25 the concept of the inquest adding information there to

1 the cause of death or identifying the cause of death
2 would have been discussed. Additionally, these other
3 streams of work were proceeding and ultimately in July,
4 before the review had finished, we were considering
5 involving the Royal College of Paediatrics and Child
6 Health. So in July, before I'd even received the final
7 review report, I was talking to Dr Stewart, seeking
8 advice.
9 Why was I talking to Dr Stewart? Dr Stewart is the
10 Regional Adviser for Paediatrics in Northern Ireland.
11 I was asking her advice on how to proceed generally with
12 the competency issues, and following on from that in
13 a conversation between myself and Dr Mills, we were
14 pretty determined we were going to include the
15 Lucy Crawford case in the review if the Royal College of
16 Physicians, Royal College of Paediatrics and Child
17 Health would agree.
18 So from that point of view, we had already in our
19 mind that the Royal College of Paediatrics and Child
20 Health were coming in to do a review and that this case
21 would not be left out of that review, would be
22 incorporated into it. So in that sense there was the
23 concept of a further look at this case.
24 Q. That isn't a complete answer to Dr McFaul's point
25 because as you know, the Royal College review under

1 the auspices of Dr Stewart was designed primarily to
2 focus upon the competence of Dr O'Donohoe, albeit --
3 I was going to say indirectly, but in a fairly direct
4 way also looked at Lucy Crawford's death; isn't that
5 right?
6 A. Correct.
7 Q. But the balance, as Dr Stewart would explain or has
8 explained, was in terms of the conduct and competence of
9 Dr O'Donohoe, and she wouldn't, she says, regard her
10 report as a full-blown medical report on Lucy Crawford.
11 A. And I accept that, looking back. At the time, bringing
12 the Royal College of Paediatricians and Child Health in
13 to look at cases and deciding that we'll look at
14 specific cases, to me, constituted a good external
15 review, a further external review.
16 Q. I cut you off earlier when you were listing the steps
17 that were taken by the senior management team, and in
18 particular Mr Mills, when he received the review report
19 and you say he sent a report to the chairman of the
20 board, the Trust board that is.
21 A. Yes.
22 Q. He also sent it to the Western Health and Social
23 Services Board.
24 A. That's my understanding.
25 Q. Yes. Was there anything else you wanted to add to the

1 steps that were taken?
2 A. I would share with the inquiry that there were other
3 steps taken in terms of recognising some other issues
4 relating to the review. For example, we were concerned
5 about transfer arrangements of young children to
6 Belfast, and you're aware from the other oral evidence
7 from others of the difficulties. So I met with
8 anaesthetists twice that autumn to try and bottom out
9 how we would deal with this if it were to happen again,
10 and we came up with interim guidance for the movement of
11 pregnant mothers and children. So that was one area.
12 A second area arising out of the review was the
13 identification of a problem with a paediatric
14 ventilator. So again, that was addressed through
15 hospital council and meetings. So there were aspects of
16 the review that also were addressed beyond those
17 recommendations.
18 Q. Let me take you to the interaction with the
19 Western Board in relation to the outcome of the review
20 report. Did you have dealings with Dr McConnell
21 in relation to that?
22 A. Not directly. As I explained yesterday, I had no formal
23 meetings or regular meetings with the Western Board.
24 That was all done through the chairman -- sorry, through
25 the chief executive, Mr Mills. So I didn't have any

1 direct meetings and therefore I had indirect
2 discussions. Well, I had direct discussions, but
3 through other meetings.
4 So the next time -- if it's helpful, counsel, I'll
5 go on -- the next time I discussed the review report was
6 with Dr McConnell -- and I think Martin Bradley was
7 present in September -- at a meeting. That meeting was
8 in relation to other agendas to do with acute hospital
9 provision across the Province. I travelled to their
10 offices and we did discuss the issues in relation to the
11 review. We discussed the other streams that were
12 ongoing in terms of concerns in relation to competency
13 and how I might proceed to address those.
14 Q. Do you know whether the Western Board ever replied
15 formally to the review report?
16 A. I don't know for certain, but I don't believe they did.
17 Q. Dr McConnell recalls in his witness statement to the
18 inquiry that since the specific cause of Lucy's death
19 was still unclear after the review, he concluded that
20 further work or a further review would be desirable to
21 resolve this. And if I could have up on the screen,
22 please, 286/1, page 7. That is witness statement 286/1,
23 page 7, just to place the context around what he's
24 saying.
25 A. Can you direct me, counsel?

1 Q. Yes. At the top of the page, he's saying:
2 "[He] has no recollection of the detail of any
3 advice [he] may or may not have provided to [you] or any
4 other person within the Trust."
5 If we could highlight that, please.
6 THE CHAIRMAN: If you bring up 7 and 8 together.
7 MR WOLFE: Yes.
8 THE CHAIRMAN: If you look at 15(a), the last two lines,
9 after the number 4, Dr McConnell is saying that:
10 "The specific cause of death and cerebral oedema was
11 still unclear and that further work and review would be
12 desirable to resolve this."
13 He says that is a conclusion he reached upon reading
14 the review report. Did you gather that from him?
15 A. No. I think, on the first paragraph on page 7, he's
16 referring to the conversations that might have occurred
17 or might not have occurred, but it's not very clear.
18 Looking at that first paragraph, he's describing me as
19 an experienced medical director. I'm in the post under
20 a year at that stage, so I'm not sure what stage the
21 process is that he's referring to in these. If it
22 helps, Dr McConnell did not write to me, ring me at that
23 stage and say, "You really need to do a further wider
24 review on this", but he would have been appraised that
25 autumn of my plans to -- he would have been appraised

1 not just of the plans that ... I was actively in
2 discussion because I had written to the College
3 in September. So he would have been aware that I was
4 actively discussing, with the College, them coming in to
5 look at the performance. He may have been aware at that
6 stage that I wasn't(?) planning to include the
7 Lucy Crawford case. I hope that's helpful.
8 MR WOLFE: I'll try again with the reference. WS286/2 at
9 page 5. It's arising out of his answer to the
10 earlier (c), he's asked:
11 "Why did you reach the view that a wider review
12 involving experts from outside the span of the
13 Western Board area was necessary?"
14 He goes on to say:
15 "Any review of a medical event needs to have
16 credibility in the eyes of the family involved, the
17 wider public and health professionals."
18 He goes on to say:
19 "There could therefore be a risk that Dr Quinn's
20 view alone could be viewed as in some way biased towards
21 the service which he had once been a part of. This
22 would not be fair either to the family or to him.
23 Equally, a review conducted only by external doctors
24 from more specialist centres may not necessarily take
25 into account the context within which services were

1 provided and, in consequence, I felt that both
2 perspectives would be advantageous."
3 He's asked whether he ever put his view in writing
4 and he says at (d):
5 "I am not sure whether I ever put my views in
6 writing to Dr Kelly. It would have been unusual to do
7 so."
8 At (e):
9 "How did Dr Kelly respond to your view that he
10 should consider having a wilder review? From memory,
11 Dr Kelly understood and agreed with the perspective
12 which I had given and agreed to take the points back to
13 discussions within the Sperrin Lakeland Trust."
14 That's the position that he has articulated to the
15 inquiry.
16 A. Do you want my response to that?
17 Q. Of course.
18 A. My response to the first section is that Dr McConnell
19 was specifically alerted to the involvement of Dr Quinn
20 by Mr Mills and my understanding -- certainly Mr Mills
21 never expressed to me there was any concern in that
22 relationship. I additionally had written to
23 Dr McConnell, advising him of Dr Quinn's involvement
24 in May and asking Dr -- inviting Dr McConnell to make
25 any comments he wanted at that stage. There was at no

1 stage in the process, during the active process, any
2 suggestion from Western Board officers that Dr Quinn
3 might not have been a suitable candidate. If there was,
4 I can assure you I would have intervened and changed it.
5 I believe that he's referring to 2001 rather than 2000
6 when ongoing conversations about the sheer extent of
7 concerns I had for the practice of Dr O'Donohoe, that he
8 would be advising me to get a wider look at it, and that
9 would have been the second -- I'm speculating here,
10 chairman, and it was -- he's mixed this up, 2001 with
11 2000.
12 Again, this concept that I had a good working
13 relationship with Dr Kelly. At that time, I had been
14 a medical director for under a year, so I'm puzzled by
15 the phrase. It feels that it's out of the timing.
16 Q. Tell me this, doctor, and just this sole point: the
17 report went to the Western Board; at any time was the
18 Western Board saying to the Trust, so far as you're
19 aware, whether to you directly or to anyone else, that
20 the review is inconclusive, therefore you need to
21 broaden this out and take another look at it?
22 A. I'm certain that that was never expressed to me directly
23 or indirectly from another Trust officer like Mr Mills
24 or Mr Fee.
25 Q. As you've explained before the review was completed, you

1 had engaged with the Royal College to conduct a review
2 of Dr O'Donohoe's competence and conduct; is that fair?
3 A. Can I put it in order? I sought advice firstly from
4 Dr Moira Stewart, as the Regional Adviser, on how to
5 proceed and would there be a role or help from the Royal
6 College of Paediatricians and Child Health available?
7 They had never been brought into a situation like this
8 before in our hospital. It was a very radical thing to
9 do, so I needed to check did they do that sort of thing,
10 what could they cover? I had a wide range of things to
11 be addressed. So we had a long conversation in relation
12 to what might or might not be possible. Then
13 Dr Stewart, on that phone call, agreed that she would
14 discuss it with the senior officers at the headquarters
15 of the Royal College of Paediatricians and Child Health.
16 So that's how the process started. That started in the
17 summer.
18 Q. This initial contact, from your witness statement, seems
19 to have been made by telephone on 16 July.
20 A. I don't know if I can give it specific dates, counsel.
21 I think I'm saying after I came back from leave, so
22 I might be wrong on that, but from memory -- I wouldn't
23 be able to produce a date that I made the phone call,
24 but it would have been towards the end of July, I think.
25 Q. And from there, you wrote to Dr Patricia Hamilton on

1 14 September.
2 A. Yes, the follow-on from that phone conversation,
3 Dr Stewart obviously makes contact with the officers,
4 they agree there's potential, and Dr Stewart then passes
5 to me the contact details of Patricia Hamilton, who was
6 the honorary secretary. I phone her and write to her
7 and I think the letter is in the papers, I don't know
8 the reference there of my letter to Patricia Hamilton.
9 Q. It's 036A-009-006. We don't necessarily need it up on
10 the screen.
11 MR GREEN: 016, in fact.
12 MR WOLFE: Thank you.
13 The next stage, doctor, is for Ms Hamilton to
14 respond in November, indicating that Dr Stewart had
15 agreed to act as the nominated College representative to
16 carry out the review.
17 A. That's my understanding, yes.
18 Q. And in terms of your understanding of the work that she
19 would carry out, specifically with regard to
20 Lucy Crawford's case, Lucy's case was one of the, if you
21 like, the problem cases which Dr Asghar had identified
22 in his letter.
23 A. A total of four cases.
24 Q. Yes. But I'm not interested in going to the other
25 cases. I'm focusing on Lucy Crawford. What was your

1 understanding of the work which Dr Stewart would be
2 doing around that case? What were her terms of
3 reference in that respect?
4 A. My understanding was that Dr Stewart would be
5 representing the Royal College of Paediatrics and Child
6 Health, would be coming into the Trust, interviewing,
7 looking at the situation, and reviewing these four
8 cases, and obviously the one you want to focus on,
9 Lucy Crawford's case, and providing us with information
10 relating to any ongoing concerns of how that was
11 managed, particularly in relation to Dr O'Donohoe.
12 Q. So if I could unpack that. She was going to be looking
13 at Lucy Crawford's case with a view to seeing whether
14 his management of that case gave rise to any concerns?
15 MR GREEN: I wonder if, in fact, that document my learned
16 friend has referred to a moment ago, 036A-009-016, could
17 be brought up? Because I think it may assist us all.
18 MR WOLFE: Thank you.
19 Does that assist you?
20 A. It clarifies for the inquiry the range of complex issues
21 I'm discussing. It clarifies that we are upfront in
22 demonstrating this clearly involves looking at an
23 adverse incident and the death as part of the review and
24 that the focus is on predominantly the competency of
25 Dr O'Donohoe. Now, that's the letter that went.

1 Q. Sorry, I'm not sure I follow, doctor, in terms of how it
2 assists us with regard to Lucy Crawford's case.
3 A. It doesn't specifically assist you with it. I'm just
4 sharing that this is the letter that went to the
5 College, a range of issues not just -- the case reviews
6 is the redacted bit of that -- and we're asking the
7 college, can they assist us with that, and we're
8 including in this letter a case. We're referencing it,
9 that it is our intention to include that in the review.
10 Q. But in terms of what Dr Stewart was going to be doing
11 with the Lucy Crawford case, what was your
12 understanding?
13 A. My understanding is she was going to be coming, looking
14 at the case, providing the Trust with comments on how
15 the case was managed, with particular reference to
16 Dr O'Donohoe. It would be -- how to put this? --
17 unthinkable that they would come in and ignore major
18 problems and not mention them and simply go, "That case
19 was fine, Dr O'Donohoe was fine", or, "That case is
20 fine, such another person is fine", and not actually
21 reference if they saw major problems in the care.
22 Q. But was it your understanding that she would be looking
23 at the case from the perspective of: did Dr O'Donohoe
24 manage that case in an appropriate clinical manner? Or
25 was she going to be looking at it from the perspective

1 of trying to work out what had happened to the child?
2 Or was it a combination of both?
3 A. To me, in all four cases, it was a combination of both.
4 What way had the child been managed in any of the four
5 cases? The other three cases were not deaths, by the
6 way. How they had been managed by the clinical team,
7 which Dr O'Donohoe was the lead of, if he's the
8 consultant of that patient. Was the patient's journey
9 managed appropriately? Were there additional things
10 that could have been done better? The primary focus
11 being on Dr O'Donohoe leading that case.
12 THE CHAIRMAN: Let's break for the stenographer now and be
13 back at 12 o'clock. What I would intend to do, if at
14 all possible, doctor, is to continue the next session
15 until your evidence is complete.
16 (11.47 am)
17 (A short break)
18 (12.05 pm)
19 MR WOLFE: If I could take up with the process leading up to
20 the report of Dr Stewart. We know that, on
21 9 November 2000, Ms Hamilton wrote confirming that
22 Dr Stewart was prepared to work as the nominated College
23 representative for this task.
24 Could I bring you to a letter which Dr Stewart wrote
25 to you on 25 January 2001? It's at 036a-015-050.

1 (Pause). It doesn't appear to be on the system, or at
2 least my reference may not be right.
3 By January 2001, doctor, Dr Stewart had not yet
4 received all of the notes in respect of the children
5 that she was going to be carrying out her work
6 in relation to; isn't that correct?
7 A. That's correct, yes.
8 MR GREEN: In Dr Kelly's witness statement -- I don't need
9 a page pulled up, but there's a reference to that
10 letter, 036a-015-030. We could see if that's --
11 MR WOLFE: I called out 050. Let's try 030. That's it,
12 thank you.
13 THE CHAIRMAN: Mr Green, don't hesitate to rise!
14 MR WOLFE: In this letter, Dr Stewart's writing to you
15 following a telephone conversation of the day before.
16 She has received a copy of Patricia Hamilton's letter,
17 which was written to you, and then she says that:
18 "[She thinks] it would be helpful if she had an
19 opportunity to go through the relevant case notes before
20 meeting with the individuals involved. [She] would hope
21 to do that within the next few months. It may be
22 necessary to seek paediatric specialist for an opinion
23 in one or more of the cases."
24 And she says:
25 "Once all the information has been collected, I will

1 try to make sure a report is prepared at the earliest
2 opportunity."
3 The point that Dr MacFaul makes in relation to all
4 of this is that in a matter as important as seeking to
5 identify why Lucy Crawford suffered in the way that she
6 did, this seems to have been an inordinately long period
7 of time before we get to the stage of briefing an expert
8 to provide a report.
9 A. Okay. Well, if it's helpful to the inquiry I'll try and
10 explain the process from my letter.
11 So my letter in September contained all of those
12 areas that I would wish the College to consider. The
13 College obviously spent a number of weeks, into months,
14 considering that, and then coming back to me with
15 Dr Hamilton's letter. Dr Hamilton includes within that
16 letter a whole series of indemnity forms that have to be
17 completed. That was then passed through Mr Mills,
18 because obviously I can't sign indemnity forms on behalf
19 of the Trust, Mr Mills through, presumably,
20 Bridget O'Rawe and the legal team, to finalise. Then
21 I think I have written back to Patricia Hamilton
22 in December, from memory -- you'd have to check that --
23 sending back those signed indemnity forms.
24 So that's a long part of the process. I have said
25 in that letter -- because she had indicated in her

1 letter that Dr Stewart would be the appointed officer on
2 behalf of the College -- I have said I would make
3 contact with Dr Stewart. I did do that, presumably some
4 time in the second week in December, given I'm writing
5 this letter to them in December and making sure they
6 were happy with the signed indemnity forms. I phoned
7 Dr Stewart in December and Dr Stewart advised me that
8 she wouldn't want to start until into January. So
9 therefore, there was another delay while we made contact
10 again in January. So that's the process leading up to
11 that letter and conversation.
12 Q. Were you frustrated that this process, which
13 underpinning it was a desire to get to grips to whether
14 there was a patient safety issue, could not have been
15 expedited?
16 A. I think frustrated is the wrong phrase. I was surprised
17 at how long the process takes working with an
18 organisation like the College, and if you do the timings
19 on the second College report, you'll see it equally --
20 and that's with the benefit of experience and indemnity
21 forms and all -- took seven to eight months. And it
22 seems to be -- how do I put this? -- par for the course
23 in reviews working with the College that it takes that
24 kind of length of time, but that's what it seems to be
25 to me.

1 Q. Were you concerned at the delays? I know that you've
2 explained that there were apparently good reasons for
3 the delay. But in the context of a patient-safety
4 issue, were you concerned about them?
5 A. The answer to that is yes, and both Mr Mills and myself
6 in conversation expressed concern about how long this
7 was all taking.
8 Q. You have referred in your witness statement to receiving
9 what you've called a first draft of report from
10 Dr Stewart in April 2001. And then subsequently, you
11 talk about forwarding a full report from Dr Stewart to
12 Dr McConnell on 27 June 2001.
13 A. Yes.
14 Q. I know that the reference to a first draft of a report
15 is something which Dr Stewart would take issue with.
16 You only received from her one report, isn't that right,
17 which was followed-up by a meeting?
18 A. Yes, I think that's correct. My understanding of the
19 process at the time was Dr Stewart was going to do
20 a report and then we were going to have a sit down meet
21 to clarify any issues, et cetera, that might be included
22 in her report. That's what the process, as I understood
23 it at the time, was going to be.
24 Q. Let's turn to Dr Stewart's report. You received the
25 report, as we've noted, in or about the end

1 of April 2001, and you proceeded to arrange a meeting
2 with her, which took place in or about 31 May 2001;
3 is that correct?
4 A. That's correct.
5 Q. What was the purpose of the meeting?
6 A. Well, as identified in our conversations, she would do
7 the case review. Originally, her intention was to come
8 to the hospital, and you see that -- it would be
9 convenient for yourself and the Trust and individuals
10 involved that she would do that. That was the original
11 intention as of January or in a letter received there
12 in February. That was the intention. Halfway through
13 the process, she felt she was making sufficient progress
14 through the notes that she didn't need to come to get
15 extra information from the Trust. So I was acutely
16 aware of that and felt therefore it was important that
17 the original offer of meeting afterwards on points of
18 clarification would occur.
19 Q. So the purpose of the meeting was to clarify her report?
20 A. It was if there were any issues that I wished to make
21 and points of clarification. That was my understanding
22 of the process at that time.
23 Q. Let's look at certain aspects of her report briefly
24 before moving to the meeting which you had with her. If
25 I could have up on the screen, please, 036a-025-056. If

1 I could also have up beside it 057.
2 She is telling you within this report that it is
3 difficult to determine the nature of the episode that
4 occurred at about 2.55 am, although nursing records
5 indicate some form of seizure activity. Then she refers
6 to the various measurements, including the hyponatraemia
7 and the hypokalaemia.
8 There are several possible explanations that she
9 outlines in her report; isn't that right?
10 A. Correct.
11 Q. And you can see them there?
12 A. Yes.
13 Q. One of which, at (ii), is:
14 "A seizure-like episode due to underlying
15 biochemical abnormalities."
16 She alludes or refers to the original sodium
17 reading, the repeat sodium reading, and then says:
18 "Biochemical changes are often well tolerated and
19 easily corrected with appropriate fluids replacement,
20 although these results do show a change over
21 a relatively shortly period of time."
22 That's an issue that was taken up with you at the
23 meeting; isn't that correct?
24 A. That's correct, yes.
25 Q. If we can move over the page -- sorry, just before doing

1 so and for completeness, at (iii), she deals with the
2 issue of the cerebral oedema and coning, and declares
3 that that was the episode that occurred at 3.15 am at or
4 about the time of the respiratory deterioration.
5 If we could just go to the bottom of the page, she
6 commences there by talking about the fluids that the
7 child had received; isn't that right?
8 A. Yes.
9 Q. And she explains that the fluid balance records between
10 admission and the events at 3 am are incomplete. This
11 is the recording or the documentary issue which the
12 review had picked up upon; isn't that right?
13 A. Yes.
14 Q. And then she says:
15 "0.18 per cent saline commenced at 10.30 pm, but the
16 rate is not prescribed on the fluid balance sheet."
17 Over the page, please. She goes on to say:
18 "This continues at a rate of around 100 ml per hour
19 until around 3 am when the adverse episode occurred."
20 She says:
21 "Once shock has been corrected with 20 ml of normal
22 saline, APLS guidelines for a child with moderate severe
23 dehydration would be ..."
24 Then she refers to a calculation for the fluid that
25 would go in in a 7.5 per cent dehydration situation.

1 A. Mm-hm.
2 Q. Do you see that?
3 A. I do.
4 Q. And then on the other side, the fluid that would go in
5 for a maintenance situation. She goes on to conclude:
6 "The volume given, therefore, does not appear
7 excessive. There is debate about the most appropriate
8 fluid to use. APLS guidelines show deficit should be
9 replaced with normal saline and maintenance with
10 0.18 per cent."
11 Was that the first time that you had observed
12 reference to APLS guidelines in your handling of this
13 case?
14 A. Yes. As clear-cut as that, yes.
15 Q. Then she goes on to say, correctly quoting the APLS
16 guidelines, that:
17 "For convenience, the two fluids are often combined,
18 leading to the use, in practice, of a solution of 0.45
19 of saline in 5 per cent dextrose."
20 This is the point I put to you yesterday. Although
21 she expresses herself in terms of there being a debate
22 about the most appropriate fluid to use, she's saying
23 clearly that the APLS guidelines identify a need for
24 normal saline to be used in a dehydration situation.
25 A. Yes, she's identifying that.

1 Q. Let me bring you to the meeting with Dr Stewart. You
2 made a note of that meeting; isn't that correct?
3 A. I went to that meeting having read the report and
4 considered the report, as had Mr Mills, and I made some
5 notes in a sense of questions for each case. So
6 that's -- this note looks very strange because I had
7 pre-prepared questions.
8 Q. Let's look at it then. It's 036a-027-067.
9 A. So, chairman, these questions were typed in advance and
10 then I'm putting the answer at the end.
11 Q. Are you typing as she's speaking to you?
12 A. No, no, these were typed in the days before I went to
13 the meeting, going, "What's my thoughts going into this
14 meeting, what questions do I need to ask for clarity?",
15 and because there were four cases, I typed them up in
16 advance and then afterwards added the answer in.
17 Q. Right. So these are the questions, as we see at the top
18 of the page, specific to Lucy. You combine answers 1 to
19 5 in the same short note; isn't that right?
20 A. "A1 to 5" means "answer 1 to 5".
21 Q. Could I just have your view on this? Dr Stewart has
22 said that, referring to this note, it's a brief summary
23 of a much longer conversation; isn't that right?
24 A. Well, naturally and obviously, yes.
25 Q. And so far as the note is concerned, let's just read it:

1 "Capillary refill time. Raised urea. CO2 level
2 point to circulatory failure. IV fluids were indicated
3 earlier. Overall amount of fluids once started not
4 a major problem, but rate of change of electrolytes may
5 have been responsible for the cerebral oedema. Royal
6 Victoria Hospital ward guidelines would recommend normal
7 saline, not one-fifth normal as the replacement fluid.
8 Other issues: was this child bagged with mask for one
9 hour? Anaesthetist's involvement."
10 Just on one point of accuracy, I think Dr Stewart is
11 clear in her recollection that Royal Victoria Hospital
12 ward guidelines was not what she was referring to; she
13 was referring to APLS guidelines. Could that be
14 correct?
15 A. I don't think so. Well, it could be correct, but it's
16 not my interpretation of it. I wouldn't use -- I think
17 in her witness statement, she alluded to that she would
18 never use a phrase "RVH ward", but that would be what
19 I would call the Royal Belfast Hospital for Sick
20 Children. That would be a phrase that wouldn't run off
21 the top of my tongue; when I'm talking I'd be saying,
22 "This is RVH ward". So my perception at that time, my
23 leaving that meeting, was that we were talking not about
24 APLS guidelines, but the Royal Children's ward
25 guidelines. That would be my perception of that.

1 Why would there be any potential difference there?
2 APLS guidelines are something out there based on
3 training round the paediatric life support. Often
4 updated every four years. And they would, I would
5 imagine, be the basis of any guidelines or practices
6 that the Royal wards are working to. I hope that's
7 helpful.
8 Q. Let me see if you can help us with the interpretation of
9 the note. Where it says, "Overall amount of fluids once
10 started not a major problem", do you see that, the
11 second line?
12 A. Yes.
13 Q. Can I put to you Dr Stewart's perspective on what she
14 was talking about in that context? She's told us in her
15 witness statement that her opinion was that a volume of
16 400 ml of fluid given to a child with evidence of shock
17 over a four-hour period, including resuscitation,
18 maintenance and replacement fluids, would not usually be
19 excessive. So she's saying 400 ml wouldn't usually be
20 excessive if it contained fluids for each of those
21 problems. But what she is saying is that the exclusive
22 use of hypotonic fluids such as Solution No. 18, as was
23 used in this case, led to a rapid fall in sodium and
24 resulted in the acute deterioration around 3 am or
25 thereabouts.

1 So I realise that your note is very condensed to the
2 point that it's abbreviating what is being discussed,
3 but do you share Dr Stewart's view that that is what she
4 was saying to you?
5 A. Well, my view on this would be as strong as this: if
6 Dr Stewart was saying under no circumstances use No. 18
7 Solution in this mix, I would have recorded a version of
8 that. If she's saying that as clear as that, then there
9 would be a -- that would be the note.
10 Q. Well, is she saying, just reading that line in its
11 totality, that sentence, "overall amount of fluids"
12 through to the words "cerebral oedema", is she saying,
13 to you -- she seemed to have combined a number of points
14 in the one sentence. This note indicates that there was
15 a need for normal saline for replacement; isn't that
16 right? That's what the guidelines say.
17 A. Yes.
18 Q. And she seems to be saying, or the note seems to be
19 saying, that the fluids caused a change in the
20 electrolytes, which may have been responsible for the
21 cerebral oedema; is that a fair way to read that?
22 A. If I put it into what actually, in my impression,
23 happened at the meeting, was that key question -- the
24 first two questions are fairly obvious and are dealt
25 with. She is identifying, yes, this should have been --

1 this child was sicker than you folks realised, she
2 should have got intravenous fluids earlier, and while it
3 is reasonable in mild dehydration to push oral, in this
4 case she should have got intravenous fluids earlier.
5 That's the first two questions. The second question is
6 obviously mine and the insertion the line.
7 The next two questions are about a very specific
8 question. I was very surprised in the report with the
9 notion that a sodium of 127 would lead in itself to
10 seizures. I did not expect that. As I've said to you
11 earlier, in adults, care of the elderly medicine, we
12 deal with sodiums down at 119, even lower, without
13 seizures, not commonly, but on an irregular basis, so
14 we would not expect, as a geriatrician, as a physician
15 geriatrician, we would not expect to see seizures with
16 sodiums of 127. It would be below the 120 mark that
17 we would really start to get concerned about seizures
18 and neurological problems.
19 Q. If I could just make this point to you because I think
20 it's important: she was explaining, in a report to you,
21 that the rate of drop may have been significant.
22 A. Yes.
23 Q. Isn't that right?
24 A. That's correct. So she's then going on to elaborate
25 that point for me, nice and clearly, "Yes, this could

1 have caused a seizure", and has gone on to say, "and may
2 have been a factor in the brain oedema". So that is my
3 understanding of that conversation.
4 MR DAVIES: Mr Chairman, if I may assist. It may assist the
5 inquiry if the context of this passage is addressed and
6 identified. Because I think it was Dr Kelly's earlier
7 evidence on whether the change in practice was discussed
8 in the context of the death of Lucy Crawford at all that
9 it wasn't. It was in this context at this time in the
10 meeting when the use of Solution No. 18 was discussed
11 and that discussion went on to a more general discussion
12 about the appropriateness or otherwise of such a regimen
13 in this case. So there was a specific discussion, so
14 that it's clear, about the appropriate use at this
15 point.
16 THE CHAIRMAN: Yes. And I think that's what the sentence
17 says, isn't it?
18 "RVH ward guidelines would recommend normal saline."
19 A. So the conversation that's leading me to record that is
20 we don't use No. 18 Solution any more, virtually at all,
21 in terms of replacement maintenance mixes, so that's my
22 understanding of that.
23 THE CHAIRMAN: I think Mr Wolfe's specific point to you
24 is that the report suggests -- and this is confirmed
25 here -- that the rate at which Lucy's sodium level fell

1 may have been responsible for the cerebral oedema.
2 A. Yes.
3 THE CHAIRMAN: So it's a point which was made in a report
4 and then entrenched at the meeting?
5 A. I agree.
6 MR WOLFE: Just to be clear: Dr Stewart has told us that,
7 with regard to question number 5 on the screen, she
8 remembers you asking her if she really thought that the
9 electrolyte disturbances had caused the seizure. That
10 was a question that came from you. And her response was
11 an unequivocal yes. She says, from recall, she then
12 went on to elaborate on guidelines for types of fluid
13 for replacement of dehydration and for treatment of
14 shock. Does that accord with your memory?
15 A. Not specifically in the order in which you're
16 describing. As I said, the question was, "Do you really
17 think electrolyte changes caused the seizure?", and
18 I would have asked that again in the room and Dr Stewart
19 went, "Yes, they could have caused it" -- she didn't go,
20 "They definitely caused it" -- "They could have caused
21 the seizure", and would have explained to me that the
22 young brain -- because I was obviously expounding the
23 theory that I wouldn't expect a seizure at that kind of
24 level, and she is then going on to say, "Well, in the
25 younger brain the rate of change can be very

1 significant". So she is sharing with me that it's
2 different from adult medicine to that extent.
3 Q. So in terms of your understanding of the conversation
4 with Dr Stewart about the mechanism leading to death
5 here, you clearly understood that she was saying: that
6 the fluid use affected the electrolytes, which in turn
7 caused the seizure, albeit in a child's case; it would
8 be unusual for an adult to suffer seizures at a 127, but
9 because of the particular make-up of a child this could
10 well have been a problem; and then that led to the
11 cerebral oedema?
12 A. I think my understanding of it was that Dr Stewart's
13 telling me that 127, even in a child, you wouldn't
14 automatically expect a seizure, but the rate of change
15 of electrolytes could have caused the seizure or likely
16 caused the seizure. The issue for me was that did not
17 go on to saying, "This is clearly the cause of death or
18 this is clearly the cause of very significant brain
19 oedema". That conversation didn't follow from that,
20 which is the way you're presenting it.
21 Q. Just to be clear before we move on --
22 THE CHAIRMAN: Sorry. But your note says that. The third
23 line in answer 5:
24 "The rate of change of electrolytes may have been
25 responsible for the cerebral oedema."

1 A. Yes. So I'm having this conversation with Dr Stewart
2 and she is saying, "Could have caused the seizure and
3 may have been responsible for cerebral oedema", but what
4 I'm saying is we weren't going on to have a conversation
5 of: this is what caused the death, this is what is the
6 only cause. We're still on "there's a range of
7 possibilities", so I wasn't getting from her: look,
8 you have given her far too much hypotonic fluid, it's
9 caused a very significant seizure and she's gone on to
10 develop gross cerebral oedema. That was not expressed
11 in anything like those terms in that meeting.
12 MR WOLFE: We asked her specifically, doctor, whether she
13 identified the change in electrolytes with the
14 administration of Solution No. 18 -- the exclusive use
15 of Solution No. 18 in this case -- prior to the
16 collapse, and she says, to the best of her recollection,
17 that's what she told you, that the fluids were
18 responsible.
19 A. And I can say that if I was told, "The fluids are
20 responsible as the cause of death, this is the final
21 answer in Lucy Crawford", I would definitely have
22 recorded it. And equally when I put my note in the
23 context of Dr Stewart's report, it's not there to say
24 that.
25 Q. Well, what else was discussed in terms of the causation?

1 A. Well, the other aspect, could there have been any other
2 underlying condition. The pneumonia was discussed, the
3 significance of that.
4 Q. And what was discussed in that context?
5 THE CHAIRMAN: Let me ask you this way: did she take you
6 closer to identifying a cause of death for Lucy than you
7 had previously been with your internal review and
8 assistance from Dr Quinn in Altnagelvin?
9 A. Not specifically in that terminology. She took us
10 through the range of possibilities and was also flagging
11 up that: there's been a change, we don't use this fluid
12 anymore, and the fluid may have been part of the
13 process.
14 THE CHAIRMAN: Right. Thank you.
15 MR WOLFE: When we asked you, doctor, in the context of your
16 discussions with Dr Stewart to explain your
17 understanding of what might have caused the rate of
18 change of electrolytes, you answered by saying that:
19 "[You] cannot recall giving specific consideration
20 to this question, but [you] had concluded that the rate
21 of change may have been due to the underlying
22 gastroenteritis and the bronchopneumonia."
23 Arising out of your conversation with Dr Stewart,
24 how can that be correct?
25 A. Well, my -- I suppose I was getting the following

1 information: 1, this child was much more sick than we
2 realised, the dehydration was a moderate to severe
3 dehydration. She had clearly got severe diarrhoea and
4 therefore was losing sodium all the time. So that's
5 one. Rotavirus, which we had checked back when the
6 review was being done, is known to cause quite
7 significant sodium loss and can in itself cause
8 neurological problems. We had a second issue of
9 pneumonia, which in children and in adults can give rise
10 to low sodium, probably through an SIADH mechanism --
11 I think that would be the thinking nowadays --
12 Q. Yes.
13 A. -- and particularly pneumonias in children can do this.
14 So I'm sitting with a child that has died with a low
15 sodium, what might have changed those electrolytes? A
16 developing pneumonia, a worsening gastroenteritis and
17 fluids. So the three things are in my mind at that time
18 if I'm challenged as to what way I was thinking. That
19 would be the kind of approach.
20 Q. Did Dr Stewart mention pneumonia?
21 A. We discussed it.
22 Q. Did you note it?
23 A. I didn't note it down, but we definitely discussed it.
24 Q. You were aware from what Dr O'Donohoe had written in
25 a note to you, going back to the time of the receipt of

1 the post-mortem report, that he was sceptical about the
2 post-mortem's analysis that the bronchopneumonia might
3 have been present for some time because he had carried
4 out chest X-rays post-seizure; isn't that right?
5 A. I didn't know that at the time.
6 Q. He did write to you, didn't he, upon receipt of the
7 post-mortem report?
8 A. He did not write to me. He left a copy of the
9 post-mortem on my desk with a scribbled comment on the
10 top of it. I think the comment was, "Don't know what to
11 make of bronchopneumonia". At the time --
12 Q. And the suggestion that it was of some duration?
13 A. Well, I presume that's quoting from the post-mortem.
14 Q. Yes.
15 A. At the time I interpreted that as a kind of defensive
16 position, "I'm not sure what to make of this pneumonia
17 that I might have missed".
18 Q. In terms of what Dr Stewart was saying to you, was she
19 giving you any basis to think that the bronchopneumonia
20 that was identified at post-mortem was in any sense
21 a significant factor as compared to the fluid
22 mismanagement in the development of this child's
23 terminal disease?
24 A. Can you ask that again? I lost the train of it.
25 Q. Was she giving you any reason to believe during this

1 discussion with you that the presence of the
2 bronchopneumonia that had been identified at the
3 post-mortem was in some sense as important a factor to
4 take into account when assessing the deterioration
5 leading to death?
6 A. We were definitely considering that as a possibility
7 that might be more significant, but if you ask, "Was it
8 more probable or more significant than one of the
9 others?", it wasn't done in that fashion that, "Well,
10 the potential is pneumonia here, potentially, not sure
11 what to make of it, could be something else going on,
12 could be fluids". There wasn't a sort of ranking order
13 or priority, "This is the one", or, "That's to be
14 dismissed".
15 Q. So just to be clear: when Dr Stewart tells us that she
16 explained during the meeting that the exclusive use of
17 hypotonic fluids led to a rapid fall in sodium and
18 resulted in the acute deterioration in Lucy's condition
19 at 3 am, it just didn't happen in that way; is that your
20 take on what she's saying?
21 A. I apologise. I didn't follow the two parts of that
22 question.
23 Q. We have asked her what she meant on this note where it's
24 recorded:
25 "Overall amount of fluids, once started, not a major

1 problem."
2 We have asked her to explain what that part of the
3 discussion was about, and she has come back to us and
4 said that:
5 "My opinion is that 400 ml of fluid at most, given
6 to a child, wouldn't be a problem --
7 A. Right.
8 Q. -- if it was a fluid that was properly composed of both
9 replacement rehydration and maintenance fluids."
10 Which of course wasn't the situation here; isn't
11 that right?
12 A. That's correct, yes.
13 Q. She goes on to say that:
14 "The exclusive use of hypotonic solution in this
15 case led to a rapid fall in sodium and resulted in the
16 acute deterioration at or about 3 am."
17 So she is clearly reflecting the view that that was
18 what she was articulating to you at that meeting.
19 A. And my response to that is that's not what was
20 articulated to me. It wasn't articulated in those
21 terms. It would be impossible for me not to have
22 recorded that and not to have asked further questions on
23 it if that was the case. So it would have been
24 recorded.
25 THE CHAIRMAN: Let's look at the second report then.

1 MR WOLFE: The second report that you obtained from the
2 Royal College in August 2002 identified hyponatraemia as
3 the cause; isn't that right?
4 A. If we call up the report, sorry.
5 Q. We can do that.
6 A. The summary page, it would be helpful.
7 Q. This is Dr Boon. Dealing with the second report, we
8 don't need to deal with the context of why you're
9 obtaining that report, we can leave that to one side.
10 You obtained a second report, which again, as well as
11 focusing on Lucy's death, looked at some other deaths.
12 Sorry, some other -- I shouldn't have said that.
13 A. No other deaths at all.
14 Q. Some other patients.
15 A. Yes.
16 Q. Looking at Lucy Crawford's case then, if we could have
17 up on the screen 036a-149-306, under the heading "Poor
18 documentation", Dr Boon and Dr Stewart write the
19 following conclusion with regard to Lucy:
20 "The prescription for the fluid therapy for
21 Lucy Crawford was very poorly documented and it was not
22 at all clear what fluid regime was being requested for
23 this girl."
24 So that's a problem on, if you like, the important
25 administrative side: the failure of communications and

1 the use of the prescription.
2 A. Yes.
3 Q. They say:
4 "With the benefit of hindsight, there seems to be
5 little doubt that this girl died from unrecognised
6 hyponatraemia, although at that time this was not so
7 well recognised as at present."
8 We don't need to worry about the phrasing there,
9 about the benefit of hindsight, and the inquiry has the
10 explanation for that in the statements.
11 Dealing with what they were saying about
12 unrecognised hyponatraemia, doctor, how did you
13 interpret that?
14 A. I ... What do you mean by interpret it?
15 Q. You read this report?
16 A. Yes.
17 THE CHAIRMAN: Did this give you a cause of death that you
18 hadn't previously had?
19 A. Yes, this is clear-cut: it's saying the hyponatraemia is
20 a direct cause of death and it's linked to the fluid
21 regime.
22 MR WOLFE: And was that an advance of what you'd received
23 before?
24 A. Yes. I think -- I mean, in very simple terms, if you
25 put the reviews stacked up one after the other, the

1 first review doesn't identify this issue at all,
2 effectively. The second review, the Royal College of
3 Physicians one, raises the possibility or the link to
4 fluids. The next is the medico-legal, which again says
5 it's difficult to make firm conclusions, but there may
6 be or there is a suggestion that the fluids resulted in
7 hyponatraemia, and again emphasises this was not
8 recognised at the time, and these fluids were used
9 commonly at that time. And then this one, the fourth
10 one, which is the most specific off at all in that. And
11 that's the order that I was receiving this information
12 in and all the time being reminded that this was not
13 generally known about at the time, and the use of these
14 fluids was in common practice.
15 Q. Yes. Having received that view, doctor, you
16 disseminated the report to your colleagues internally;
17 is that correct?
18 A. It went, obviously, to the chief executive. The
19 chief executive -- it'd be important to recognise at
20 this time, the team -- Dr Boon, Dr Stewart, came and
21 interviewed all of the teams -- but this is all about
22 the governance and the management of Dr O'Donohoe -- and
23 then met with the chief executive before they got the
24 report to share what had happened and what each of the
25 cases were. So the chief executive was heavily involved

1 at the end of the review and receiving the report. The
2 chairman of the Trust also received it, the report.
3 I took it down through the clinical directorate and to
4 the head or lead paediatrician, and then to each of the
5 participants, shall we put it like that.
6 So Dr Asghar, sat down with him, through a copy of
7 the report, because he had raised most of the issues
8 relating to starting the review, and Dr O'Donohoe. So
9 all that occurred as part of the process, and my
10 understanding is that a copy went to Dr McConnell. I'm
11 not sure if a copy also went to Martin Bradley later on
12 that summer.
13 Q. And that was my next point. You very well disseminated
14 it internally, you tell us.
15 A. Sorry, it wasn't so much disseminating it; it was
16 actioning it.
17 Q. Okay, it was discussed internally at those various
18 levels.
19 A. Chairman, what's not visible here is there are a number
20 of very significant recommendations relating to
21 Dr O'Donohoe, Dr Asghar, et cetera, so there were
22 actions needing to be taken at the point in time.
23 That's what I mean by not disseminating it. It wasn't
24 sent out; it was actually sat down with people to get
25 responses to it and work out how we would change for the

1 better.
2 Q. To what extent was it made known outside of the Trust
3 that fluid mismanagement had led to Lucy's death?
4 A. I'm not sure what you mean by "outside the Trust". It
5 was obviously to the Western Board --
6 Q. Yes.
7 A. -- and that's our -- as we discussed at length
8 yesterday, that was our reporting mechanism at the time.
9 Q. Yes. You've told us that you would have expected
10 Mr Mills to have briefed Dr McConnell in relation to
11 that report.
12 A. Yes.
13 Q. But you're not sure that he did so; is that fair?
14 A. I can't be certain he did. I know that I discussed the
15 report with both Dr McConnell and Martin Bradley later
16 on in the year, I think I might have given dates in my
17 statement or approximate dates, and that was about
18 achieving more change within the paediatric department,
19 and that is reflected in securing additional funding for
20 two consultants, which was almost part of the
21 recommendation, "You need to build this didn't up", and,
22 additionally, changes in terms of other aspects of the
23 service. So I was speaking to the commissioners about
24 the report, they were fully aware of it, as was a new
25 person who came into the mix, which is Margaret Kelly,

1 who had an involvement on acute services.
2 Q. And the family, doctor? Were they going to be told that
3 their child had died as a result of fluid mismanagement?
4 A. We were in the middle of litigation and I was concerned
5 about the ongoing evidence that we were accruing, and as
6 we discussed yesterday, the fact that the family were
7 not involved or informed. So I raised that concern in
8 2002 with the Trust and with DLS, seeking an opportunity
9 to go to the family, but we were in active litigation at
10 that time. I suggested to DLS at the end of 2002 that,
11 you know, we would need to settle this and talk to the
12 family. I even used and quoted a phrase at the end of
13 2002, Lord Justice Woolf's, I think it's called
14 "reaching for justice", which was a concept of mediation
15 at the time, that I'd heard in presentations, and I said
16 to the Trust legal team, "Is there any chance of
17 reaching out to the family through mediation, even if
18 the litigation isn't closed?". And I can share with you
19 that the response twice over was no.
20 THE CHAIRMAN: We can't [inaudible] out of privilege. Can
21 I take you back a bit on this, doctor? You're saying in
22 2002 that you wanted to speak to the family. When you
23 were asked earlier by Mr Wolfe yesterday and this
24 morning why the family wasn't spoken to as part of the
25 original review, the review which was done with the

1 assistance of Dr Quinn, you said that that wasn't really
2 the practice at the time. We're talking about
3 a two-year gap between 2000 and 2002.
4 A. Yes.
5 THE CHAIRMAN: You also said to me that, in 2000, there was
6 no template for the review, there were no guidelines and
7 that you were really following common sense.
8 A. Yes.
9 THE CHAIRMAN: If you're following common sense and there
10 aren't any guidelines, where does the convention come
11 from that you don't speak to the family? Because you
12 rely on that convention as excusing the failure of the
13 internal review not to discuss with the family.
14 A. Chairman, I would -- I think I'm ... I'm uncertain here
15 on ... Here's the position I would go back to: the
16 intention was to speak to the family --
17 THE CHAIRMAN: After the event?
18 A. After the event.
19 THE CHAIRMAN: But not as part of the review?
20 A. Yes.
21 THE CHAIRMAN: If there's no template and no guidelines
22 which militate against speaking to the family as part of
23 the review, particularly when they appear to have
24 relevant information to give, or even if they don't have
25 relevant information to give, why not speak to them?

1 A. What changed?
2 THE CHAIRMAN: No. Why not speak to them? There's no
3 guideline or template which is steering you away from
4 speaking to the family, so why not speak to them?
5 A. Are you talking in 2000?
6 THE CHAIRMAN: Yes.
7 A. Absolutely, I agree. Looking back, it seems absolutely
8 obvious and we should have done that.
9 THE CHAIRMAN: Sorry, when you said it seems obvious looking
10 back that we should have done it, you also said, "But
11 that wasn't the convention at the time". But there was
12 no convention. According to you, this was a new area.
13 A. There was no template, there was no formal template.
14 THE CHAIRMAN: Exactly.
15 A. You're absolutely right.
16 THE CHAIRMAN: So you don't need hindsight to say, "We
17 should have spoken to the family"?
18 A. Correct.
19 THE CHAIRMAN: Thank you.
20 MR WOLFE: The first report from --
21 MR GREEN: Once again, I find myself on my feet. It's
22 a slightly knotty point.
23 THE CHAIRMAN: You got there by yourself
24 MR GREEN: Mr McMillan didn't give me any help whatsoever.
25 THE CHAIRMAN: If only we had Mr Fortune

1 MR GREEN: Mr Hayton's chair is seeing greater occupancy
2 than it was several months ago.
3 The reason that I rise, in seriousness, is
4 in relation to the note of the consultation which
5 Dr Kelly seemed to be referring to a moment ago, which
6 I drew to the inquiry's attention yesterday. I'm
7 raising it in this slightly cautious way because
8 I recognise that Ms Simpson yesterday indicated to you
9 that that had been inadvertently allowed to make its way
10 into the inquiry papers as opposed to any waiver of it
11 in the proper sense.
12 That leaves me, at the moment, in a slightly
13 invidious position where there is something I would like
14 to draw to the inquiry's attention, where it appears
15 that this very issue of family involvement was
16 specifically discussed and particular advice given by
17 counsel now in silk and a solicitor at DLS.
18 THE CHAIRMAN: I remember that from yesterday. It was
19 Mr Good, wasn't it?
20 MR GREEN: It was indeed. I raise it because it appears
21 this was something specifically raised, contact with the
22 family. I don't feel I can or should ask for it to be
23 called up or go any further at this stage because of
24 Ms Simpson's indication. It may well be that you take
25 a different view on this, in fact it's out there now, it

1 has been waived and it's something that will assist the
2 inquiry.
3 THE CHAIRMAN: Is the gist of it that it confirms the
4 evidence that your client has just given, which is that
5 he did raise the idea of engaging with the family and
6 was steered away from it?
7 MR GREEN: Absolutely.
8 THE CHAIRMAN: Thank you very much.
9 MR WOLFE: As I understand it, this would appear to be
10 contained within a document disclosed to the inquiry by
11 this witness's solicitors and which would have gone
12 live, I think, on the website, comparatively recently.
13 THE CHAIRMAN: I think I've got the point. I'm not
14 particularly anxious to bring it back up again. I don't
15 want, at this pretty advanced stage, to get bogged down
16 into an argument of privilege or waiver of privilege or
17 inadvertent disclosure. I've got the point and I accept
18 the gist of your intervention, which is that it supports
19 what Dr Kelly's just said in relation to the latest
20 event in 2002.
21 MR GREEN: I'm very grateful. It's just that Mr Wolfe's
22 understanding may not, in fact, be correct. The origin
23 of this is that it came direct, I'm instructed, from the
24 Trust to the inquiry as opposed to being sent by my
25 instructing solicitors to the inquiry. So there can be

1 no fair suggestion that we have, as it were, generated
2 inadvertent disclosure on behalf of DLS, that they've
3 been helpless to prevent. That was all.
4 MR WOLFE: What I allude to, just to be clear, is something
5 that was said on this doctor's behalf to the GMC in
6 defence of a particular position. And that document is
7 with the inquiry and it has come via the witness's
8 solicitors. I will move on. If any further issue
9 arises, no doubt it can be dealt with at an appropriate
10 moment.
11 Doctor, just in terms of the various reports
12 obtained from the Royal College: the first report you
13 sent to Dr McConnell; is that correct?
14 A. I did, with a covering letter inviting any additional
15 comments he wished to make.
16 Q. And you met with him and Mr Bradley in October 2001 to
17 discuss the report?
18 A. That's correct.
19 Q. Did you flag up with him that during this discussion
20 that, arising out of this Royal College report, there
21 was now a concern -- that seems to be your
22 interpretation of what Dr Stewart was saying to you --
23 that the fluids may have had something to do with this?
24 In other words, you were a stage further on than you
25 were with Dr Quinn, but you hadn't quite reached the

1 stage, you would say, as was indicated in the second
2 Royal College report? In other words, did you raise
3 this fluid issue with him?
4 A. Yes. If I explain to the chairman, the conversation --
5 the meeting wasn't directly relating to that report.
6 The meeting, again, was about other strategic
7 initiatives. Martin Bradley joined us at the end of
8 that meeting to discuss the report and I took them
9 through the report and the changes I was effecting
10 in relation to -- and to the management, the ongoing
11 management, of some of the governance issues arising out
12 of that report. So that's a major section of that
13 discussion.
14 In terms of the fluids, we had a conversation,
15 I shared with him that Dr Fulton and myself had been
16 unhappy, made sure this was raised, and that regional
17 guidance might be forthcoming that we had heard that
18 perhaps the department was taking it forward.
19 He shared with me that he had also spoken or --
20 I think at that meeting I heard that either he or the
21 chief executive of Altnagelvin had spoken to the
22 department. So I was hearing a confirmatory response
23 that this issue was being addressed regionally in some
24 form or fashion. No more than that.
25 Q. So the issue arose in that context in more of a general

1 way about the fluid issues that were by now developing
2 arising out of Raychel Ferguson's death, and that being
3 taken forward?
4 A. We weren't dismissing that Lucy Crawford's death had
5 fluid issues and that No. 18 Solution and hypotonic
6 solution may have been a factor and may have been
7 an important factor. So it wasn't that we played it
8 down.
9 Q. You're telling us that Dr McConnell was aware of that
10 context because that's what you were telling him?
11 A. Well, I mean -- as I say, I have no notes of the
12 meeting, but that would be the context around things
13 that were being discussing because I was adding in this
14 discussion of, "This has gone to regional for advice, to
15 be rolled out", which, as you know, it ultimately came
16 out in March 2002 with a new guideline.
17 Q. Moving to the second report, did I pick you up earlier
18 as saying that you discussed the second report with
19 Dr McConnell?
20 A. My belief is that Dr McConnell and Martin Bradley both
21 had some discussions with myself on it as part of
22 developing a new strategic paediatric pathway, which
23 involved -- I was having to go to the commissioner to
24 get additional resources to build up the team in the
25 Erne. So in that sense, they had the report and we were

1 discussing effective long-term changes to the paediatric
2 department in the Erne. We weren't specifically
3 discussing hypotonic fluids at that meeting. I don't
4 think we were.
5 Q. That begs the question, "Why not?" Because, on your
6 analysis here, you have finally an unequivocal view of
7 what had happened to Lucy, which, after two years of
8 trying by this stage, had not led, until that very
9 point, to that conclusion.
10 A. Yes.
11 Q. Was it not an obvious thing to be bringing up and
12 discussing?
13 A. As you've said, the report was obvious, it states it
14 clearly. Dr McConnell and Martin Bradley and other
15 board members were aware of it, had read the report. We
16 were therefore discussing the next stage on, which is,
17 "What change are in place in relation to paediatrics
18 in the Erne for safety?", and, "Have the guidelines been
19 introduced?"
20 Q. By this stage, doctor, this is now getting on for late
21 2002, it was clear to you by this stage that no inquest
22 was planned; isn't that right?
23 A. I think I learnt at that stage that there was no inquest
24 planned.
25 Q. And here you now had a conclusion which implicated the

1 fluid management of the child in her death; isn't that
2 right?
3 A. Correct.
4 Q. Was anybody saying to you or were you saying to
5 yourself, "This rather ought to go back to the coroner
6 because it slipped through the net"?
7 A. Well, the first part of the question, nobody was saying
8 it, nobody was suggesting it, and of course I was in
9 a regular(?) room of the scrutiny committee and having
10 discussions about the ongoing process.
11 Obviously I don't want to release anything that's
12 privileged here in this discussion. So I was -- the
13 team that would be dealing with any inquest, et cetera,
14 were in the room. I was getting no advice from them to
15 ring the coroner or to clarify it. I have to take it on
16 myself that it didn't occur to me at that stage that
17 I should ... Once I'd heard the coroner has known about
18 this case and has closed it and a death certificate has
19 been issued at that stage, that was my thought, "Oh,
20 that's strange", but I didn't know you could go and open
21 it up again, chairman.
22 THE CHAIRMAN: Did you know that Raychel's death was going
23 to the coroner?
24 A. I didn't know anything about Raychel's death, chairman.
25 THE CHAIRMAN: Whether you knew Raychel's name, you knew

1 there had been an event in Altnagelvin.
2 A. Oh yes, I knew that.
3 THE CHAIRMAN: And you knew that was leading to regional
4 guidance. Did you not also know that was going to
5 inquest?
6 A. I think I did know it was going to inquest, yes.
7 THE CHAIRMAN: If you knew a hyponatraemia death in
8 Altnagelvin was going to inquest and you knew that
9 a hyponatraemia death in the Erne was not going to
10 inquest, how could it not possibly have occurred to you
11 to think that "Maybe we need to revisit this"?
12 A. Well, it didn't, and I have said that in both my GMC
13 statement and in my witness statement, and I regret that
14 it didn't occur to me.
15 MR WOLFE: Dr O'Donohoe, was he apprised of the unequivocal
16 conclusion contained in the second Royal College report?
17 A. Yes. Mr Fee and myself sat down formally with
18 Dr O'Donohoe, took him through the report, and all of
19 the aspects of it, sought his insight and that he went
20 on to demonstrate it and identified a number of changes
21 to practice and learning that he needed to deliver on.
22 MR WOLFE: At this stage, sir, I have no further questions.
23 THE CHAIRMAN: Okay.
24 MR QUINN: I have nothing, sir.
25 THE CHAIRMAN: Before I go to Mr Green, does anybody have

1 anything for this witness?
2 Mr Green?
3 MR GREEN: No, thank you, nothing, sir.
4 THE CHAIRMAN: Doctor, thank you very much. You have given
5 us a lot of time to give your evidence. You don't have
6 to say anything more, but if you do want to say anything
7 more, you can do so now before you leave the witness
8 box.
9 A. Chairman, many of us involved in this inquiry have
10 reflected over the years on a regular basis on the
11 events that occurred in this period. To have lost
12 a loved one -- we've all, at some stage, lost a loved
13 one -- is painful and hurtful. To lose a child --
14 I have three children -- and then learn it might have
15 been preventable must give unbearable pain, it really
16 must. I can only say my condolences to all the
17 families. I have watched the families demonstrate great
18 composure and dignity through the torturous process
19 we've all been through. For my own part, any action or
20 inaction that has added to that suffering or pain, I am
21 truly and deeply sorry.
22 THE CHAIRMAN: Thank you very much indeed, doctor.
23 (The witness withdrew)
24 We'll start with Mr Fee at 2.05. Thank you.
25 (1.10 pm)

1 (The Short Adjournment)
2 (2.05 pm)
3 Timetabling discussion
4 THE CHAIRMAN: Just before we start, Mr Wolfe, I want to do
5 a few quick announcements. The first is that tomorrow
6 morning, as I think some of you at least know, we're
7 going to start at 9.30, when I will outline the position
8 I'm going to take about Professor Kirkham and various
9 other points which were debated last Friday afternoon.
10 Secondly, moving forward on the timetable generally,
11 I had hoped to start the governance hearings in
12 Raychel's case on Tuesday 2 July for four days and then
13 finish them in September. For a variety of reasons, I'm
14 afraid it's no longer practical to do that. What will
15 happen over the next few weeks is that I will finish the
16 evidence about the aftermath of Lucy's death. It looks
17 as if we can finish that on Monday 1 July with
18 Professor Lucas and Dr Gannon. I'm going to hold
19 Tuesday 2 July in reserve in case it is needed for any
20 evidence, but I'm not convinced it will be and I'd be
21 very keen not to go into 2 July. That leaves me then to
22 outline what the timetable will be to be the autumn.
23 Insofar as the governance issues in Raychel's case
24 are concerned, we have already explored some of them,
25 some of them quite fully and others in part at least

1 in the clinical hearing, and I think then, on looking
2 forward to what is left to be dealt with, I think
3 Mr Quinn, that two weeks will be sufficient to do that.
4 I very much hope so anyway.
5 MR QUINN: I would hope so, sir.
6 THE CHAIRMAN: What I am going to do, in order to make up
7 for the time we've lost at the end of this term, I'm
8 going to resume on Tuesday 27 August, which is the day
9 after the last Bank Holiday in the summer. I'll do four
10 days that week. And in the following week, which starts
11 on Monday 2 September, I'll do another four days, but
12 that week will be Monday, Tuesday, Wednesday, Friday.
13 I can't sit on Thursday the 5th.
14 The next segment will be in relation to the issues
15 arising from the death of Conor Mitchell. Can I say
16 again that I understand entirely that, to his family and
17 friends, Conor's death was as great a loss as those of
18 Adam, Claire, Lucy and Raychel were to their families
19 and friends, but for reasons which have already been
20 explained at some length, Conor's part in this inquiry
21 is limited to issues about the implementation of the new
22 hyponatraemia guidelines and whether they were followed
23 during Conor's treatment. What I intend to do is to
24 conduct that segment of the public hearings in the week
25 beginning Monday 9 September for three days. That is

1 Monday, Tuesday and Wednesday, 9, 10 and 11. And then
2 Monday 16 September, if necessary, for five days.
3 I anticipate, from the comparatively limited number
4 of witnesses involved in that segment, that that should
5 be enough, but if it isn't, I will run over into the
6 week of Monday 23 September.
7 That then leaves the final segment of the public
8 hearings, which is about the involvement of the
9 department. The reality is that we have already heard
10 a lot of evidence from, for example, Mr McKee, Dr Carson
11 and Dr McBride, to name just a few, about the
12 organisation of the Health Service before 2003 and from
13 2003 in particular. We will also hear in this segment
14 from the senior coroner for Northern Ireland,
15 Mr John Leckey, and Professor Gabriel Scally. I have
16 been told more times than I care to remember that
17 everything is very different now. It's one of the
18 points that Dr Kelly made to me repeatedly over the last
19 day and a half.
20 For instance, I have been told that trusts are more
21 likely to report doctors to the GMC than they were
22 before. I've been told that doctors are more likely to
23 report other doctors than they were before. I've been
24 told that the bar for reporting deaths such as Claire's
25 to the coroner is set lower, notwithstanding the fact

1 that there has been no change in the legislation, and
2 I have been told how much better root-cause analysis and
3 auditing is than it was 10 or 15 years ago.
4 And what I want to focus on in the departmental
5 section is not so much the various historical issues but
6 to focus on some of the narrow, more specific areas.
7 These will include the following. Why we were lagging
8 behind England and Wales in the development of
9 governance in the late 1990s and early 2000s? What did
10 senior officials in the department know about the deaths
11 of the various children? How did those senior officials
12 respond to what they knew or found out about the deaths
13 of the children? How have they ensured that the
14 guidelines which have been introduced have been
15 implemented? And fundamentally, what confidence can
16 we have that similar episodes are unlikely to recur?
17 This last point is vital because, unless I'm
18 mistaken, the message that has been coming through from
19 the families, what I have gathered from them, is that
20 they want to know at the very least that important
21 lessons have been learned so that when doctors and
22 nurses make mistakes, as inevitably they always will,
23 those mistakes are properly investigated, they're faced
24 up to and learned from. And accordingly, what I intend
25 to do over the next few days is to reframe the

1 departmental issues which are currently set out in the
2 list of issues on our website. I will then issue those
3 for consultation and for comment and then finalise what
4 areas need to be focused on, taking account of all the
5 evidence that we've had to date. What I hope this will
6 do is pave the way for four weeks of hearings on
7 departmental issues, which I want to start on Monday
8 7 October, and continue in the weeks beginning 14, 21
9 and 28 October.
10 If that works, then that will bring an end to the
11 public hearings. I'm sorry if these revised schedules
12 cause any difficulties, but I have to emphasise that
13 I need to adhere to them unless there are reasons which
14 make it absolutely impossible to do so. So if anybody
15 has any fundamental scheduling problems, perhaps they
16 would let us know over the next few days.
17 One final point about Monday coming. You're aware
18 that the G8 conference is being held in
19 County Fermanagh. We've been alerted to the fact that
20 there will be major disruption in Belfast on Monday
21 morning as various world leaders arrive and make their
22 way to Fermanagh. I understand that the courts in
23 Belfast are not going to sit until midday on Monday
24 because various major arteries such as the Sydenham
25 bypass, Oxford Street, the city centre and parts of the

1 motorway will be closed during the morning. It seems to
2 me that the best way round this is to see if we can
3 start here on Monday morning with Mr Mills at 9 o'clock.
4 In other words, if we can get here before the delays
5 kick in in Belfast.
6 First of all, Mr Simpson, could you find out for me
7 if at all possible if Mr Mills could do that? If
8 Mr Mills can arrange to be here, if the legal
9 representatives could arrange to be here, and if any of
10 the families who intend can arrange to be here on Monday
11 morning, I think it makes sense to start with Mr Mills
12 at 9 o'clock. I don't know whether the visiting counsel
13 from England and Scotland fly in usually on Monday
14 morning or Sunday night, but I think on this occasion it
15 might be better for you to arrive on Sunday night. I'm
16 sure you can find somewhere to stay in Banbridge.
17 Unless there's anything else, we'll proceed now with the
18 evidence of Mr Fee.
19 MR EUGENE FEE (called)
20 Questions from MR WOLFE
21 MR WOLFE: Good afternoon, Mr Fee.
22 You have provided a number of witness statements to
23 this inquiry already in writing. They are numbered
24 WS287/1, WS287/2, and they're dated 1 November 2012 and
25 19 January 2013 respectively. Do you remember providing

1 those?
2 A. Yes, I do.
3 Q. In addition to that, you have been interviewed on
4 several occasions on 16 March 2005 by the Police Service
5 of Northern Ireland. Those interviews have obviously
6 been documented and they come under series 116-031-032
7 and 033 and 034. Taking all of that written material
8 together, Mr Fee, do you wish to adopt that evidence as
9 part of your evidence to the inquiry to be supplemented
10 by your oral evidence?
11 A. Yes.
12 Q. Thank you. I will now proceed to ask you some questions
13 arising out of your involvement in the Lucy Crawford
14 case.
15 Just before doing that, you were employed as the
16 director of acute services in the Sperrin Lakeland Trust
17 in or about April 2000, or that was your job at that
18 time.
19 A. That's correct.
20 Q. And you also held, in unison with that, a director of
21 nursing role; is that correct?
22 A. That's correct.
23 Q. Your background in terms of your career was as a trained
24 nurse with a brief period in nursing practice before
25 going into nursing management; is that fair?

1 A. I trained originally as a mental health nurse and then
2 I done my general training. I worked in clinical
3 practice, both as a staff nurse and as a charge nurse
4 for a number of years. Both those were in mental
5 health, I should add.
6 Q. Yes. If we look just briefly at your witness statement
7 at page 2, it's 287/1 at page 2, that helpfully
8 summarises your career. You have now retired from the
9 post of director of nursing and director of acute
10 services.
11 A. That's correct.
12 Q. And as we see from that chronology, you worked in that
13 capacity for about eight years from January 1997.
14 A. I believe it was 1995 to 2005.
15 Q. That's when you first came to the Erne; isn't that
16 right? And then I think what's reflected in that
17 chronology is the various posts you held once the
18 hospital achieved Trust status. I suppose you have set
19 out the different chronological periods to reflect the
20 organisational changes.
21 A. Yes.
22 Q. We have your job description as an appendix to your
23 witness statement, which I don't think we need open.
24 Could I ask you, Mr Fee, just some questions about
25 your experience in the paediatric field? Had you any

1 nursing experience in the paediatric field?
2 A. I had one short placement during my general nurse
3 training programme. I think it was four weeks. And it
4 was in the surgical paediatric department of the Belfast
5 City Hospital.
6 Q. When you went into the nursing management field, did you
7 maintain your training as a nurse?
8 A. Yes.
9 Q. But none of that involved paediatrics, that was all on
10 the mental health side?
11 A. Yes.
12 Q. In terms of fluid management in children, had you any
13 experience at all of, if you like, the practice of fluid
14 management?
15 A. No. Not that I can recall. I may have seen some
16 children with IV drips during my short placement, but
17 I don't recall them, to be honest.
18 THE CHAIRMAN: And in the space of four weeks, you wouldn't
19 have been picking up very much about the ins and outs of
20 it?
21 A. I wouldn't, no.
22 MR WOLFE: Can I run that out a little? So in terms of,
23 let's say a situation where a child's coming into
24 hospital dehydrated, a background of gastroenteritis and
25 requiring intravenous fluid management, would you have

1 had any sense, prior to your involvement in
2 Lucy Crawford's case, of the issues, the clinical
3 issues, attendant upon that kind of medical problem?
4 A. I can't say that I have any extensive experience or
5 knowledge of those types of management, those types of
6 cases, no.
7 Q. Well, would you, for example, have had any knowledge
8 about the kind of risks that might attend an intravenous
9 fluid management situation?
10 A. I can't recall at this stage. No, I can't.
11 Q. The word "hyponatraemia", had that ever come across your
12 path prior to involvement in investigating
13 Lucy Crawford's death?
14 A. I don't believe I actually ever heard the word until
15 much later after the investigation or the review.
16 Q. So it wasn't even a word used at the time of the review,
17 so far as you can recall?
18 A. It may well have been. I don't recall being aware of it
19 at that time.
20 Q. The issue of electrolyte derangement or electrolyte
21 imbalance and the processes that might lead to cerebral
22 problems in a child, is that something you had any
23 experience or knowledge of?
24 A. I wouldn't have considered myself to be knowledgeable
25 about that, no, I would not.

1 Q. Let me ask you something about the governance
2 arrangements that were in place at that time. You have
3 told us that so far as an adverse incident situation is
4 concerned there wasn't a standard process or pro forma
5 to work to at that time; is that fair?
6 A. That's fair, yes.
7 Q. You say that in or about 2003, 2004, clinical governance
8 structures emerged in Northern Ireland. Did that change
9 the way in which adverse incidents were investigated
10 within the hospital setting?
11 A. I think arrangements were already beginning to develop
12 in advance of that, but that's when the formal clinical
13 governance arrangements, from memory, came into place.
14 For example, I think, from memory, there was a clinical
15 and social care governance committee in place within the
16 Trust from about late 2000.
17 Q. Yes. Dr Kelly's told us that that process was erected
18 in shadow form towards late 2000 and then, in fact, you
19 were the chairman of one of the committees that fed into
20 that process.
21 A. Yes, there were a number of committees in advance of
22 that before, I might say, I had ever heard of the words
23 "clinical and social care governance". For example,
24 there was an infection control committee, which I had
25 chaired both in my days of mental health -- and then

1 latterly in my days in acute services.
2 Q. You were telling us, Mr Fee, in or about April/May 2000,
3 you were appointed to carry out the review into
4 Lucy Crawford's death, and as I say, you're telling us
5 there was no pro forma or protocol to work to.
6 A. That's correct.
7 Q. The formation of this structure, which was called
8 clinical and social care governance from late 2000,
9 various committees doing various tasks, feeding into
10 a central committee called the clinical and social care
11 governance committee, but in terms of how deaths or an
12 adverse incident short of death would be investigated,
13 come the development of these governance arrangements,
14 how different was that and in what way was it different
15 from what had gone before?
16 A. I don't recall the details, to be quite honest, but
17 there were structures being put in place. There were
18 some arrangements prior to that as well in terms of, for
19 example, perinatal mortalities, which were outside of
20 the Trust and were national, as I understand it, or as
21 I recall.
22 Q. Do you know whether there were any differences in the
23 sense that, when you did the task of carrying out the
24 review with Dr Anderson, you hadn't got a template to
25 work to?

1 A. That's correct.
2 Q. But if the same incident had happened in 2001, would you
3 then have had a template to work to?
4 A. I can't recall whether there was a template at that
5 stage or not.
6 Q. Right. Before the changes to the governance
7 arrangements, you have set out in your witness statement
8 what you would have expected to happen in the event of
9 an adverse incident leading to death such as we have in
10 Lucy's case. You say that the general approach would be
11 for a manager of the area to submit a clinical incident
12 form; is that right? That would start the process?
13 A. Yes. I think from memory that the clinical incident
14 reporting arrangements or forms were actually developed
15 within women and children's services or it was being
16 piloted around that stage.
17 Q. So that would be written up -- and we'll come to the
18 specific one in this case -- and then that would be
19 submitted to the medical director or the
20 chief executive?
21 A. Well, the management structure within the acute hospital
22 directorate was the wards or departments report to
23 a clinical director and a clinical services manager.
24 They in turn would relay to myself or Dr Kelly or the
25 chief executive in turn.

1 Q. And then there would be a discussion on whether to take
2 the incident forward into a formal review; is that the
3 likely approach?
4 A. That would have been a likely approach, yes.
5 Q. And in some cases, a review might not occur, just
6 depending upon whether the issue was sufficiently
7 serious or whether, for example, it was part of
8 a repeated series of untoward incidents.
9 A. Yes, I think that was the intention to, I suppose, track
10 patterns as well as individual incidents.
11 Q. In certain instances, a decision would need to be made
12 whether to report the adverse incident outside of the
13 Trust to, for example, the commissioner for services,
14 which in this case was the Western Health and Social
15 Services Board.
16 A. Yes, but I don't recall it being a formal structure
17 arrangement for that either at that time.
18 Q. That was just the practice?
19 A. It was the practice, yes.
20 Q. And the inquiry is advised by one of its experts that
21 with the formation -- this is Professor Scally. Have
22 you read his report?
23 A. I have, yes.
24 Q. What he says is that with the formation of the Trust,
25 there was no direct managerial link-up between the

1 Western Board and the Trust. Rather, the accountability
2 mechanism or the accountability linkage was between the
3 Department of Health and the Trust; do you follow?
4 A. Yes.
5 Q. Was that your understanding of the arrangements?
6 A. I can't recall at that time what my understanding was,
7 but yes, I understand that is the arrangement or was the
8 arrangement. But on a day-to-day basis, our more direct
9 link was with the Western Health and Social Services
10 Board because they were the main commissioner of
11 services from our Trust.
12 Q. So notwithstanding the absence of a formal managerial
13 arrangement between the commissioner of services and the
14 Trust, nevertheless the Trust felt that there was an
15 onus to report to the Western Board?
16 A. Yes.
17 Q. And do you understand or can you help us in terms of why
18 that onus was in play?
19 A. I don't know whether it was explicit or implicit, but
20 certainly it was the way the things were done at that
21 time.
22 Q. And was there, to the best of your knowledge, an
23 expectation that the Department of Health and Social
24 Services would be informed of adverse incidents?
25 A. I don't recall at this stage whether that was my

1 expectation at that time or not.
2 Q. Did you contact the Department of Health in relation to
3 Lucy's death?
4 A. No.
5 Q. You're familiar with Dr William McConnell, who was the
6 director of public health in the Western Health and
7 Social Services Board at that time?
8 A. Yes, I knew Dr McConnell.
9 Q. And would you have had frequent dealings with him?
10 A. I would have had some dealings with him. I don't know
11 how frequent it was. The people I'd have been more
12 directly in contact with is Dr Conor(?) Hamilton and
13 other people involved in the interface on the
14 commissioning side.
15 Q. And Mr Bradley, who was the chief nursing officer?
16 A. Yes. He was involved in the commission of acute
17 services, from memory, at that time.
18 Q. Dr McConnell has told the inquiry that it was his
19 impression that the Trust had reported Lucy's death to
20 the department, and he has suggested that information
21 provided by you and Mr Mills caused him to reach that
22 view or form that impression. Can you help us on that?
23 A. I can't comment on that. I don't know where he got that
24 impression from.
25 Q. But what you're telling us is that, so far as you're

1 aware, the death hadn't been reported to the department?
2 A. No, the question you asked me was, "Did I report it?",
3 and I said the answer was no. I have no recollection of
4 personally reporting to the department and I don't know
5 whether it was reported to the department or not at the
6 time.
7 THE CHAIRMAN: Can I ask you a slightly different way?
8 Can you remember reporting anything to the department
9 over the years that you held these senior positions as
10 opposed to providing information on various issues on
11 the Western Board?
12 A. I don't remember ever reporting anything directly to the
13 department. I do remember having or being in attendance
14 at a number of meetings to the department on a range of
15 things, including beyond the inquest on Lucy.
16 I remember myself and -- I think it was Mr Mills -- met
17 with Dr Campbell and some other people in the
18 department.
19 THE CHAIRMAN: Let's step back a bit. Would the meetings
20 that you were typically at, which involved departmental
21 officials, were they more along commissioning lines and
22 would therefore have included the Western Board as well?
23 A. They may have. I remember in a couple of specific
24 instances having meetings with the department where
25 there were service changes proposed, around the change

1 of cancer services or trauma services. I remember at
2 a particular time having a meeting with department
3 officials in respect of budgetary pressures, but those
4 are the types of things it would generally have been,
5 more one-off type of encounters.
6 THE CHAIRMAN: And would they also have featured people from
7 the Western Board?
8 A. Some of them probably did, I just can't remember who was
9 at the meetings.
10 THE CHAIRMAN: Thank you.
11 MR WOLFE: Let me deal, Mr Fee, with your contact with the
12 Western Board. You made contact with Dr Hamilton of the
13 Western Board, you tell us, on or about 14 April 2000,
14 which was the day of Lucy's death.
15 A. Yes. That's true.
16 Q. Dr Hamilton was one of the team in the Western Board;
17 what was his function?
18 A. My recollection is that he was consultant in public
19 health, but he was on the commissioning team for acute
20 hospital services, as far as I can recall. He certainly
21 attended on a regular basis the monthly meetings that we
22 had in relation to acute services.
23 Q. What were you reporting to him?
24 A. I think I reported to him the fact that -- I can't
25 recall at this stage whether I knew Lucy was dead or

1 whether she was seriously ill at the time. And I also
2 advised him that we were planning to have a review, as
3 far as I can recall. And I think there may have been
4 an issue around potential press interest, which I wanted
5 to advise him of, and I don't know whether that was on
6 that occasion or on a separate occasion.
7 Q. The note would seem to suggest that was perhaps on the
8 Monday.
9 A. Perhaps.
10 Q. Why would that be a relevant consideration, the press
11 attention?
12 A. Well, I can't recall the thinking behind that at the
13 time, but certainly if there was an issue that was
14 likely to feature in the press, again whether it was
15 explicit or implicit, we would have certainly been aware
16 that the Western Board would like to have known about
17 that.
18 Q. How was it brought to your attention that this incident
19 had arisen in order to cause you to contact Dr Hamilton?
20 A. I think the first contact I had was actually from
21 Dr Kelly. I think it was on the same day, on the 14th.
22 I advised him of the incident and also requesting that
23 I would coordinate a review along with Dr Anderson.
24 Q. Help us if you can: what were your original
25 instructions, if you like, from Dr Kelly in terms of

1 what had happened to cause there to be a need for this
2 review?
3 A. I can't recall the detail of the conversation, but
4 I think that Dr Kelly had been advised by Dr O'Donohoe
5 of the deterioration in the child's condition and the
6 transfer. And again, I don't recall in terms of timing
7 whether Lucy was still alive at the time or whether she
8 was not alive at the time.
9 Q. And did that message about the deterioration in the
10 child's condition come with it an explanation of what
11 might have happened to cause this?
12 A. I don't recall whether that did or did not at the time.
13 Q. If it was known that the child had died or was dying of
14 what might be described as natural causes, if that was
15 regarded as perhaps the inevitable outcome of her
16 illness, there wouldn't have been a need to ask you to
17 conduct a review; is that fair?
18 A. I think that's probably fair enough, yes.
19 Q. So you were being asked to conduct a review because
20 Dr Kelly perceived that there was a problem in terms of
21 the medical or nursing management of the child?
22 A. I think he probably requested it because there was an
23 unexpected deterioration in the child's condition.
24 Q. So you're telling us that you simply can't remember
25 whether that was further explained to you?

1 A. I can't remember. I'm sure it probably was at the time,
2 but I just don't recall the exact details of the
3 conversation.
4 Q. Your further contacts with the Western Board, let me
5 tidy those up before we move on. You met with
6 Mr Bradley on 10 May 2000, according to your witness
7 statement. As I said, he was a commissioner and chief
8 nurse in the Western Health and Social Services Board.
9 A. That's correct.
10 Q. And you don't have notes of that meeting, but you think
11 that that might have been one of the monthly meetings
12 that you tended to hold with the board's commissioners.
13 A. Yes. There was a regular monthly meeting. I suspect it
14 may have been a regular meeting, but I can't be certain
15 of that.
16 Q. Subsequently on or about 12 May, Mr Bradley visited the
17 hospital to speak to staff; do you remember that?
18 A. I vaguely remember, but there is a note to say that he
19 actually visited the hospital and visited the ward, to
20 the best of my memory.
21 Q. Was that an unusual event?
22 A. It wouldn't have been that usual, but it wouldn't have
23 been the first time that we had Mr Bradley visit.
24 Q. And what would the purpose of his visits tend to be?
25 A. Well, in this type of scenario?

1 Q. Leaving aside this one, because I think you tell us that
2 so far as you can recall, you think his visit was to
3 gain a further insight into the events surrounding
4 Lucy's death and to meet staff on the children's ward
5 who were, if you like, affected by this.
6 A. Yes.
7 Q. Otherwise, what would be the reason for visiting the
8 hospital?
9 A. Mr Bradley had a professional role within the board and
10 he would have visited the clinical areas from time to
11 time to meet with staff and, I suppose, pick up what the
12 issues were for people -- for his profession, I'm
13 talking about.
14 Q. Do you recall or did you form the impression that he was
15 coming to visit staff on this day because he was
16 interested in what had happened to the child?
17 A. My impression, from memory, was that he was coming
18 twofold: one to get a better sense of what the issues
19 might have been, and also to offer support to staff who
20 may have been involved.
21 Q. And who had delegated the task of helping him to
22 understand what the issues might have been? In other
23 words, who spoke to him about those issues?
24 A. I don't recall who actually met him on the day.
25 Q. Was he, if you like, speaking to front-line staff on the

1 ground, nurses and clinical staff, or was he speaking to
2 management?
3 A. No, he spoke to the staff on the ward. From memory,
4 that's who he spoke to. I think he met with me as well
5 on the same day.
6 Q. Was his interest to find out what had happened or was
7 his interest to find out how they were coping with what
8 was obviously a very stressful and tragic incident?
9 A. I think, from memory, it was both.
10 Q. And arising out of his visit, did he provide you with
11 any feedback or response?
12 A. I don't recall so, no.
13 Q. Could I show you a letter which was sent to Dr McConnell
14 by Dr Kelly on 15 May 2000? If I could have up on the
15 screen, please, 036a-046-098 and the following page,
16 099.
17 You can see, Mr Fee, that this is a letter addressed
18 to Dr McConnell. It has been written a month after
19 Lucy's death and it has been written at a stage when
20 you've had the opportunity of speaking to
21 Dr Murray Quinn. You spoke to him earlier in the month.
22 And Dr Kelly tells us that:
23 "In order to be in a position to write such
24 a letter, [he] would have inevitably had a briefing of
25 some kind from [you]."

1 A. I'm sure that's true.
2 Q. Because you were the person, along with Dr Anderson
3 perhaps, who was most familiar with what had happened
4 because you were investigating it; is that fair?
5 A. We were reviewing the case, yes.
6 Q. Could I ask you about a number of aspects of the letter?
7 Paragraph 2, that's a description of how the child
8 appeared at the time of what we're calling the event or
9 the incident, at or about 3 am on 13 April. And it's
10 described in those terms in keeping with decorticate
11 rigidity. Leaving aside that technical term, which
12 Dr Kelly thinks you probably didn't use, were you in
13 a position to provide him with a description of how the
14 child was at the time of the event?
15 A. I probably was.
16 Q. And how did you obtain that description?
17 A. We obtained a number of reports from the staff who were
18 involved and, from memory, at least one of them would
19 have had a description of what happened at the time that
20 you classify the event.
21 Q. Do you know who that was?
22 A. I just don't recall offhand, but it'd be in the reports
23 that are attached to the review.
24 Q. Could I bring you to item 2 on the right-hand page? It
25 says:

1 "There are concerns in relation to the rate of fluid
2 replacement at the Erne, essentially the regime for a
3 shocked infant was continued longer than the anticipated
4 two hours."
5 Did he obtain that information from you?
6 A. I'm not sure.
7 Q. Just the description of a regime being prescribed or
8 intended for a period of two hours: can you think from
9 any of the descriptions that were provided to you where
10 that would have emerged from?
11 A. I'm not sure. I'm not sure where it emerged from.
12 Q. And the description of "a replacement regime", do you
13 know where that came from?
14 A. Again, I'm not sure. I don't recall.
15 Q. It's the inquiry's understanding of what Dr Quinn will
16 say that he anticipated that the doctors looking after
17 Lucy had intended a maintenance regime for the child.
18 A. Right.
19 Q. Do you appreciate the difference between a maintenance
20 regime and a replacement regime?
21 A. Yes, I do, yes.
22 Q. Was it being suggested to you that it was a replacement
23 regime that was intended for the child?
24 A. I can't recall whether it was or was not.
25 THE CHAIRMAN: When you say that you know the difference

1 between a maintenance and a replacement regime, is that
2 something that you now know because of all the
3 subsequent publicity or is that something that you think
4 you knew in 2000?
5 A. It is probably something that I know now.
6 MR WOLFE: Let me turn to the subject matter of the review,
7 Mr Fee. You tell us about receiving contact from
8 Dr Kelly to tell you about the incident, you're not sure
9 whether Lucy was yet dead, but you were being asked to
10 coordinate a review; is that fair?
11 A. That's correct.
12 Q. You were also told that Dr Anderson would be involved
13 in the review; is that right?
14 A. Yes.
15 Q. In terms of your participation in such reviews, had you
16 any experience of performing one?
17 A. I have no recollection of being involved in a clinical
18 review before. I was involved in the review of
19 a hospital response to the Omagh bomb, but that was
20 a different type of review, I would suggest.
21 Q. That was an assessment of how the hospital functioned
22 during that emergency?
23 A. Yes.
24 Q. So you have no recollection of having an experience in
25 this kind of review, which is looking at a specific

1 clinical adverse incident?
2 A. I have no recollection of being so, no.
3 Q. Had you training for the purposes of carrying out such
4 reviews?
5 A. I have no recollection of having training at that stage.
6 I did participate or engage in root-cause analysis
7 training, but that was a number of years later.
8 Q. And I think you have told us there was no guidance to
9 work to or no protocol to work to at that time.
10 A. That's correct.
11 Q. The terms of reference for the review, perhaps we can
12 put them up on the screen, please. 033-102-264. You
13 recognise that document?
14 A. Yes.
15 Q. That's the front page or first page of the final review
16 report?
17 A. Yes.
18 Q. And the purpose of the review is set out there, (a), (b)
19 and (c). Can I ask you this: when you were asked to
20 coordinate the review, did you receive any indication
21 from management in terms of what the purpose of the
22 review was?
23 A. I don't recall receiving any such information at that
24 time.
25 Q. The terms that appear in front of us, who drafted them?

1 A. I think the -- I don't recall, to be honest, but I think
2 they were probably drafted by myself and Dr Anderson,
3 perhaps in consultation with Dr Kelly.
4 Q. Certainly Mr Mills recalls that the draft terms were, as
5 you say, drawn up by yourself and agreed with Dr Kelly
6 and Dr Mills; is that fair, do you think?
7 A. That's probably correct.
8 Q. You talk in the terms of reference about:
9 "Examining whether there's any connection between
10 our activities and actions and the progression and
11 outcome of Lucy's condition." And, secondly:
12 "Whether or not there was any omission in our
13 actions and treatments, which may have influenced the
14 progression and outcome of Lucy's condition."
15 So it's a case of looking at the acts and omissions
16 of the team that looked after Lucy; is that right?
17 A. That's what the record would show, yes.
18 Q. Could I ask you this: what lay underneath that? What
19 were the acts and omissions that you were concerned
20 about?
21 A. I don't recall the exact timing in terms of drafting
22 these, but it may have been after we reviewed the case
23 notes, so it may have been stimulated by some of our
24 thinking following the review of the case notes.
25 Q. Right. You see, so far you have told us that you've had

1 a conversation with Dr Kelly, who -- and I don't mean
2 this pejoratively -- rather blandly told you that there
3 has been this incident and there's a need for a review.
4 You can't remember him telling you anything about the
5 detail of why there was a need for a review. You then
6 draft these terms of reference, which may have been
7 before or after you considered the notes. But what
8 I would like you to explain is: did anybody explain to
9 you what the suspected problem was that was requiring
10 everybody to go to all this bother to carry out
11 a review?
12 A. I think at that stage we also had the clinical incident
13 report.
14 Q. Right.
15 A. And there was some reference in the report -- I just
16 can't remember the detail -- some reference in the
17 report that there was some concern about the fluid
18 management.
19 Q. Yes, but before you got that, and we'll turn to that in
20 a moment, had anybody said to you, "There has been an
21 error with regard to the fluid management of this
22 child"?
23 A. I don't recall that having been said to me, no.
24 Q. Did anybody say to you that there may well have been or
25 could have been an adverse drug reaction?

1 A. I don't recall that being said either.
2 Q. So in terms of people talking to you, presumably there
3 was some noise and some conversation about all of this?
4 Am I right in forming an impression from your evidence
5 so far, Mr Fee, that nobody was actually telling you
6 about the nature of the suspected problem here?
7 A. They may well have done, I don't recall that.
8 Q. Nothing stands out in your mind?
9 A. No.
10 THE CHAIRMAN: Can I take it, Mr Fee, that in
11 a comparatively small hospital like the Erne, what had
12 happened to Lucy, first of all, it would have been very
13 well-known very quickly, would it, the fact that this
14 girl had come in and had died so soon afterwards?
15 A. It probably was.
16 THE CHAIRMAN: So there was bound to be talk about what on
17 earth went wrong?
18 A. There may well have been, I don't recall that.
19 THE CHAIRMAN: It would be unusual if there wasn't, wouldn't
20 it?
21 A. It probably would, yes.
22 MR WOLFE: Let me move to look at the role of Dr Anderson.
23 He has told the inquiry that you very much took the lead
24 in relation to the review and, in essence, he was your
25 assistant during the review. Was that your

1 understanding of the nature of the relationship?
2 A. No, it was not.
3 Q. What was your understanding?
4 A. My understanding was that we were partners, equals.
5 Q. And did he behave or perform as a partner and equal
6 during the review?
7 A. I can't recall him not acting as an equal or partner.
8 There may have been some parts that perhaps I done and
9 there was a brief, I think, developed after the review
10 of the case notes, and it was identified there were some
11 things I would do and some things he would do. So there
12 were some things I led on and some things he led on.
13 Q. Let's try to work out what you can remember rather than
14 what you can't remember, Mr Fee. What can you remember
15 he did?
16 A. Sorry, I'm not sure ...
17 Q. What can you remember in terms of Dr Anderson's role
18 in the review? What steps did he specifically take?
19 A. Following the request, myself and Dr Anderson,
20 I believe, met with the staff involved to advise them of
21 the review and to offer them support. I recall
22 Dr Anderson and myself meeting -- I think it was on the
23 Wednesday afterwards -- and reviewing the case notes,
24 and we drafted basically an action plan out of that,
25 which I understand is on record.

1 Q. Yes.
2 A. We also met on a number of other occasions -- I think it
3 was seven occasions in total throughout the -- from the
4 contact from Dr Kelly until the conclusion of the final
5 report.
6 Q. Seven occasions did you say?
7 A. Seven occasions, yes. From memory, he was also the
8 person who linked directly with the medical staff in
9 respect of requesting statements and getting those
10 statements.
11 Q. We'll look at some of those matters in a moment.
12 The first conversation with him was when you agreed
13 that you would meet to sit and look at the notes;
14 is that about right?
15 A. No, that's not correct. From memory, I actually
16 telephoned Dr Anderson following the discussion I had
17 with Dr Kelly and we actually met on that same day at
18 around lunchtime in the Erne Hospital.
19 Q. What was the purpose of that meeting?
20 A. I think it was first of all to agree what we were going
21 to do and what the first steps were, and, from memory,
22 the first steps were to agree to meet with staff and
23 also to review the case notes.
24 Q. Let me look at the critical incident report with you.
25 It's at 036a-045-096 and the second page of that up as

1 well. Do you remember receiving that form?
2 A. I remember the form. I don't remember when I received
3 it, but yes.
4 Q. But as part and parcel of conducting the review, you
5 received it?
6 A. Yes.
7 Q. And, correct me if I'm wrong, is that when you found out
8 for the first time that a concern had been expressed
9 about fluids prescribed and fluids administered?
10 A. I don't remember if that's the first time or not.
11 Q. It was certainly a time?
12 A. Yes.
13 Q. And this form was completed by Mrs Millar; isn't that
14 right?
15 A. That's correct.
16 Q. She was one of the staff members who reported to you?
17 A. She's the -- clinical services manager was her role.
18 She was the partner of Dr Anderson in terms of managing
19 the women and children's directorate.
20 Q. Did you establish from her who had made this report to
21 her?
22 A. I can't remember, but I'm sure I did.
23 Q. It refers to the ward sister having made the report.
24 A. That's correct.
25 Q. In your mind, that would have been Sister Traynor;

1 is that right?
2 A. That's correct.
3 Q. Did you discuss with Mrs Millar before proceeding
4 onwards just what her view of all of this was?
5 A. I'm sure I did, but I don't have any record of that, and
6 I don't have any recollection either.
7 Q. You made a decision with Dr Anderson to review the
8 notes; isn't that right?
9 A. That's correct.
10 Q. And do you think you did that before or after meeting
11 the staff?
12 A. I think we done that after meeting the staff. From
13 memory, we met the staff on the Monday and Tuesday, and
14 indeed I have seen a record somewhere within the
15 files -- I think that's available to the inquiry -- that
16 I went to meet the staff who were on night duty during
17 that period.
18 Q. Could we look at a document which was contained as an
19 appendix to the review? You'll find it at 033-102-285.
20 This seems to be a record of the initial steps that were
21 taken as part of the review. Could we have the second
22 page up as well, please? You're familiar with this
23 document?
24 A. I recall it, yes.
25 Q. It was drafted by you.

1 A. Yes.
2 Q. It says halfway down the page:
3 "Between Monday and Tuesday, 17 and 18 April,
4 Dr Anderson and Mr Fee met ..."
5 And then there is a list of staff identified:
6 "... to offer them support and to advise them of our
7 intent to conduct a review."
8 Did those meetings happen?
9 A. I believe so, yes.
10 Q. Did Dr O'Donohoe attend?
11 A. I don't recall.
12 Q. His name is mentioned there.
13 A. His name is mentioned and the note was typed on the
14 21st, so it was within a day or two later.
15 Q. He told the inquiry on 6 June when he gave evidence that
16 the suggestion that he met with the two of you is
17 incorrect. He said:
18 "I don't believe that meeting ever happened."
19 And he said:
20 "I don't believe I was ever formally informed who
21 was conducting a review."
22 In terms of your memory, Mr Fee, perhaps assisted by
23 this note, do you remember meeting Dr O'Donohoe during
24 the early parts of this review?
25 A. I don't recall the meeting specifically now at this

1 point in time, but the note was typed fairly immediately
2 afterwards and I have no reason to believe that it
3 didn't happen.
4 Q. When we read the note, and it refers to you and
5 Dr Anderson meeting with this list of staff, are we to
6 read that as suggesting that together -- that is as
7 a review team -- you met with the staff?
8 A. Yes, that's the way I would read it and that's the way
9 I believe it happened.
10 Q. Right. We know from the documents appended to the
11 review report that you sent out a number of pieces of
12 correspondence to the nursing staff. In other words,
13 you were writing to them and asking them for their
14 contribution to the review in terms of a report or
15 a statement; do you remember that?
16 A. Yes.
17 Q. Let me perhaps show you one by way of example. I'll
18 come back to that maybe in a moment.
19 In terms of --
20 THE CHAIRMAN: Did you want one as an example?
21 MR WOLFE: Yes, perhaps.
22 THE CHAIRMAN: 033-102-299 and 300.
23 MR WOLFE: Yes. This is obviously the one sent to
24 Sister McManus and it's signed off by yourself. You can
25 see certainly with this particular nursing sister that

1 quite apart from, at the bottom of the left hand page,
2 asking for her account of the sequence of events, you're
3 asking her to make specific comment about the fluid
4 regime; do you see that?
5 A. Whereabouts on the page?
6 Q. On the top right-hand:
7 "These issues include ..."
8 A. Right.
9 Q. And all of those questions surround the fluid
10 administration.
11 A. Yes.
12 THE CHAIRMAN: You also pick it up at the last sentence on
13 the left-hand page:
14 "I would be particularly interested in ..."
15 A. Yes.
16 MR WOLFE: The review report which you compiled, as I say,
17 it had a number of appendices, which included the
18 correspondence issued to each of the nurses, the
19 correspondence issued to Dr Quinn, but it didn't contain
20 any correspondence relating to contact being made with
21 the three doctors who had involvement with Lucy's case,
22 that is Dr Auterson, Malik and Dr O'Donohoe. Does that
23 suggest, Mr Fee, that those doctors were not the subject
24 of a written request for a report or a statement?
25 A. No, I don't think it does.

1 Q. Do you think they were written to?
2 A. I can't be sure, but I think I seen, having reviewed
3 some of the transcripts of this hearing -- I can't
4 remember which of the doctors -- one of the doctors said
5 he had received a request in writing.
6 Q. Dr O'Donohoe, I think, said that --
7 A. Right.
8 Q. -- but he couldn't find it.
9 A. Yes.
10 Q. Why did you include on the review report as appendices
11 the correspondence with the nurses?
12 A. I don't recall the rationale behind that or the
13 rationale not to include ones for the medical staff if
14 they were available.
15 Q. Presumably you wanted to illustrate the fact that you
16 had taken this step and you wanted to illustrate the way
17 that you'd taken this step?
18 A. That may have been the case. I don't recall.
19 Q. Did you ever see a letter written to a doctor in respect
20 of these issues?
21 A. I can't recall having seen one, no.
22 Q. And if a letter was written to any of the doctors
23 in relation to this matter, can you explain why they
24 wouldn't have been appended to the report?
25 A. I can't explain that, no.

1 Q. Could we go back to the document showing the meeting
2 with the staff? You'll find it again at 033-102-285 and
3 the subsequent page. At note 3 at the bottom of the
4 left-hand page, it says:
5 "Dr Anderson is to speak to Dr O'Donohoe and request
6 that he share with staff concerned, in confidence, the
7 verbal report of the cause of death received."
8 Why was that issue addressed in that way?
9 A. I don't recall why it was addressed in that way, but it
10 may well have been something that had come up in the
11 discussions with the staff, that they were anxious to
12 know what the cause of death was.
13 Q. And do you know whether that meeting happened?
14 A. I don't, no.
15 Q. It goes on at number 4 to say:
16 "[You] are to seek an appropriate method of advising
17 Lucy's parents and that we will arrange an opportunity
18 to share with them information on the nature of Lucy's
19 illness, the treatment given, and the cause of death,
20 addressing where possible any questions they have, when
21 we have established the necessary information and facts.
22 Mr Fee will speak to Ms Murphy, health visitor, to
23 establish what support is being given to the family and,
24 if it is possible, to make this offer through the Health
25 Visiting Service."

1 You would be aware that when the family were told in
2 or about October 2000 that a review had been undertaken
3 that Mr Crawford expressed, to put it mildly, some
4 surprise that that could have happened without the
5 family being notified; do you remember that?
6 A. Yes, I'm aware that he expressed that view, yes.
7 Q. It would appear, if that is right, that there was no
8 communication with the family to tell them that a review
9 was being undertaken.
10 A. I wouldn't accept that. I believe that the family were
11 advised, certainly that was the request that I made to
12 the health visitor concerned. I recall -- I think
13 there's a record somewhere that I spoke to the health
14 visitor after the visit to make sure that she had
15 visited. I also seem to recall somewhere -- and I don't
16 know whether it's in the transcripts of this hearing or
17 some of the other documents that are available, but
18 I recall seeing a note from Dr O'Donohoe, I think it
19 was, when he met with the family that he also advised
20 them there was going to be a review or that there was
21 a review underway.
22 Q. That's not quite what he said in his evidence.
23 A. Is it not? Well, perhaps you can correct me then.
24 Q. You say you sought reassurance from the health visitor
25 that she was telling the family and had told the family

1 that a review was being undertaken?
2 A. First of all, I tried to establish was there a health
3 visitor involved with the family. I assumed there was,
4 and I established that through Ms Murphy. She advised
5 me that Mrs Doherty was the health visitor. I spoke
6 with Mrs Doherty, from memory, and I think there's some
7 reference to that in the reports. My recollection of
8 what I asked her to do was that I asked her to see what
9 support she could offer. I also, from memory, advised
10 her to let them know that we would share what
11 information we had with them when that became available
12 and, to the best of my recollection, I also asked her to
13 advise them of the fact that we were having a review.
14 Q. And it says all of that in terms on the page in front of
15 us. We don't need to refer to any other source for
16 that. What I'm asking you is whether you established
17 that your instructions to the health visitor had been
18 carried out. Can I put it in this way: if Mr Crawford's
19 letter contains accurate sentiments, he certainly didn't
20 get that message.
21 A. Yes, I'm aware that Mr Crawford believed that he hadn't.
22 Q. So did you seek reassurance from the health visitor that
23 she had followed your instructions?
24 A. From memory, I think there's a record somewhere in these
25 documents, I spoke to the health visitor on a second

1 occasion to check that she had visited the family and so
2 on.
3 Q. So she had visited the family?
4 A. Yes.
5 Q. Had she carried out your instructions?
6 A. I don't recall the exact conversation I had with her.
7 Q. So you can't help us with that?
8 A. No.
9 Q. Why not write formally to the family and tell them that
10 the Trust was going about its business in this way, i.e.
11 carrying out a formal review?
12 A. I can't recall what the rationale or the thinking was of
13 doing it through the health visitor rather in writing
14 was at the time.
15 Q. Was any consideration given to asking the family to
16 contribute to the review?
17 A. I don't recall whether that was a consideration at the
18 time or not.
19 Q. Well, can you help us with this? Why do we not see any
20 request to the family to contribute to the review?
21 A. I can't explain that. I can't explain that at this
22 point in time.
23 Q. Is it fair to deduce from the absence of such
24 communication that they weren't asked?
25 A. I think that's fair that they weren't asked.

1 Q. And can you help us in terms of why, as one of
2 coordinators to the review, they weren't asked?
3 A. I can't explain what the rationale was asking or not
4 asking at that time. Obviously we didn't ask, but
5 I can't explain the rationale behind that.
6 THE CHAIRMAN: Sorry, is that because you can't think now of
7 a rationale for not --
8 A. No, I just can't remember the thought processes at the
9 time. I don't think it would be helpful for me to
10 speculate in terms of what --
11 THE CHAIRMAN: Okay, thank you.
12 MR WOLFE: It says at point 6 on the right-hand page,
13 Mr Fee:
14 "It was agreed that Dr Anderson and Mr Fee would
15 need an external expert paediatric opinion on the
16 management of Lucy's care."
17 And you were to test the source of such an opinion
18 with Mr Mills. Was that conclusion reached as a product
19 of your consideration of the notes, the clinical notes,
20 that were available to you?
21 A. I believe so.
22 Q. I think you told the Police Service of Northern Ireland,
23 when you were interviewed in relation to all of this,
24 that upon considering the notes and records, it was
25 clear that some of the documentation wasn't as good as

1 you might have expected; is that right?
2 A. That's correct.
3 Q. In what way was it not as good as you might have
4 expected?
5 A. From memory, there was no written prescription for the
6 fluids to be administered. There also seemed to be some
7 discrepancies in terms of the fluids that were actually
8 administered.
9 Q. Sorry, I didn't catch that last bit.
10 A. From memory, there also appeared to be some discrepancy
11 in terms of the adding of fluids as one might have
12 expected them on a fluid balance chart.
13 Q. You mean the calculation of them?
14 A. The calculation, yes.
15 Q. Apart from a concern about the amount of fluids and the
16 calculation of the fluids, was there any concern from
17 your consideration of the notes about the type of fluid
18 that had been administered to Lucy?
19 A. I don't recall that being a concern at that time, no.
20 Q. Could you help us with this: what notes did you go
21 through, Mr Fee? Was it all of the, if you like,
22 medical notes and the nursing notes?
23 A. Yes, I believe all of the notes were available to us at
24 that time.
25 Q. And with those, you would have had the electrolyte or

1 the biochemistry results?
2 A. Yes.
3 Q. Could I show you one particular document and ask you
4 whether you recognise it? When Dr Anderson gave
5 evidence -- maybe I'll get the record up on the screen
6 first. 027-017-057. Could we put on the left-hand side
7 the next page, 058? In other words, have 058 on the
8 left.
9 In chronological order, Mr Fee, the left-hand page
10 is the first page of the nursing kardex. Then it
11 continues into the right. Sorry, it continues on to the
12 left.
13 THE CHAIRMAN: They're on the wrong side.
14 A. The page to the right is the first page, is it?
15 MR WOLFE: Yes. And the question I want to ask you, once
16 you familiarise yourself with it, is: those were notes
17 that appear to have been briefed to Dr Quinn as well as
18 much of the other notes that appear on what we call
19 file 27. The curiosity is this: Dr Anderson, when
20 looking at the page that's in front of you on the
21 left-hand side, appeared to tell the inquiry that he had
22 never seen that document before. Is it a document that
23 you remember from your presumably repeated perusal of
24 these notes at the time?
25 A. From memory, all of the notes were available to both of

1 us.
2 Q. The particular significance of the note on the left-hand
3 side is that it appears to give a sequence in terms of
4 the normal saline that was administered to the child
5 following her collapse. It says that that was run
6 freely into the IV line; do you see that?
7 A. Yes.
8 Q. It's about halfway down.
9 A. Yes.
10 Q. And the nurse writing this has, a few lines further
11 down, said, "Repeat U&Es ordered"; do you see that?
12 A. I see that, yes.
13 Q. That's urea and electrolytes. But it's a note that
14 you're familiar with, Mr Fee?
15 A. I would have seen it, yes.
16 Q. Could we turn to 027-010-024? If we go to the entry
17 at the bottom of the page, 14 April. This is a note
18 entered by Dr O'Donohoe following a conversation which
19 he'd had with Dr Peter Crean of the Royal Belfast
20 Hospital for Sick Children on the day before, 13 April.
21 As appears from that, Dr Crean is phoning to ask
22 what fluid regime Lucy had been on. Dr O'Donohoe told
23 him that a bolus of 100 ml over one hour followed by
24 0.18 of normal saline in dextrose at 4 per cent at 30 ml
25 per hour thereafter; do you see that?

1 A. Yes, I see that.
2 Q. And Dr O'Donohoe has explained, both in this forum and
3 to the GMC, that a bolus connotes the use of normal
4 saline. Upon your consideration of these records, you
5 would have seen that Lucy did not receive what
6 Dr O'Donohoe has said he had intended for her.
7 A. Yes.
8 Q. In particular, you could have observed from the fluid
9 balance chart that had been compiled that she had
10 received 100 ml per hour of Solution No. 18; isn't that
11 right?
12 A. Yes, but I wouldn't have picked it up from that there
13 that he intended to prescribe a bolus of saline or
14 normal saline.
15 Q. Right. You would have had to ask him that; isn't that
16 right?
17 A. I wouldn't have picked it up from that, no.
18 Q. You would have had to ask him that?
19 A. Yes. She had received 100 ml in the first hour. It
20 wouldn't have ... I can't recall that it would have
21 occurred to us at the time that it might have been
22 a different solution that he intended.
23 Q. It didn't occur to you?
24 A. I can't recall it having occurred to me at the time.
25 THE CHAIRMAN: From what you said at the start of your

1 evidence, it wouldn't strike you as being on your radar
2 at all what type of fluid she received?
3 A. No, it wouldn't. I would have been aware of the word
4 "bolus" as a sort of upfront measure.
5 MR WOLFE: And what would a bolus have meant to you in the
6 context of a dehydrated child?
7 A. I wouldn't have felt qualified to make a judgment on
8 that.
9 THE CHAIRMAN: I think you said it a few moments ago,
10 correct me if I'm wrong, that a bolus is a way of giving
11 her some initial fluid quite quickly.
12 A. Yes.
13 THE CHAIRMAN: If a dehydrated child needs to be rehydrated,
14 then it would make sense to you that she gets the
15 initial fluid administration quite quickly and then she
16 gets a continuing prescription of fluid?
17 A. I'm sure that would have made sense, yes.
18 MR WOLFE: Did you pick up from the notes that when Lucy's
19 bloods had been taken for repeat electrolyte analysis
20 that a quantity of normal saline had been run in before
21 that?
22 A. I can't recall me having picked that up, no.
23 Q. You didn't pick that up?
24 A. I can't recall having picked that up. I may well have
25 done, I just can't recall it.

1 Q. It's not something that's stayed in your mind as
2 a significant point then?
3 A. No.
4 Q. And you would have observed from the notes that a report
5 from the Royal had indicated the presence of cerebral
6 oedema?
7 A. Yes.
8 Q. Did you carry out the task of looking at the notes with
9 Dr Anderson?
10 A. Yes.
11 Q. And what were your initial conclusions?
12 A. I think, from memory, we were probably concerned with
13 the volume of fluids.
14 Q. Could you help us a little further? What was the nature
15 of that concern?
16 A. Well, I think we felt we weren't qualified to know
17 whether that was an appropriate volume or not, hence our
18 decision ultimately to ask for an opinion on it.
19 Q. Was it your impression that she had probably received
20 too much?
21 A. I don't know whether we had put it in them terms or
22 whether we considered she'd had too much or not, but
23 from the records available to us it seemed that the
24 child had 400 ml of fluid in advance of what was
25 described as the episode. We weren't in a position to

1 know whether that was appropriate or inappropriate, but
2 we were aware it was a young child, a child of just over
3 a year-and-a-half old.
4 Q. You see, Dr Anderson told us on Tuesday afternoon that
5 he formed the view that this child did have too much
6 fluid and it was his view, albeit an inexpert view, that
7 the fluids were implicated in the child's deterioration.
8 I think that's a fair summary of what he said. And he
9 said that he would have discussed -- or it's his
10 recollection that he would have discussed that with you.
11 A. I'm sure he did at the time. I would say to you that
12 the remit that was drafted for Dr Quinn reflected those
13 issues.
14 Q. You seem to have gone through two stages: you have
15 spoken to the staff, you have considered the notes and,
16 arising out of the consideration of the notes,
17 a decision has been reached to seek further assistance
18 via an expert such as a paediatrician.
19 A. Yes.
20 Q. And you, as I understand it -- or perhaps jointly --
21 made a approach to Mr Mills to request that such
22 assistance be provided.
23 A. I believe it was myself who approached Mr Mills on
24 behalf of myself and Dr Anderson.
25 Q. Of course. Could I ask you some questions about how you

1 envisaged taking the review forward? Obviously,
2 Mr Mills was going to consider and make a decision on
3 whether a paediatrician was going to be granted to you.
4 He made that decision and you were told that Dr Quinn
5 was appointed and we'll come to him in a moment. But in
6 terms of your own staff, you had made a request for them
7 to provide a written report; is that right?
8 A. That is correct. From memory, that was probably after
9 that meeting though. I think the eight points or
10 whatever it is was one of the actions arising out of
11 that.
12 Q. Yes, and I think it said in the record associated with
13 that meeting that the staff were asked to provide
14 a report.
15 A. Right.
16 Q. And your letter, obviously, would have gone out after
17 that.
18 A. That's correct.
19 Q. Obviously the reports or the statements filtered back to
20 you at various times. Was there a process in place
21 between yourself and Dr Anderson to review what you were
22 being told in those statements?
23 A. I believe we met on a number of occasions and reviewed
24 the material that was being received.
25 Q. In terms of the review of that material, what were you

1 looking for when the material came in? Were you looking
2 to ensure that you had a definite account or narrative
3 about what had happened that night?
4 A. I think the staff were asked for an account of what
5 their contribution was to the care of Lucy, from memory,
6 but I'd need to refer in more detail to the letters that
7 were sent to them.
8 Q. Can we focus maybe on the medical staff? They were
9 asked presumably -- and we don't have the
10 correspondence -- as some of them have said, to provide
11 a factual account of their involvement in Lucy's case;
12 is that fair?
13 A. That would be fair, yes.
14 Q. The focus of your review or your investigation was very
15 much on the fluid management of Lucy; is that right?
16 A. Well, the focus, certainly of the enquiries made to
17 Dr Quinn, was specifically on those issues.
18 Q. And presumably you would have expected to hear from the
19 medical staff what fluids had been prescribed, what
20 fluids had been received, and an explanation, if they
21 could give one, for any difference between the two?
22 A. I'm assuming that's what we expected, yes, but I don't
23 recall the thought processes at the time.
24 Q. Well, when the reports came back from Auterson, Malik
25 and Dr O'Donohoe, did you read them?

1 A. I believe we did, yes.
2 Q. Did you recognise in them a complete failure to deal
3 with the fluids that Lucy had received?
4 A. I don't recall whether that was considered at the time
5 or not, but certainly I have looked at these on a number
6 of occasions since and, yes, that is a clear omission.
7 Q. It stares out at you, doesn't it, Mr Fee?
8 A. Yes.
9 Q. Dr Auterson, when he gave evidence, described the fluids
10 issue as the elephant in the room. How could you have
11 tolerated a situation where these clinicians were
12 sending you statements about their involvement in Lucy's
13 care where they didn't mention the fluid arrangements?
14 A. I don't recall the reason for that.
15 Q. Well, were they deliberately avoiding the fluid
16 management of the child in the account that they gave?
17 A. I don't know whether they were or were not. I'd be
18 speculating if I were to say yes or no.
19 THE CHAIRMAN: If they were deliberately avoiding it, it was
20 up to the reviewers to ensure that they couldn't or
21 didn't avoid it; isn't that right?
22 A. I accept that, yes.
23 MR WOLFE: It's correct to say, isn't it, Mr Fee, that
24 nobody went back to these doctors to say, "What are you
25 playing at? Where is your account of the fluid that

1 Lucy received and the implications, so far as you're
2 concerned, of the fluid error?"
3 A. Sorry, the question?
4 Q. Nobody went back to the doctors to compel them to
5 account for the fluid regime, its implications and their
6 understanding of the fluid error?
7 A. I don't remember having done that personally, no.
8 Q. Can you explain why not?
9 A. I don't recall the rationale behind that.
10 THE CHAIRMAN: Mr Wolfe, I'm going to take a short break
11 now.
12 Mr Fee, I hope you don't mind, but in order to make
13 sure that we finish your evidence tomorrow morning and
14 finish Dr Quinn's evidence tomorrow afternoon, I'm going
15 to sit on towards 5 o'clock this afternoon, but I won't
16 sit beyond 5.
17 We'll take a short break.
18 (3.45 pm)
19 (A short break)
20 (4.00 pm)
21 MR WOLFE: Mr Fee, having received reports from the doctors
22 which were absent any comment in relation to the fluid
23 regime which Lucy had received or indeed any explanation
24 for the apparent fluid error, you could have exercised
25 the option of interviewing those members of staff; did

1 you give that any consideration?
2 A. I can't recall whether that was considered or not.
3 Q. Would you accept that while conversations may have taken
4 place with clinicians associated with Lucy's care, you
5 didn't interview them in relation to their statements?
6 A. I didn't interview them.
7 Q. Was there any impediment to interviewing them?
8 A. None that I can recall.
9 THE CHAIRMAN: When you say, "I didn't interview them",
10 you're not distinguishing yourself from Dr Anderson
11 in that, are you?
12 A. The question I was asked was did I interview them.
13 THE CHAIRMAN: You said no.
14 A. No.
15 THE CHAIRMAN: You don't believe that Dr Anderson did
16 either?
17 A. I don't know whether he did or he did not.
18 MR WOLFE: If he had interviewed them as part of the review,
19 he should have been reporting that back to you?
20 A. I expect that if he had interviewed them, I would have
21 heard, yes, but I don't recall him having told me so.
22 Q. Dr Kelly, would he have known that you didn't and that
23 you and Dr Anderson, so far as you can tell, didn't
24 interview the staff? Would Dr Kelly have been apprised
25 of that?

1 A. I don't know whether Dr Kelly was made aware of that or
2 not.
3 Q. He has expressed surprise that you wouldn't have
4 interviewed the staff. In his evidence yesterday he
5 indicated he thought in fact that is exactly what you
6 should have been doing. Was your failure to do it due
7 to a reluctance to engage with the clinicians on this
8 delicate issue?
9 A. I don't believe so, no.
10 Q. Well --
11 THE CHAIRMAN: Can I ask you it this way? Given your
12 background, would you have been more comfortable
13 interviewing the nurses and Dr Anderson more comfortable
14 interviewing the doctors? Would that matter in the
15 context of this review?
16 A. I can't speak on behalf of Dr Anderson, but if you're
17 asking me was I personally afraid to interview the
18 doctors, no, I wouldn't have been.
19 THE CHAIRMAN: I think I'm getting at a bit more than being
20 afraid. If they got into areas that you might be less
21 familiar with than Dr Anderson, what they were saying
22 might mean less to you than it might to Dr Anderson.
23 A. I would accept that, yes. I'd also accept that I'd
24 probably be more comfortable in the nursing arena, yes.
25 MR WOLFE: Was any consideration, Mr Fee, given to seeking

1 evidence to assist your review from the Royal Belfast
2 Hospital and the clinicians there?
3 A. I don't recall whether that was considered or not.
4 Q. Is it fair to say that, whether it was considered or
5 not, it wasn't done?
6 A. That's correct.
7 Q. Dr Kelly has told us that there were no restrictions on
8 the scope or extent of this review and whatever
9 resources, within reason, would have been made available
10 to you; is that a fair description?
11 A. I think that's a fair description, yes.
12 Q. Can you recall being told that?
13 A. I don't recall it being told, but I wouldn't, from
14 memory, have had any impression that there was
15 a restriction.
16 Q. So the omission, if it is an omission, to go to the
17 clinicians in the Royal or to seek information from the
18 family or to interview staff members within the Erne,
19 those omissions didn't occur because you felt restricted
20 in any way?
21 A. No.
22 Q. But you don't have any explanation for why these sources
23 of evidence weren't exploited?
24 A. I can't explain it now, no.
25 Q. When the reports from staff members came in to you, did

1 you carry out any task such as writing up a narrative of
2 what various people were saying?
3 A. I don't recall doing that, no.
4 Q. Did you identify any gaps in the account that you were
5 given, the accounts that you were given?
6 A. I can't recall whether I did or did not.
7 Q. Well, there was this large issue about what Dr O'Donohoe
8 had said he directed for the child's fluids and what she
9 was given by the nursing team; do you remember that
10 issue?
11 A. Yes, I do, yes.
12 Q. That issue in terms of an explanation for it, seems to
13 have been left uncovered by the review; is that fair?
14 A. No, I don't think it was. I think it was clearly
15 understood that there was two opposing views in terms of
16 what the instructions were.
17 Q. Dr O'Donohoe didn't say anything in his account about
18 what the child actually received. So there was a gap
19 there in the evidence in terms of what he might say
20 about the appropriateness of the fluids that she
21 received; is that fair?
22 A. That's fair, although I think, in one of the documents
23 you showed me earlier, Dr O'Donohoe had written down
24 what he thought he had instructed to be given.
25 Q. Yes.

1 THE CHAIRMAN: That's one thing, but I think what Mr Wolfe
2 is saying is that Dr O'Donohoe was never asked: if he
3 said she was to get X and instead she got Y, what
4 difference do you think that made?
5 A. That probably is the case, yes.
6 THE CHAIRMAN: That he wasn't asked that?
7 A. I don't recall having asked him.
8 MR WOLFE: Just while we're on this issue of gaps -- and
9 it's an issue that will emerge from time to time in
10 subsequent questions -- there is an issue on the
11 documents about how much normal saline the child
12 received in the post-seizure period. There is a note
13 made by Dr Malik that said that 500 ml was run in in
14 60 minutes; do you remember that?
15 A. I don't offhand, no.
16 Q. If we could have up on the screen, please, 027-010-024.
17 You see halfway down, past "large, foul-smelling stool":
18 "Normal saline 0.9 per cent. 500 ml given over
19 60 minutes."
20 Do you see that?
21 A. Yes.
22 Q. It appears from one of your notes that we will look at
23 in due course that you were told by a nurse that Lucy
24 had received something less than that.
25 A. Yes.

1 Q. That she had received 250 ml.
2 A. That's correct.
3 Q. This discrepancy or inconsistency must have been obvious
4 to you at the time, was it?
5 A. I'm not sure it was. I think that note was following
6 a telephone conversation with Dr Quinn when he had asked
7 for clarification in relation to how much saline the
8 child had actually received.
9 Q. Yes, and one of the sources of information for you was
10 the note that we have in front of us.
11 A. Yes.
12 Q. Did you look at that?
13 A. I can't recall whether that was looked at at that time
14 or not.
15 Q. It's a very clear indication of what she got.
16 A. Well, my understanding -- and again it's from basically
17 what I've read since or at the time, I can't recall
18 which -- is that note says it was written at 3.15 or
19 3.20, and if the fluid was erected at that time,
20 it would not have been given at that time.
21 THE CHAIRMAN: Because?
22 A. It would have been started to run in at that stage.
23 THE CHAIRMAN: Yes.
24 MR WOLFE: Well, it's a note describing what happens over
25 a period of 60 minutes. Regardless of the quality of

1 the note or your misgivings about the note, it says she
2 got 500 ml, doesn't it?
3 A. Yes.
4 Q. Was that something that you hadn't picked up on during
5 your review?
6 A. I don't recall whether that was picked up on at the time
7 or not.
8 Q. You can't remember whether something as important as
9 what fluid she had after the seizure was picked up on?
10 A. I don't recall, looking back. This is 13 years we're
11 talking about.
12 Q. Of course. Well, perhaps the issue can be put into
13 sharp focus in this way: you seem to have taken a note
14 from a nurse that said 250 ml was given --
15 A. Yes.
16 Q. -- and yet you have this other note, which says 500 ml.
17 Can I take it, Mr Fee, that this inconsistency, which
18 we're looking at today, wasn't explored by you then?
19 A. I can't recall whether it was or was not.
20 Q. Well, have you any memory of going to Dr Malik and
21 saying, "You have written a note saying 500 ml has gone
22 in or was given over 60 minutes. I have a nurse telling
23 me only 250 ml has gone in; can you account for the
24 difference"?
25 A. I can't remember going to Dr Malik, no.

1 Q. And if you'd gone to Dr Malik, would it be fair to say
2 that, doing your conscientious best, you would have
3 recorded that fact?
4 A. I probably would have.
5 Q. Can we conclude from those two examples, Mr Fee, that in
6 terms of any cross-referencing or analysis of the
7 reports that went in, if you did that, if you performed
8 that task at all, it was done on a very superficial
9 basis?
10 A. I don't recall the detail of what went on at the time,
11 but looking back, yes, you could put it that way.
12 Q. Let me turn to your dealings with Dr Quinn. The
13 appointment of Dr Quinn, as you have explained, followed
14 an approach from you and Dr Anderson, or you on behalf
15 of yourself and Dr Anderson, to Mr Mills. And Mr Mills
16 sourced Dr Quinn to provide the assistance; isn't that
17 right?
18 A. That is correct.
19 Q. And you had no input in that appointment?
20 A. No.
21 Q. I think you have told us that you didn't know Dr Quinn
22 personally; isn't that right?
23 A. I have no memory of ever meeting Dr Quinn before that,
24 or indeed of knowing of him, for that matter.
25 Q. I think you have told us that you knew he was a senior

1 paediatrician working in the Province.
2 A. Perhaps, yes.
3 Q. That was as far as it went?
4 A. Yes.
5 Q. And you tell us that you spoke to Dr Quinn on the
6 telephone, following Mr Mills' initial contact with him,
7 and you told him verbally what you knew about the case
8 at that stage.
9 A. That would be correct, yes.
10 Q. And you asked him would he be happy to provide a review
11 of the case for us, and he said that he would, so you
12 wrote to him formally, and we have the letter which you
13 wrote to him. If we could put that up on the screen,
14 please. It's 033-102-296.
15 This is the briefing letter to Dr Quinn. During
16 your telephone conversation with him, did you explain to
17 him the kind of task that you wished him to perform? In
18 other words, did you tell him how you expected him to
19 carry out the task?
20 A. I can't recall the details of the conversation.
21 Q. Well, it appears ultimately that Dr Quinn received the
22 medical and nursing notes associated with Lucy's case;
23 isn't that right?
24 A. That's correct.
25 Q. But he didn't receive the witness statements that you

1 were gathering from the nursing staff and clinicians;
2 isn't that right?
3 A. That's correct.
4 Q. Can you help us at all in terms of how that situation
5 arose? Would I be unfair to suggest that where you're
6 asking an expert to carry out a piece of work for you,
7 you would try to brief him with as much detail as
8 possible and here is a situation where he wasn't
9 receiving the statements from the staff? How did that
10 come about?
11 A. I don't recall why that happened. I do note that the
12 conversation and the letter was in advance, probably, of
13 most of the statements being received.
14 Q. Yes. That's right. I think one of the first statements
15 you received was from Dr Auterson on 20 April. So
16 obviously before his final report was produced for you
17 on or about 22 June there was plenty of time to get him
18 the statements as they came in. Was this something he
19 didn't want to see or did you make a decision that he
20 shouldn't see them?
21 A. I don't recall whether he told us he wanted to see them
22 or not and I don't recall whether we decided that he
23 should see them or not.
24 Q. So you can't help us one way or the other on that?
25 A. No, I'm afraid not.

1 Q. The brief that we have up on the screen in front of us
2 to Dr Quinn, did you draft that?
3 A. I think I drafted it, but I believe I probably had input
4 from both Dr Anderson and Dr Kelly.
5 Q. Dr Kelly would say that he was on leave at or about that
6 time and doubts how he could have contributed to it.
7 A. Right.
8 THE CHAIRMAN: It wouldn't stop him from speaking to you
9 before he went on leave if he knew that you were going
10 to write to Dr Quinn.
11 A. I don't recall, to be honest.
12 MR WOLFE: I mean this with due respect, but is the language
13 of the brief and the questions that you were asking him
14 something that you would be capable of constructing from
15 your background as a mental health nurse?
16 A. I'm sure it would have been, but I'm also sure that
17 I had discussions with other people involved, and
18 I don't recall, to be perfectly honest, whether I spoke
19 directly to Dr Kelly or not, but I thought I had.
20 Q. Do the issues that you have on paper reflect a concern
21 that there had been fluid mismanagement or a suspicion
22 that there had been fluid mismanagement?
23 A. I think the three issues that are raised in the letter
24 do indicate a concern that we had in terms of the volume
25 of fluid.

1 Q. And they also reflect that that fluid mismanagement,
2 perhaps in association with other factors such as the
3 gastric losses that have been expressed there, could
4 have caused the electrolyte imbalance?
5 A. Yes. It's clear from the letter that we also knew that
6 the child had been considered as having cerebral oedema
7 at post-mortem.
8 Q. Yes. And you're interested to know the cause of that?
9 A. Yes.
10 Q. And was there a concern or a suspicion that the
11 electrolyte imbalance, having been caused by the fluid
12 mismanagement, that might have caused or contributed to
13 the cerebral oedema?
14 A. I don't recall the stimuluses behind this, but from the
15 information we had at hand we knew there was a change in
16 the electrolyte balance at the time. We knew that there
17 was cerebral oedema that had been identified at
18 post-mortem.
19 Q. You have described this as:
20 "A request for assistance with regard to an initial
21 review of events."
22 Do you see that?
23 A. Yes. I see that, yes.
24 Q. Why did you describe it in those terms?
25 A. I don't recall what the reasons were, but I suspect it

1 was that we weren't sure what was going to happen beyond
2 that stage.
3 Q. So depending upon the information coming back to you,
4 this might have been a prelude to something else?
5 A. Perhaps, yes.
6 Q. Was that something that was being discussed with you?
7 A. I don't recall whether it was being discussed or not,
8 but the letter of the 21st seems to indicate that we had
9 considered there were other possibilities.
10 Q. Dr Quinn has told the inquiry that he imposed some
11 restrictions or restraints around his involvement in the
12 review. Perhaps I could list those for you. He's told
13 the inquiry, and indeed told the Police Service, that he
14 didn't wish to engage with meeting the staff or meeting
15 the parents. He didn't wish to assist with a complaints
16 process and didn't wish to provide his report on a, if
17 you like, a medico-legal footing. Do you remember him
18 expressing those kinds of concerns to you?
19 A. I don't remember him expressing them to me.
20 Q. You told the police when you were interviewed that you
21 do recall his view that he wasn't going to provide
22 a medico-legal report; do you remember saying that?
23 A. I don't remember saying it, but if it's on paper, I must
24 have said it, yes.
25 Q. Of course, he wasn't being asked to provide

1 a medico-legal report.
2 A. No.
3 Q. Can you recall him ever saying to you or did you hear
4 through colleagues that he was saying that in certain
5 circumstances the Trust should seek an external view
6 from some other paediatrician from outside the area?
7 A. I don't recall him saying that to me and I don't see any
8 reference to it in his report either.
9 THE CHAIRMAN: And since you have already said that you were
10 operating on the basis that, within limits, you had to
11 go ahead to engage whoever's help you needed, if
12 Dr Quinn had said, "Look, I'd advise you to get somebody
13 from outside the Western area", that would have been
14 open to you to do?
15 A. Yes.
16 MR WOLFE: You sent him the case notes under copy of this
17 letter; is that right?
18 A. That seems to be the fact, yes.
19 Q. And if you like, you left him to his own devices to form
20 a preliminary view before speaking to him by telephone
21 on 2 May; is that right?
22 A. That's correct.
23 Q. There was no interim discussion between the two of you?
24 A. I don't recall any discussion with him between those two
25 dates.

1 Q. You appear to have made a handwritten note arising out
2 of that telephone conversation.
3 A. That's correct.
4 MR COUNSELL: I wonder if we can go back one step to the
5 evidence we've just heard about what Mr Fee said to the
6 PSNI? I wonder if we could bring up, please -- I think
7 this is the reference that my learned friend had in
8 mind, in fact, page 116-032-002, and the answer that
9 Mr Fee gives to DS Cross in the middle of the page when
10 DS Cross is asking him about Dr Quinn's conversation, in
11 fact, on the doorstep of his home. He says in the
12 middle of that answer, if I can pick it up there for the
13 witness:
14 "We hadn't asked him for a medical/legal opinion and
15 that wasn't the purpose of our intentions. If we were
16 looking for a medical/legal opinion, we could go to
17 a solicitor and asked them to identify a doctor to give
18 us one."
19 I don't know if that concurs with his thinking on
20 the matter or not and I wonder if that is Mr Fee's
21 recollection now.
22 MR WOLFE: Through me, you can answer that question.
23 A. Sorry, what ...
24 Q. Is that your recollection now, that that was your
25 thinking at the time?

1 A. I was --
2 THE CHAIRMAN: Sorry, Mr Fee.
3 Is this a nuance on the question? Are you trying to
4 pin down more precisely the question Mr Wolfe asked,
5 Mr Counsell?
6 MR COUNSELL: Exactly that. He mentioned that there had
7 been a reference in the interview and I suspect this was
8 it.
9 MR WOLFE: If it was ...
10 THE CHAIRMAN: Just give me one moment to go back to the
11 question.
12 MR WOLFE: Yes, this is the reference I had in mind.
13 THE CHAIRMAN: I think what Mr Counsell is correcting is
14 just a slight nuance. Your question, Mr Wolfe, was:
15 "You told the police when you were interviewed that
16 you do recall his view that he wasn't going to provide
17 a medico-legal report."
18 And I think Mr Counsell is just putting the precise
19 question and answer with the police. This isn't a point
20 against you, it's just correcting the record, really.
21 Okay? Thank you.
22 MR WOLFE: As I understand Dr Quinn's perspective, he has
23 said to the inquiry -- the reference is WS279/1 at
24 page 11 -- that he made known to you, Dr Kelly and
25 Mr Mills, his views on these restrictions or

1 constraints, as you can see at the top of the page
2 at (f). So he said:
3 "I had stated and made clear what I was willing to
4 do to all three of the individuals with whom I had
5 contact (Mr Mills, Dr Kelly and Mr Fee). My
6 understanding therefore was that the persons who were
7 receiving my report were all aware of the constraints
8 applicable to its preparation. In the event that I had
9 been aware at that time that the report may be
10 circulated or used by anyone else, then I accept it
11 would have been prudent to have set out the constraints
12 within the written report."
13 But just to summarise the position, I think what
14 you're telling us is, as has been noted in your police
15 interview, that so far as you were concerned you weren't
16 asking for a medico-legal report; if you'd wanted
17 a medico-legal report you would have asked the Trust to
18 instruct its lawyers to arrange one?
19 A. That's correct.
20 Q. If we could turn to your discussion on 2 May. I want to
21 clarify what you've written down in a handwritten note,
22 which appears to arise out of that telephone
23 conversation. Could we have up on the screen, please,
24 034-042-101? I wonder, Mr Fee, could you, doing your
25 best, read through that note for us, just verbatim as it

1 appears? Obviously, if there's a need to explain any
2 gap, that you would tell us.
3 A. Okay.
4 THE CHAIRMAN: Just before you start, is the original
5 available?
6 MR SIMPSON: Yes, it is. I have taken the opportunity
7 before he gave evidence to let him see it and go through
8 it. If it's helpful, he can have it in front of him
9 rather than try to read it off the screen. I have also
10 shown it to Mr Counsell.
11 THE CHAIRMAN: If you're happy enough just to go ahead and
12 do it off the screen, you can go ahead and do so, or we
13 can get the original in front of you if that's easier.
14 A. If it's handier.
15 MR WOLFE: [inaudible] because as, far as I know, there's
16 a note on the underside of the page.
17 MR SIMPSON: There is, and there's also a note on the --
18 it's clearly a pad of paper with only two sheets of
19 paper left in it. It is written on two sheets and on
20 the back of the second and also on the cardboard pad on
21 the back, so it's all there.
22 MR WOLFE: Can you read it as soon as you're ready, Mr Fee?
23 A. It starts off:
24 "On 2/5/00, 2.30 pm ..."
25 From my recollection, Dr Quinn rang me on that

1 occasion. I didn't ring him, just for clarity.
2 "Lucy Crawford, Dr Quinn issues. Difficult to get
3 a complete picture of child. Type of fluid was
4 appropriate. The amounts was dependent on dehydration.
5 May expect 80 ml per hour. From 7 pm to 2 am,
6 approximately 80 ml per hour. No clear instruction of
7 volume of fluid. And then --
8 THE CHAIRMAN: Sorry, just pause. You read out "no clear
9 instruction"; is it "no clear indication" or
10 "instruction"?
11 A. To my reading, it's:
12 "No clear instruction --
13 THE CHAIRMAN: Okay, thank you.
14 A. -- on volume of fluid, nor volume taken over the
15 seven-hour period. Appears reasonable. Query: was the
16 child floppy?
17 THE CHAIRMAN: Sorry, just stop one moment, Mr Fee. I think
18 it's, "Query, why was the child floppy".
19 A. Sorry, "Query, why was the child floppy. Did the child
20 have a seizure or was it rigid as symptom of coning?"
21 THE CHAIRMAN: Thank you. Is that the end of the first
22 page?
23 A. That's the end of the first page.
24 THE CHAIRMAN: Let's go on to the second page.
25 A. "Valium was not not extensive. Could have been up to

1 4.5 milligrams Valium. Query was resuscitation
2 adequate? Was there a --
3 I apologise for the spelling and so on. I think the
4 word I intended to write was, "Was there pneumonia?"
5 "How much of the normal saline was run in? If
6 500 ml may have affected appearance and level of
7 cerebral oedema experienced at the time of PM. If child
8 was rigid at the time of calling the nurse. Question,
9 was there an event that was in advance of the mother
10 calling the nurse?"
11 And then there's a question mark at the bottom.
12 THE CHAIRMAN: Right. That's the bottom two pages that
13 we have, but from my understanding from Mr Simpson
14 there's more.
15 A. On the back of the second page is written:
16 "Sodium level probably not cause of seizure ?
17 Relevance of rest of blood results. Urea level
18 indicated."
19 Then on the back of the card -- I don't know whether
20 you want that or not.
21 THE CHAIRMAN: Is there a 104? Then what's on the card,
22 I think, is new.
23 A. "Question, Nurse McManus re fit [I think it is]. 3.15,
24 normal saline introduced. Given 250 ml by at 4 am."
25 THE CHAIRMAN: Sorry, read that again. "Given 250 ml".

1 A. "Given 250 ml by at 4 am. Put on 30 ml per hour for
2 next two hours".
3 THE CHAIRMAN: And that's it?
4 A. That's it.
5 THE CHAIRMAN: Thank you very much.
6 MR COUNSELL: I wonder if I might just query one part on the
7 bit he just read out.
8 THE CHAIRMAN: Yes.
9 MR COUNSELL: On the second page.
10 THE CHAIRMAN: That's 034-042-102.
11 MR COUNSELL: In the paragraph which begins "if 500 ml", is
12 the word in the middle of the second line "and" or "re"?
13 A. Sorry, which word are you asking?
14 THE CHAIRMAN: "If 500 ml may have affected appearance ..."
15 A. "And level of cerebral oedema".
16 MR COUNSELL: That's "and", is it?
17 A. Yes.
18 MR COUNSELL: Thank you.
19 MR WOLFE: That written note, Mr Fee, did you have that
20 typed up?
21 A. I can't recall whether it was typed up or not.
22 Q. There is a note that relates to that 2 May conversation
23 which was appended to the review report. If we could
24 have that up on the screen, please, 033-102-287. Do you
25 recognise that document?

1 A. Yes.
2 Q. That's, as you can see, appendix 5 to the review report.
3 A. Yes.
4 Q. Can you help us in terms of whether you directed that
5 that be typed up at the time or whether you did it
6 yourself or how come this document was formed?
7 A. I probably put it on a Dictaphone and the secretary
8 probably typed it.
9 Q. It's quite clear that you're not dictating verbatim what
10 appears on your written note.
11 A. I would need to compare the two, but that's probably the
12 case.
13 THE CHAIRMAN: And that would be a normal thing to do when
14 you have a handwritten note that you dictate it in a way
15 which is a bit more coherent?
16 A. Yes.
17 MR WOLFE: Just comparing the two for, if you like,
18 differences of any substance -- and I don't pretend to
19 have a monopoly on this, I am sure other people will
20 have a view -- I can't see in the note in front of us
21 a reference to the question, "Was there a pneumonia?".
22 A. Let me just try and ... No, I don't see that there. It
23 seems to skip from "Was resuscitation adequate?" to "How
24 much normal saline was run in?"
25 Q. Am I also right in saying that on this typed note the

1 sentence "Sodium level probably not cause of seizure",
2 that doesn't appear?
3 A. I'm just trying to see whether that was in the
4 handwritten note. That doesn't appear to be on it, yes.
5 Q. Sorry, I didn't hear you.
6 A. That doesn't appear to be on the typewritten version.
7 Q. Yes. Can you account for the difference in respect of
8 the notes with regard to those two points?
9 A. I can't, no.
10 Q. The note in relation to the sodium level probably not
11 being the cause of the seizure, could you just hold up
12 for me where that appears?
13 A. It appears on the back of the second page.
14 Q. Is that a continuation of what appears on the front of
15 the page or is it an isolated note?
16 A. It looks as though -- and I don't recall ... It looks
17 as though the pad was like so (indicating) with
18 a sticker on the top of it and I wrote 1, 2, and then
19 wrote on the back of that.
20 Q. Help us if you can. In terms of that question, sodium
21 level probably not -- that comment, sodium level
22 probably not cause of seizure, is that verbatim what it
23 says?
24 A. Yes, that's correct. Probably not the cause of seizure.
25 Q. Is that a conclusion that you have reached or where does

1 that comment derive from?
2 A. I think that was a comment that Dr Quinn made, as was
3 query the relevance of the rest of blood results, urea
4 level indicated.
5 Q. And in terms of the things being said by Dr Quinn, the
6 sodium level probably not being the cause of the
7 seizure, is quite a significant thing to have said, yet
8 it doesn't appear in, if you like, the note that formed
9 part of the official report of the review.
10 A. I accept that, yes.
11 Q. Can you assist us on how that could have occurred?
12 A. I can't recall or give you an explanation as to why that
13 was missed, those two points were missed.
14 Q. The discussion with Dr Quinn at that time, how long did
15 it last, to the best of your recollection?
16 A. I think it was probably one and a half to two hours.
17 Sorry, this discussion here, sorry? The telephone
18 discussion, sorry? I don't recall. It probably lasted
19 10, 15, 20 minutes.
20 Q. And were you writing your notes as he spoke?
21 A. I'd have been on the phone writing, yes.
22 Q. And then you probably can only tell us this by reference
23 to your habit. How quickly do you think you had the
24 note dictated thereafter?
25 A. I probably dictated it fairly immediately afterwards,

1 I'd have thought. But I can't be sure of that.
2 Q. The views that were expressed by Dr Quinn and which make
3 their way on to this record we have in front of us, were
4 you in, can I describe it as listening mode and simply
5 noting what he was saying, or was there -- was what
6 he was saying the subject of enquiry or debate?
7 A. I don't recall, to be honest, but I suspect it was a two
8 way dialogue.
9 Q. In other words, you were seeking clarification of what
10 he meant from time to time?
11 A. I most likely would have been, but I don't recall the
12 detail of that on this.
13 Q. One of the things that has been the subject of comment
14 in terms of what he has said is that the type of fluids
15 appeared appropriate. Can you recall whether you
16 challenged or queried that in any way?
17 A. I can't recall challenging or querying it. To be
18 honest, the type of fluid may not have been of relevance
19 to me.
20 Q. Another point at number 3:
21 "When the fluids are divided over the length of
22 stay, the child received approximately 80 ml per hour."
23 That's an issue that has attracted comment because
24 rather than using the four hour period or four and
25 a half hour period from the commencement of the

1 intravenous fluids as the divisor, Dr Quinn has instead
2 used something like a seven hour period or a bit longer
3 as the divisor, starting with the time at which she was
4 admitted to the hospital. Was that the subject of any
5 discussion?
6 A. I don't recall whether that was discussed at the time or
7 not, but I know when Dr Kelly and I met with Dr Quinn
8 later, that issue recurred again, he'd done a whole lot
9 of calculations in terms of what would have been the
10 normal requirement for the child.
11 MR COUNSELL: I just wonder whether I could ask the witness
12 if he could clarify that. Because, of course, his note
13 doesn't contain the words "when the fluids are divided
14 over the length of stay the child received". It may be
15 that --
16 THE CHAIRMAN: Sorry, you mean his handwritten note as
17 opposed to his typed note?
18 MR COUNSELL: His handwritten note actually simply says,
19 I think, "from 7 pm to 2 am", and then there's a gap,
20 "approx 80 ml per hour". The line in the typed text
21 doesn't appear, of course, in the handwritten note at
22 all.
23 THE CHAIRMAN: Does the line -- point 5 on the screen,
24 Mr Fee, the volume taken over the seven hour period
25 appears reasonable.

1 MR COUNSELL: Sorry, not that line, the line at numbered
2 paragraph 3.
3 THE CHAIRMAN: Sorry, thank you.
4 MR WOLFE: You're being asked to compare that, Mr Fee, with
5 the entry on 034-042-101, about halfway down the page
6 from 7 pm. Do you see that?
7 A. I'm not quite with you just in terms of what part you're
8 asking me to compare.
9 Q. Sorry. If we perhaps have the typed version up on the
10 screen because the witness has his handwritten notes in
11 front of him. Thank you.
12 So you're being asked to compare that entry with the
13 entry from -- I think it says 8 pm. Is that what we
14 established? From 8 pm to --
15 A. No, my handwritten note says "from 7 pm to 1 am [sic],
16 approximately 80 ml per hour".
17 Q. No. You think -- you help us, it's your writing. I'm
18 reading that as either "from 7 pm to 2 am", but it could
19 be "8 pm to 2 am". What do you say?
20 A. I'm just saying the handwritten note that I've written
21 here, it states on it "from 7 pm to 2 am, approximately
22 80 ml per hour". Now, the typewritten note says when
23 the fluids were divided over the length of stay, the
24 child received approximately 80 ml per hour.
25 THE CHAIRMAN: Thank you.

1 MR WOLFE: I was working through a number of entries on the
2 typewritten note, Mr Fee, and asking you about some of
3 the ones that have attracted comment, particularly from
4 Dr MacFaul, the inquiry's expert. Your answer to each
5 of them was you can't recall whether you entered into
6 debate or discussion over them. Would that be the same
7 approach to any of the points that I raise with on you
8 this letter or this note?
9 A. Sorry, just remind me again what ...
10 Q. I said to you, did you enter into any discussion with
11 Dr Quinn in relation to whether the fluid type was
12 appropriate? He was telling you the fluid type was
13 appropriate and I asked you whether you engaged in
14 discussion on that topic and you said you couldn't
15 recall. And secondly, when I asked you whether you got
16 into discussion about the period of time over which the
17 fluids ran leading to 80 ml per hour, you say you can't
18 remember discussing that, although it was an issue that
19 was to come up later --
20 A. Yes.
21 Q. -- at your meeting on 21 June. Can you remember
22 a discussion about any of these particular points?
23 A. I don't really remember whether we had a discussion
24 about that. I suspect we had a two way conversation,
25 but I don't recall the detail.

1 Q. Number 11:
2 "If 500 ml was given, this may have affected the
3 level of cerebral oedema experienced at post-mortem."
4 And then there's a footnote, and you have said:
5 "Nursing staff advise that normal saline was
6 commenced at 3.15 am and 250 ml had been administered."
7 It's your note in front of you, your handwritten
8 note, that that was McManus who told you that?
9 A. The note says "query Nurse McManus re fit". Now,
10 I don't know whether I was asking myself to query that
11 or Nurse McManus or I did actually query it with -- then
12 it goes on to say "at 3.15, normal saline introduced,
13 given 250 ml by 4 am, put on 30 ml". So I suspect it
14 was Nurse McManus that I raised that query with, but
15 I can't be certain of that.
16 THE CHAIRMAN: So that is a follow-up query with Nurse
17 McManus after you've finished the telephone call with
18 Dr Quinn?
19 A. I suspect that. Probably, yes.
20 THE CHAIRMAN: Thank you.
21 MR WOLFE: Can I just put one thing before you to see your
22 reaction. Could I have Staff Nurse McManus' interview
23 with the police in front of us, please. It's
24 116-022-005 and 006. DS Cross is putting various fluid
25 issues before the nurse. And if I'm inferring

1 correctly, about halfway down the left-hand page he's
2 asking:
3 "The entry at 3 am, it says '500 normal saline' and
4 I'm not sure what that is meant to read at 4 am. There
5 is a mark there, but what would that mean to you as it's
6 written?"
7 And she says:
8 "I would say that 500 has been given in that hour."
9 And then he goes on to say -- he refers to, "There's
10 a slight difficulty because then you go on to --" and
11 the sentence isn't finished. Let's try to make sense of
12 what he's talking about. The penultimate entry on that
13 page is:
14 "I think that Dr Sumner and Sue Chapman just weren't
15 really sure".
16 They're the experts the police were using at that
17 time:
18 "I think there's 250 ml mentioned when she was in
19 intensive care and there was a debate about whether only
20 250 ml of this had been given and it was finished, but
21 I think it is accepted that ..."
22 She answers by saying:
23 "I wasn't there when it was being ..."
24 And then she doesn't finish her sentence.
25 She goes on to say at the top of the right-hand

1 page:

2 "I was there when it was put up, but I wasn't there

3 when it was finished, so there could have been half a

4 bag left, I couldn't be 100 per cent certain."

5 So making sense of all of that, doctor, you appear

6 to have a note which is attributing to Staff Nurse

7 McManus the view that 250 ml of normal saline had been

8 given; isn't that right? That's your interpretation of

9 your note?

10 A. I'm assuming, but I've said to the chairman in response

11 to this earlier point that I'm not sure whether that

12 relates to Nurse McManus or not. I'm assuming from the

13 way it's written it was Nurse McManus he(?) made that

14 query from.

15 Q. Whereas she has told the police that she can't be

16 certain because she wasn't there when the fluid

17 finished, so she can't say how much was given.

18 A. I think the police statement was taken in 2004.

19 Q. Yes.

20 A. It's quite some time later.

21 Q. Oh, of course.

22 THE CHAIRMAN: In fact, if I understand it right from your

23 report, Nurse McManus in effect declined to make a

24 statement for the purposes of your review because the

25 only note I have from her is a two-page document in

1 which she's saying, "Look, I don't want to sound petty,

2 but I would like to clarify what this account will be

3 used for. If it's for official use at a later date,

4 then I would like more time to be able to compose it",

5 and so on.

6 A. Yes.

7 THE CHAIRMAN: Did you ever get a statement from her? Apart

8 perhaps from a quick chat or discussion with her about

9 this particular point, did you ever get a statement from

10 Staff Nurse McManus?

11 A. I don't recall if there's a statement on file from Nurse

12 McManus or not.

13 THE CHAIRMAN: I'll assume, Mr Fee, that there isn't because

14 there isn't one appended to your report.

15 A. Right. There probably isn't then.

16 MR COUNSELL: I wonder if I can assist on that with two

17 documents. One is the first page of that letter, which

18 is at page 314, and I wonder if that could be brought up

19 on the left-hand side of the screen.

20 THE CHAIRMAN: Yes. 033-102-314.

21 MR COUNSELL: It's the second paragraph where she appears to

22 indicate that she had no involvement. Then a

23 discussion -- and this may assist Mr Fee -- at

24 033-102-295, I think. It has been amended, the page

25 number on my copy. Yes, that's it. There's

1 a discussion at the bottom of there, which, of course,

2 is shortly before the telephone conversation with

3 Dr Quinn.

4 THE CHAIRMAN: Yes.

5 MR COUNSELL: I don't know whether that helps the witness.

6 THE CHAIRMAN: So on two occasions she appears to be saying,

7 "I really have nothing to contribute". But your note at

8 the end of the call with Dr Quinn seems to record what

9 her understanding of the volume of normal saline was?

10 A. I'm perhaps misinterpreting what the note actually says.

11 It says, "query Nurse McManus re fit".

12 MR WOLFE: Then your typed note refers more generally to

13 nursing staff.

14 A. Yes. So I may not have asked Nurse McManus about that,

15 it may have been some other nurses, I can't recall.

16 Q. Could I just conclude this sequence by asking you, in

17 terms of the clarification which you say you got in

18 terms of the amount of fluids, was that passed to

19 Dr Quinn?

20 A. I believe it was.

21 Q. Sorry?

22 A. I believe it was.

23 Q. And at what stage do you believe it was?

24 A. I don't recall whether it was passed to him once or

25 twice. I suspect, if I'd got that fully immediately

1 after our telephone discussion, that I'd have contacted

2 him, but I don't have any note of that. I certainly

3 have seen a note of the meeting that Dr Kelly and myself

4 had with Dr Quinn and there's a reference there to the

5 fact that we had clarified that we understood that it

6 was 250 ml.

7 MR WOLFE: Yes. Let me take that point up with you

8 tomorrow.

9 THE CHAIRMAN: Mr Fee, if you don't mind we'll stop there

10 for today. Thank you for accommodating us and coming

11 back tomorrow.

12 I have to give some indications at 9.30 about some

13 other steps which are going to be taken and then, if

14 needs be, can we start Mr Fee at 9.45? Since we're

15 going to be here at 9.30 anyway, if my business takes

16 less than half an hour we could maybe start Mr Fee at

17 9.45. You'll be finished before lunchtime tomorrow.

18 Thank you.

19 (5.07 pm)

20 (The hearing adjourned until 9.30 am the following day)

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1 I N D E X

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3 DR JAMES KELLY (continued) 2

4 Questions from MR WOLFE (continued) 2

5 MR EUGENE FEE (called) 98

6 Questions from MR WOLFE 98

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