Tuesday, 18 June 2013

(10.00 am)

(Delay in proceedings)

(10.11 am)

THE CHAIRMAN: Good morning. Mr Wolfe?

MR WOLFE: Good morning, sir. The next witness is Dr Moira Stewart.

DR MOIRA STEWART (called)

Questions from MR WOLFE

MR WOLFE: Good morning, doctor. The first thing I want to ask you about this morning is in relation to your contribution to the inquiry to date. You've provided the inquiry with three witness statements; isn't that correct?

A. That's correct.

Q. They are numbered 298/1, 298/2 and 298/3, and dated 19 November 2012, 18 January 2013 and 21 March 2013 respectively; isn't that right?

A. That's correct.

Q. We ask witnesses who come along whether they wish to adopt their written evidence and to be read and supplemented by what they say today in evidence before the inquiry. Would you like to adopt your witness statements?

A. Yes.

Q. In addition to your witness statements, you have recently and helpfully provided us with an updated CV. If we could have that up on the screen, please. 315-023-001. The first thing to note, doctor, are your current appointments, which we see at the bottom of that page. You're a senior lecturer in child health at the Queen's University of Belfast and a consultant paediatrician in the Belfast Trust.

A. I have retired from Queen's at the end of March this year. I continue my five NHS sessions under Belfast Trust.

THE CHAIRMAN: Thank you.

MR WOLFE: We note on this page your qualifications. You graduated with a medical degree in 1977, you obtained -- is that a diploma in child health?

A. That's correct.

Q. In 1981 from Dublin. A member of the Royal College of -- is that Physicians?

A. Yes.

Q. In 1982. Is that a fellow of the Royal College of Physicians then?

A. That's correct.

Q. In July 1994. A fellow of the Royal College of Paediatrics and Child Health in 1996. And then working back, I think, ten years to 1986, you obtained

a doctorate in medicine?

A. That's right.

Q. From the Queen's University of Belfast?

A. Yes.

Q. If we could just go over the page, please, that helpfully lists all of your various posts through your career. It appears from a reading of that that having gone through the normal rotations of a trainee doctor, you began to specialise in paediatrics in the early 1980s; is that fair?

A. I actually did my first job as an SHO in paediatrics in 1979, 1 February 1979, through to July 1979.

Q. And that was followed by an SHO in medicine and then everything after that has been in the paediatric field?

A. That's right, yes.

Q. If we could just go over the page, please, to 003. Leading to your appointment as consultant paediatrician in July 1990, and that's a post that you have held, no doubt with changes along the way, but it's a post that you've held until the present day?

A. Yes, until the end of March this year, when I retired from the Queen's half of the job and continue in my NHS post.

Q. So in understanding that post, it was very much -- there was a clinical -- I hesitate to say clinical half of it,

but a clinical part of it and an academic part of it; is that fair?

A. Yes. I've always had five sessions of clinical work -- in fact more than five sessions because of commitments to the on-call rota, weekend working, so there was actually more clinical work than there was academic work.

Q. You describe at the bottom of the page a little bit about the consultant post that you held. You've described it as:

"The first consultant community paediatrics post in the island of Ireland."

Is that correct?

A. That's correct.

THE CHAIRMAN: Dr Steen gave evidence in Claire's case and she was working outside the Children's Hospital in Cupar Street. Is that something similar to what you were doing as a community paediatrician?

A. Yes. I actually obtained my accreditation as a general paediatrician, but our professor of paediatrics at that time was very keen that we begin to develop community paediatrics as a sub-specialty within Northern Ireland, so I did additional training in community paediatrics and then came back to this post. But I've always worked across community and acute services, and then the other

part of my job was the academic post.
THE CHAIRMAN: Thank you.
MR WOLFE: So in terms of your day-to-day work, I just want to get a sense of the physical location of where you were. Were you a presence in the Children's Hospital or were you somewhere remote from that?
A. The five NHS sessions, I did two clinics in the community, sometimes three. I always did one clinic in RBHSC Children's Hospital as well, and then I was a full member of the acute on-call rota, covering general paediatrics, weekend work, night work, and that continued right up until the end of March this year when I came off the acute on-call rota.
Q. Your intervention in the case of Lucy Crawford came as a result of your involvement with the Royal College of Paediatrics and Child Health. I just want to ask you something about your role within that organisation. You say -- if we could go over two pages, please, to 005 -- at the top of the page, helpfully, you were the regional adviser for the Royal College within that period, 1999 to 2002. I'm conscious that elsewhere in your CV you had an earlier role with the Royal College, I think I'm right in saying.
A. That's right.
Q. But just dealing with that period, because that's the

period within which we are concerned, because you, if you like, had two interventions in relation to Lucy, one was in 2000, isn't that right, leading into 2001?
A. Yes, really 2001.
Q. Yes. And the second, then in concert with Dr Boon, was in 2002?
A. That's correct.
Q. Just help us if you would in relation to the role of regional adviser. Needless to say that was in addition to your professional duties, but what did the role of regional adviser entail?
A. The main responsibility was to oversee the training of junior doctors, so it was taking responsibility for allocation of trainees to various posts throughout Northern Ireland, supervision of their training, annual assessment of the trainees to make sure they had fulfilled their training requirements for that period, and in addition at that time the Royal College also had responsibility for visiting various paediatric units across Northern Ireland to make sure that the training that was provided in those units was adequate and satisfactory.
As regional adviser at that time, not only would I have been involved in training visits across Northern Ireland, but also in training visits elsewhere

in the UK, not on a frequent basis, but certainly I was the lead assessor for one visit in Derbyshire. So I was quite familiar with going to different units and looking at the case load, the work involved in those units and making sure that it provided adequate training for trainees.
Q. You describe then, if I'm correct in how I interpret you, the Royal College, through yourself, was providing, if you like, an oversight of the education, in particular of junior doctors, in ensuring certain standards were being met?
A. Yes.
Q. Your role in relation to Lucy Crawford was somewhat different, however. It was, if you like, a particular project or a particular specific issue. Did that also come within your job description as the regional adviser?
A. It was the only time that I was ever asked to carry out a professional clinical competency review regarding the work of one individual, Dr Jarlath O'Donohoe, so it wasn't ... It wasn't a situation that arose -- I'd never known it to arise before in Northern Ireland. It maybe arose elsewhere in the UK, but it wasn't a frequent task that we were asked to do on behalf of RCPCH.

Q. It would appear that your services were sought in that sense because the Trust had received a complaint from a junior doctor about a consultant, and that coalesced with problems or perceived problems around the treatment of this particular child, Lucy Crawford, albeit that you were asked to look at three other patients as well; is that fair?
A. I didn't really have any details of what the cases involved. I can't remember a telephone conversation with Dr Kelly in the summer of 2000, but if he had asked for contacts within RCPCH, I would have been able to provide him with those details. I wasn't copied into the initial correspondence between Dr Kelly and Dr Hamilton in the College, which outlined the work that Sperrin Lakeland Trust was requesting.
Q. Yes. I want to come back and deal with how you became involved in some detail in just a moment or two, but suffice to say, I think, that you've described your role as a regional adviser and this activity with regard to the Sperrin Lakeland Trust and the requirement or the request that you explore the work of a particular consultant was unusual in terms of your role.
Can I now move to looking at the issue of fluid management. In the case of Lucy Crawford, as it emerged, this was a child who had particular fluid

needs. Could I bring you to something you've said in your witness statement? If we could have up on the screen, please, WS298/1, at page 8, and have alongside that page 9.

At the bottom of the page, Dr Stewart, question 11, if I could take you there on the left-hand side, is raising with you a series of enquiries with regard to the appropriate fluid regime for Lucy. At question (c) we ask:

"Was it appropriate to treat Lucy with Solution No. 18 at a rate of 100 ml per hour between 10.30 pm and 3 am?"

And we ask you to fully explain your view and specify the rate, type and volume of fluids which Lucy should have received during that period. And we have your answer at the top of the page. You introduce your answer by saying:

"This was a clumsy attempt to reconcile volume of fluids received."

Can I leave that just for the moment? That is you, I think, going back to something you said in your report to the Trust, and you were attempting to explain how you had expressed yourself in that way. But what I want to come to is the next bit, which is the direct answer to the question. If I could take up with:

"Solution No. 18 would have been an inappropriate solution according to accepted practice at this time."

Could I just stop there? Was that because Lucy was a child with a background of gastroenteritis, who, properly assessed, should have been identified as having moderate dehydration?

A. Yes. I always find it difficult to interpret symptoms and signs without actually seeing a child, but my impression from the notes -- and the notes were very poorly documented -- was this was a little girl who was really quite ill whenever she was admitted. And certainly nowadays, it's almost certain that she should have been given an initial bolus of normal saline, 20 ml per kilo, and that would have been really taken as initial resuscitation fluid to try and restore circulating blood volume. And then thereafter, the calculations move into maintenance fluid and into rehydration fluid.

Q. Yes.

A. At that time, Solution No. 18 was still the solution that was in general use, not just in Children's Hospital, but also across the UK as maintenance fluid for children, but it was really the ... I felt she was really quite sick whenever she came into hospital and that she needed a bolus of normal

saline at that time.

Q. Yes, and you helpfully say in your answer, if I can underline the phrase, "the accepted practice at that time", so you're saying because of her condition, she was really quite ill, she was dehydrated --

A. Yes.

Q. -- Solution No. 18 would have been an inappropriate solution by reference to the practice of the time, and then you go on to tell us what she should have received according to you. That is:

"Initial treatment with a bolus of normal saline given over a short period of time."

So that would have been, what, over a period of 20 to 30 minutes?

A. Whenever you give it, you give it as quickly as you can.

Q. You push it in?

A. You push it in, so it's given as quickly as you can, which usually means in practice about 20 minutes.

Q. And as I say, the 20 ml per kilogram would have been, in round numbers, for 200 ml, although to do it precisely would have been a little over 9 kilograms multiplied by 20.

A. Mm-hm, yes.

Q. And then, having achieved that -- and the purpose of that, doctor, was to address imminent or actual

circulatory shock?

A. Yes, imminent. She wasn't in established shock, but certainly from the information I had, I felt that she was in imminent circulatory shock.

Q. And then having treated the shock issue, you move on to the next stage, which is to work out the degree of dehydration and select the appropriate fluid for that. That's when we talk about replacement fluids; isn't that right?

A. That's correct, yes.

Q. And we realise, I think, that because you weren't treating the child, didn't see the child, you're having to make your best assessment of the degree of dehydration; is that fair?

A. That's correct.

Q. And the inquiry knows that the various doctors who have looked at this have come up with different figures. I think Dr Sumner, when he looked at it, may have considered that she was not in moderate dehydration, other doctors share your view. But you've plumped, if that's not too unkind a word, for 7.5 per cent bearing in mind all the information. The important thing is the type of fluid. Can you help us with that? You have said normal saline.

A. Yes. I very much referred to the Advanced Paediatric

Life Support guidelines on fluid management, but even without those guidelines, as a paediatrician I know that if you're replacing losses, you do it with normal saline, certainly a solution that is a much higher sodium concentration than Solution No. 18.

Q. I'm going to bring you to the APLS guidelines just now. Then, of course, a child -- or any patient, I suppose -- requires fluids for ongoing or, if you like, normal losses, and that's when maintenance fluids are necessary. So you refer to that in your answer as well. And by the standards of the time in the management of the maintenance needs of a child, Solution No. 18 would have been accepted practice; is that fair?

A. It was, it was still accepted practice in the early 2000s.

Q. You've referred to the APLS guidelines. You were an instructor on the APLS course.

A. That's correct.

Q. Can you help us a little just with a bit of background? APLS is what? Presumably it's not just focused on the fluid needs of children.

A. No. Advanced Paediatric Life Support is a three-day course. It started running in Northern Ireland in really the early to mid-1990s. By that stage, we expected all our trainee paediatricians to have become

certified in APLS before they got to registrar or middle grade standard.

APLS covers a whole range of assessment and management strategies for acutely-ill children, right through from medical emergencies to trauma, surgery, burns, poisoning. And because we expected our juniors to be certified in APLS, I felt that I also should do the course. It wasn't in existence at the time that I was training, but I felt that if we expected the juniors to be certified, then I should also be certified.

Then, depending on how you get on in the course, then some people are invited to become instructors and do a further instructor's course, which I did, and then I taught. You have to teach on -- I think it was a minimum of two courses a year in order to keep up your accreditation. So I continued to do that through to the mid-2000s.

Q. I think you've said in your CV you did it over the period 1999 to 2006.

A. Yes.

Q. So what you're telling us is that you did the course as a participant, you then took on the role of instructor, and as I understand it from your CV, when you are an instructor you have to do an instructor's course to

equip you to deliver the course?

A. Yes, that's right.

Q. We can pull it up on the screen. There was an APLS second edition. There was manual; isn't that right?

A. Yes.

Q. Would that have been on the shelf of most paediatric units or how would practitioners access the manual?

A. Well, everybody who does the course at that time got a hard copy of the manual, which is the one I worked from whenever I was checking the guidelines on fluids. I'm not sure that otherwise there would have been a copy of the guidelines in each ward. I don't think so. There may have been in intensive care, I can't remember.

Q. Okay.

A. But most of us had our own copy.

Q. Would paediatric consultants be expected to be knowledgable as to the contents of the APLS manual?

A. I think all consultants would have known about APLS. Not all consultants would have decided to do the course.

Q. Yes. Could we take a look then at --

THE CHAIRMAN: Sorry. But that means the manual is more likely to be found in the children's ward in the RBHSC than it is in Craigavon or Daisy Hill or the Erne, does it?

A. I don't think that's the case. There were just as many

instructors from outside Belfast as there were -- in fact, I think there were more instructors in Northern Ireland who were outside Belfast than within Belfast.

THE CHAIRMAN: Thank you.

MR WOLFE: Could we have up on the screen, please, 250-004-037? You may be familiar with it, doctor, but what I've got up on the screen here is the section of the APLS manual from 1997/98. It's referred to by Dr MacFaul as the second edition, and the pages that we're going to look at concern the management of dehydration.

There is a description here of dehydration, it tells us that it is:

"The result of abnormal fluid losses from the body which are greater than the amount for which the kidneys can compensate. The natural mechanisms for compensation have the primary aim of maintaining concentrating volume and blood pressure at all cost. Thus the majority of patients with dehydration maintain their central circulation satisfactorily. Loss of central circulatory homoeostasis constitutes hypovolemic shock and is dealt with [in another part of the manual]."

But it was your concern in Lucy's case, or at least it was your interpretation of the data that was

available to you, limited though you say it was, that she was at risk or at danger of developing this kind of shock?

A. Mm-hm.

Q. And it's for that reason that you, in the answer I looked at with you earlier, were suggesting a bolus of normal saline. It goes on to say:

"The major causes of dehydration in children are gastrointestinal disorders and diabetic ketoacidosis."

Lucy's background, it seemed, was of a gastrointestinal disorder, isn't that right? And the manual goes on then in this paragraph to say:

"Depending on the source of fluid losses and the quantities of electrolytes lost [and it refers back to table B3] dehydration can be divided into three types."

And it refers to, if we go over the page:

"Isotonic dehydration, hyponatraemic dehydration or hypernatraemic dehydration."

I'm not sure we need to concern ourselves with the minutiae of that, but it goes on to say:

"In all three types, there is usually a total body deficit of salt and water."

Can you help us, doctor, with this: is it by reason of the fact that there is a total body deficit of salt and water that the need in terms of replacement fluids

is to move in the direction of selecting a type of fluid which has a relatively high sodium content?

A. Sorry, I don't quite follow the question.

Q. Is the problem that you're trying to correct, in a dehydration situation, the loss of salt and water?

A. Usually it's a combination of salt and water.

Q. And in terms of the appropriate fluid for replacement purposes, given the nature of the problem, that is why a fluid that's relatively high in sodium is selected?

A. Yes. If you have a child who is becoming dehydrated because of ongoing losses such as diarrhoea and vomiting, usually those losses are relatively high in sodium and, in that case, you would be replacing with a fluid which was relatively high in sodium. Now, you do see the other situation where children become dehydrated simply because they're unwell and not drinking with no ongoing losses. Sometimes in those children, the sodium is actually too high. Now, again, that's a very specific circumstance and we're all very aware and we were all taught in great detail about this as students about the dangers of hypernatraemic dehydration and the need to bring down sodium very slowly in that situation. But certainly dehydration can be associated with low sodium or with high sodium or with normal sodium, and the fluids have to be tailored

to take account of that.

Q. Yes.

THE CHAIRMAN: In Lucy's case, her initial sodium reading on admission was 137, so although she was dehydrated to some extent, her sodium reading was not particularly a cause of concern, was it?

A. I think ... I mean, my interpretation of Lucy is that she had gastroenteritis, but she also hadn't been eating or drinking for four or five days, which may be why her sodium was relatively well maintained, even though she was -- in my opinion she was clinically dehydrated with signs of imminent shock.

THE CHAIRMAN: Okay, thank you.

MR WOLFE: So notwithstanding the normal electrolyte results that emerged from testing at the point of admission to the hospital, you would nevertheless select in her case a fluid for replacement which was relatively high in sodium?

A. The initial resuscitation fluid would still be isotonic normal saline unless you got a U&E back which showed that her sodium was high. In that case, you would still probably -- I think I may be going too far here, but you'd probably still use an intravenous solution like normal saline, but you would do it very, very slowly.

THE CHAIRMAN: And when you say unless her reading was high,

a high reading would be, what, 140 plus or even higher?

A. Whenever I'm talking about high, I'd be talking about 150/160, that sort of level, and then you'd take it very, very slowly.

MR WOLFE: I think that point is dealt with over the page in the manual and we'll come to that in a moment. Just looking to the section on down the page in front of you, "Management of dehydration":

"Mild dehydration can usually be managed with oral rehydration if vomiting is not a major problem."

But of course, you have, if you like, put Lucy into the moderate-to-severe category, so we'll turn to that. The manual tells the practitioner that:

"Moderate and severe dehydration will require more accurate replacement of fluid loss and although oral rehydration may sometimes be possible, intravenous therapy may be needed."

There's then an example given of how you work out or approach the calculation for dehydration. So the first question is how much fluid will the child need for rehydration and what sodium concentration will be required? And then a step-by-step approach is set out for the practitioner. So step 1:

"What is the fluid deficit?"

And in Lucy's case, the appropriate calculation

would have been, if she was 7.5 per cent, her weight multiplied by 7.5 multiplied by 10; is that correct?

A. Mm-hm.

Q. And then if we go over the page, please, to 039. That's the formula that I have just rehearsed. It goes on to say in that case:

"Thus the fluid deficit ..."

It's almost a like-for-like example comparison with Lucy, albeit her weight is a little lower, a kilogram lower. Let's assume for the sake of argument is 10 kilograms. It goes on:

"Thus the fluid deficit is 750 ml. The fluid deficit is essentially made up from roughly 0.9 per cent saline."

It uses the words "made up". Is that to be interpreted as: this is what you do to make up the fluid deficit?

A. That's my interpretation of it, yes.

Q. So you make up or you replace the fluid deficit from roughly 0.9 per cent saline?

A. Mm-hm.

Q. "Since it is mainly extracellular fluid that has been lost, which has a sodium concentration of approximately 140 millimoles."

It goes on to say:

"Step 2. The child also has maintenance fluid needs."

And we discussed that a little earlier. Then in terms of the practice of how you would approach and manage a child who has both these replacement needs and maintenance needs and, as the doctors found in Lucy's case, it's not always easy to fix intravenous drips to children, and the suggestion here is that rather than have two drips, it's possible to select a fluid that finds a middle ground. That was the teaching at the time, that you might select half normal saline as, if you like, a compromise --

A. Mm-hm.

Q. -- or as an approach which marries both the maintenance and the replacement needs. Could I ask you, doctor, in your approach to Lucy's case -- and we'll come to look at your report in a moment -- did you have this kind of teaching or instruction in mind?

A. Yes, very much so.

Q. The teaching or instruction that's contained within this is replicated in other paediatric literature of the time; isn't that right? You would be familiar with the publication, Forfar & Arneil?

A. Mm-hm.

Q. It, in its description, illustrates a very similar

approach. Could I just ask you to look at the sentence beginning:

"In patients with a low or normal sodium ..."

Do you see that? The first sentence of that paragraph:

"In patients with a low or normal sodium [which was of course Lucy's case upon admission] lost fluid can be replaced over 24 hours."

Can you help with us that? First of all, what does that mean in terms of the type of fluid?

A. What it means is that you'd calculate the maintenance fluids for the child based on weight, and each day the child would get that amount of maintenance fluid. At that time, if you had a child, as it says, with low or normal sodium, the deficit in this case -- my estimate was about 750 ml -- that could be added to the maintenance fluid during the first 24 hours. Nowadays -- and just recently, the guidelines are changing in that that deficit, even for children with low or normal saline, there would be a slower correction of the rehydration. But at that time, the teaching was that all that deficit could be added on to the maintenance in the first 24 hours.

Q. Could I just briefly refer you to a passage from Forfar & Arneil, please? It's 250-004-047. This is the

section of Forfar & Arneil that is dealing with gastroenteritis. You can see at the bottom left hand paragraph under the heading "Treatment":

"Prevention of infantile gastroenteritis ..."

So that's the area we're dealing with. It goes on then to say, if we look over the right-hand side:

"Moderate or severe cases. When the dehydration is moderate or severe, the infant should be hospitalised as parenteral fluid therapy will be necessary. Fluids should be given intravenously."

The point I want then to turn to is this:

"There are three main aspects of fluid therapy in infantile gastroenteritis, namely the type of repair fluid, the amount, and the rate at which it is administered. There are many regimes in use, but there's little substantial difference between them."

It says:

"The following regime is simple and has been used for many years and found to be satisfactory."

It's this reference to the regime, which is then described, which mirrors what is said in the APLS manual. It's this point about the regime or this approach being in place for many years, the approach being you assess the degree of dehydration, and if there's shock, you correct the shock, and then you move

to replacement and maintenance, selecting, if appropriate, a high-sodium solution for replacement.

In terms of this approach being in place for many years, over your career, was this the approach that was in place?

A. I think what has changed over the years is that we are more --

Q. If we could take it up, first of all, up to the year 2000, first of all.

A. Okay. I think up until then or -- no, it was before then, but certainly at the time that I was training and up until I became a consultant, there was much less aggressive approach to management of fluids. So in other words, we would not have been as quick to commence children on intravenous fluids and we would not have given such large quantities of fluid. We now use boluses of fluid, boluses of resuscitation, much more commonly in sick children than we did whenever I was a junior doctor.

I think we tried very hard to use oral replacement therapy, particularly for children with gastroenteritis. I think the trend has now moved to introducing intravenous fluids at an earlier stage.

THE CHAIRMAN: By the time you get to 2000, had you moved on from that? I think you described that as your training

years and your early years, fewer boluses and less fluid by IV. By the time you got to the late 1990s, around 2000, had the era of boluses and IV fluids arrived? I think it must have.

A. Yes. I think by that stage we were using bolus fluids more commonly than certainly 15 years earlier.

THE CHAIRMAN: And that would be why the APLS guidelines are written in the way that they are and the way Forfar & Arneil is written in the way that it is?

A. I know I've sort of stressed APLS, but I think it was -- that was the first time that there had been very specific teaching on acutely-ill children and certainly it was just introduced in the early 1990s as an adjunct to training.

THE CHAIRMAN: Okay.

MR WOLFE: In terms of the, if you like, instruction contained within the manual and indeed within Forfar & Arneil -- which seems to direct that, if you like, gastric losses which are high in sodium should be replaced on a like-for-like basis with a concentration that's high in sodium -- was that fundament of that teaching recognised for, if you like, years, as it's suggested here?

A. I think I had always been taught that, that ongoing losses -- vomiting, diarrhoea -- were likely to be high

in sodium and that therefore had to be replaced with appropriate solutions that were also high in sodium. I think, right back to the days when I was a medical student, that was standard teaching at the time.

Q. Just moving on from that -- I think you've alluded to it in your witness statement -- if a child is suffering heavy losses of sodium-rich fluid, but is receiving a fluid which is inappropriate in that it doesn't contain sufficient salt, were the dangers of that appreciated by the paediatric sector at that time?

A. Yes, I think so.

Q. And the dangers were that a depletion of sodium in the blood can lead to electrolyte derangement, seizures and cerebral problems?

A. Yes.

Q. Could I ask you to look at the guidelines that were developed in the Royal in or about the late 1990s? You had some input, I understand, in the development of the Paediatric Medical Guidelines at the Royal Hospital. There's a section in the guidelines dealing with the management of diarrhoea, which I would ask you to look at. Could we go to, just to orientate ourselves, please, 319-067a-089? This is the section we're in. If we could move over and have up alongside each other pages 090 and 091, please.

On the left hand page, first of all, doctor, it describes the various investigations, I suppose, that you might conduct after admission in a case of moderate to severe dehydration. There's a series of dos and don'ts underneath that: "Don't suggest flat Coke", that old wives' tale, I think, is a pointer. But moving on to the right-hand side, there is a description of the management of moderate to severe dehydration. There's a description of the proper approach to maintenance fluids in terms of the calculation and then a description of the proper approach to calculating, for example, 5 per cent, 10 per cent or 15 per cent dehydration.

Then it says:

"Try oral rehydration therapy by mouth, although naso-gastric or intravenous fluids may be necessary."

Then it says:

"With a situation of normal serum sodium, treat shock if present."

So that's treated with a bolus; that would have been the appropriate treatment of the time, a bolus of normal saline?

A. Yes.

Q. And then it says:

"Use 0.18 saline plus 4 per cent dextrose as the

intravenous fluid."
A. Mm-hm.
Q. "Fluid may be replaced over 24 hours."
That's by contrast with the message contained within APLS and Forfar & Arneil; isn't that right?
A. Yes. And I can't remember who did this chapter. The background to producing guidelines was that we had no guidelines at all within RBHSC really for management of anything. So a group of us got together and decided we would try and draw up some guidelines which would be available to junior staff and in the ward situation. I can't remember who did this chapter. I'm familiar with the guidelines and I have a copy with me, but I still can't remember any more details.
Q. Could I ask you this: by the standards of the time, was that erroneous advice?
A. I think it was ambiguous advice. They treat the shock, then -- the heading for it was "maintenance fluids", but it's ambiguous in that it doesn't stipulate the differences between maintenance and replacement fluid, and I accept that.
Q. If it was to be clear and unambiguous, the junior doctor who this publication was directed at should have been told, "Treat the shock if present, then move on to assess the degree of dehydration --

A. Yes.
Q. -- for which an appropriate replacement fluid should be used, such as normal saline --
A. Mm-hm.
Q. -- and then you move on to Solution No. 18 for maintenance"?
A. Yes. Yes, it should have set out the different fluids to be used for resuscitation, maintenance and rehydration.
Q. Could I then move along, doctor, to the engagement between yourself and the Sperrin Lakeland Trust for the purposes of providing what I think has been described as a review of Dr O'Donohoe's competence and performance; isn't that right?
A. That's correct, yes.
Q. I think, quite fairly, you have in your witness statement asserted that this was not a medical report, but you were being asked to provide a review of care provided by an individual consultant to four children in the Sperrin Lakeland Trust.
A. That's correct.
Q. If it was a medical report, which you say it wasn't, what would the differences be? How would they be manifest?
A. To me, there were differences in that I was just being

asked to look at the practice of one consultant. I wasn't being asked to come to conclusions about all aspects of the care of any of the children involved in the reviews and certainly, in the case of Lucy, to undertake a medical report would have needed much more information than I had been given. The documentation I had was Lucy's Erne case notes, Dr Quinn's report and the post-mortem report. But I didn't have any additional information. The other point, if I'd been asked to do a medical report, I would have said no, because I don't do medical reports and have never done medical reports.
THE CHAIRMAN: You mean medico-legal?
A. Sorry?
THE CHAIRMAN: Do you mean medico-legal reports?
A. Medico-legal reports, yes. I just haven't had -- I never had time to do it. So I had no prior information about the cases before receiving them.
MR WOLFE: I want to bring you to -- I believe there's a helpful chronology. Yes, it has been put together on your behalf, I think, by your counsel with your agreement, doctor. It's now an amendment to your witness statement. If we could have up WS298/3, page 14.
You appreciate, doctor, that Dr MacFaul, in his

analysis of all of this, is concerned that between yourself and the Trust, a delay was permitted to occur before producing a final report and, of course, our interest in this, doctor, is that obviously in circumstances where a child has died in unexpected and unexplained circumstances, there may have arisen a patient safety issue that needed to be bottomed out as quickly as possible, whereas in fact, on one view, what has happened is that the child died in April, you were contacted in July, and a final report didn't emerge until in or about 28 or 26 April 2001.
I wish to explore that and see if there was any undue or unreasonable delay in the production of a report. You received some telephone contact on or about 16 July from Dr Kelly; is that right?
A. I can't remember that telephone call.
Q. He, I think, has explained to us that he made contact with you and discussed the Trust's need for an independent external assessment of the competency of one of his consultants, which sounds, in the context of the circumstances of the time, a logical approach. But you're saying you simply can't remember it?
A. I have the vaguest recollection, but only because it has been brought up and it seems perfectly reasonable to me that I got that telephone call and gave Dr Kelly contact

details for RCPCH, but I can't remember any details.
Q. You have told us already that correspondence going to the Royal College was not copied to you or you didn't see it.
A. No.
Q. So the next entry on the chronology is a letter to the Royal College, seeking external assistance, and that would have gone to Dr Patricia Hamilton?
A. The letter of 14 September?
Q. Yes.
A. Yes, to Dr Hamilton.
Q. There was then, as we are aware from -- if we could have it up on the screen, please, 036a-010-019, a response from Dr Hamilton to Dr Kelly, identifying you as the nominated College representative to carry out this review. So presumably, you were consulted in relation to this and told by the Royal College what might be expected of you in general terms?
A. Again, there was nothing in writing. I think Patricia Hamilton telephoned me and asked me would I undertake this review, but I didn't have any further details of what was involved.
Q. Was there any sense of urgency conveyed to you, so far as you can remember?
A. No, I wasn't given that sense at any time.

Q. We know from what Dr Kelly has told us -- and I think this letter, if we go over the second page, please. Yes, he's told us, and you can see that standard indemnity forms went along with this letter. So there is, if you like, a legal process that has to be undertaken by both parties to the arrangement, the Trust on the one part and the Royal College on the other, which involves the use of indemnity forms. Again, I take it that that is something that you would complete or sign up to; is that right?
A. Yes, they had to be completed. And of course, everything was done by post rather than e-mail.
Q. Yes. So if we can accelerate along a little, doctor, into January 2001, by the time these indemnity forms and that process is completed, you are still awaiting documentation; is that correct?
A. That's right, I hadn't received any of the notes.
Q. And I understand from what is said in this chronology -- if we could have it back up on the screen, please, WS298/3, page 14, and alongside that 15, for completeness -- you are making a telephone call to Dr Halahakoon --
A. Yes.
Q. -- who is the lead paediatrician in the Sperrin Lakeland Trust. What are you seeking with that intervention?

A. The College was due to undertake a training visit to Sperrin Lakeland Trust and it was overdue at that stage, it was meant to be done in 2000, but I had been talking to the College and suggested that we delay the training visit until the professional clinical competency review had taken place. That telephone call was to Dr Halahakoon to say that we're keen to go ahead with the training visit, but we want to -- I wanted to get this other work completed in advance of that. She agreed to speak to Dr Kelly and remind him that I hadn't received any of the four sets of case notes.
Q. You did have a phone discussion, according to Dr Kelly's chronology, on 24 January. And then if I could bring up on the screen, please, 036a-015-030. This is a letter from you, Dr Stewart, back to Dr Kelly, setting out how you intended to proceed. You say:
"It may be necessary to ask a paediatric specialist for an opinion in one or more of the cases."
And in fact that's ultimately what happened. You brought in a paediatric endocrinologist, Dr Carson, to assist you with one of the cases. And you say in the last line of that paragraph:
"Once all the information has been collected, I will try to make sure that a report is prepared at the earliest opportunity."

What did you mean by all of the information having been collected? Is that a reference to the case notes for the children?
A. Yes. Uh-huh. And also the fourth review being undertaken by a colleague.
Q. Sorry, the?
A. Also the fourth review undertaken by Dr Carson.
Q. Sorry, how does that relate to the ...
THE CHAIRMAN: It relates because Dr Stewart and Dr Carson are going to have to liaise and present a single report rather than two separate reports. So your timetable and Dr Carson's timetable have to fit together; is that right?
A. Yes. Uh-huh.
MR WOLFE: You then, according to the chronology, going back to WS298/3, page 15, you then received a letter from Dr Kelly on 26 January. Is that providing you with the materials that you need?
A. Sorry, which date is that?
Q. 26 January. Does that provide you with the materials that you were --
A. That was the -- I don't think all the case notes came together. But certainly some of them had arrived by the end of January.
Q. So really, in terms of the starting point for your work,

doctor, the point at which you were able to sit down and start was at the end of January?
A. Yes.
Q. And presumably, in addition to your day job, you got on with the task of looking at these four cases?
A. Yes.
Q. And you were in a position to report -- I think it says here 28 April. I think I have another reference to 26 April, but certainly by the end of April you had reported. So that was a period of approximately 12 weeks or so?
A. Yes. I had completed the three reviews, review of three sets of case notes, by the end of March, but we were still -- I was still waiting for Dr Carson's report, which came at the beginning of April. There was further delay because the deeds of indemnity had not been signed for Dr Carson by Sperrin Lakeland Trust. So that was the delay during that month.
Q. Can you help us, doctor, in terms of whether you think there was anything that was within your power to achieve that could have speeded up this whole process through to the provision of a report?
A. I really don't think so. I mean, there's been delay at all stages from the initial contact, that telephone contact, which I can't remember, but I'm sure did take

place, right through to the letter. There was two months before Dr Kelly contacted the College and there was nearly two months before Dr Hamilton got back. The notes didn't then arrive until the end of January and then I wanted to get another reviewer, which we had agreed before I undertook the task that, if necessary, I would ask a colleague to look at notes if I felt that was appropriate. So it just seemed to sort of go on and on. But I think at no stage did I ever feel that there was any time constraints on what I'd been asked to do.
THE CHAIRMAN: Can I ask you it in this way, doctor: to an outsider, it seems that if you're being asked to do a competency review on a consultant paediatrician, that in itself indicates a degree of urgency because, although you might not have been aware of it before you started to receive the case notes, if he had turned out to be the most hopeless consultant around, the Trust as his employer and your College, if he was a member, would want him to be improved, controlled or removed as soon as possible. So the fact that you were asked to do this review, does that not in itself carry with it a degree of urgency?
I have to say, when I say that to you, I'm not picking on you for this because, as you have just said, there seems to have been delay at just about every stage

until, perhaps you would say, when you finally got the notes in late January. If you had your report done in two months on top of your other duties, nobody could reasonably ask any more of you. From the perspective now as an outsider looking back on it, would you say it took longer than it perhaps should have done?
A. That may be fair comment. I don't know, sorry, what the communication was between Dr Kelly and the College. I wasn't part of that.
THE CHAIRMAN: But from the outside, the fact that you're being asked to do a competency review -- and these are fairly rare events, as I understand it -- does that on its own indicate some degree of urgency is required?
A. I think ... That's probably a fair comment. Whenever we looked at the other three cases, there didn't seem to be particular competency issues round Dr O'Donohoe's performance. Lucy's case was obviously very tragic and very unique and in a totally different league from the other cases. My assumption at that time was that her case would have been referred to the coroner and that the coroner's inquest would be at least underway at that stage, so in a way this was almost a separate process to a coroner's inquest into cause of death.
THE CHAIRMAN: Okay. And just one more point on this: if it had been really urgent, would you have expected to have

been pushed along the way quite a degree more by the Trust?
A. If it had been really urgent, I'm not sure I would have agreed to take it on because I wouldn't have reviewed the four cases unless I felt that I could devote adequate time to them. And as you say, you know, this was very much done early in the morning or at the end of the day.
THE CHAIRMAN: Okay. Thank you very much.
MR WOLFE: You've told us that in terms of the materials that were available to you for the preparation of this report -- let's call it "report 1" because we know that report 2 is yourself with Dr Boon, and that comes the following year -- so the materials available to you for report 1 you have described as Lucy's case notes, the autopsy report and the report of Dr Murray Quinn --
A. Yes.
Q. -- which I think you have referenced in a number of places in report 1. You have told us in your witness statement that at some point, upon receiving the papers in respect of Lucy, you made contact with Dr Quinn. Could you just help us, doctor, in terms of why you did that?
A. I think I was quite perturbed whenever I got Lucy's notes. I hadn't been expecting to get the notes of

a child who had died. And also, on looking through the notes, even though the documentation was extremely poor, but even so, it seemed to me that there were problems associated with fluid prescription and administration. I'd read Dr Quinn's report and knew that he didn't share my concerns. I had worked for Dr Quinn in Altnagelvin as his registrar and I had the highest regard for his clinical knowledge and skills, and therefore I felt it was a courtesy to telephone him.

I think I was also hoping in some way that maybe he had further information than I had that could explain the sequence of events on the night that Lucy was admitted to hospital.

Q. Can you recall, doctor, what particularly jarred with you in terms of Dr Quinn's report? You say that you realised that he had reached a different view to you. What was it that concerned you and prompted the phone call?

A. It was his conclusion that the fluids used were appropriate.

Q. He went through the fluid regime and with regard to Lucy's fluid needs, he, within his report, looked at various permutations with regard to the extent of dehydration and he described the type of fluid which was used, which everybody knew to be Solution No. 18, at

least initially, he described that as appropriate. Was that what you were thinking about?

A. Yes.

Q. In fairness to Dr Quinn, who was asked about this, his only memory of the discussion, he told us on Friday last when he gave evidence, his only memory of his discussion with you was you telling him of the low carbon dioxide, he told us a reading of 16 was what you were explaining to him, from which each of you could conclude that the child was acidotic -- is that the word? --

A. Yes, acidotic, yes.

Q. -- and really quite sick. Help us if you can. Your recollection of the conversation with him, did it include a discussion of the competing views, if you like, of the appropriateness of the fluids?

A. Yes. From memory -- and it was a telephone conversation, it was a long time ago, but there were two aspects. One was that I really thought Lucy was a very sick little girl whenever she was admitted to the Erne Hospital and we went through the various -- I went through the various reasons for coming to those conclusions. Then I said that I felt that her fluid management had been sub-optimal at that time. I just asked him, was he satisfied with the report that he had produced for Sperrin Lakeland Trust, and he said yes,

he was. It was a very, very brief conversation and I have no idea, I may have caught him in the middle of clinic or something like that, but it was very brief and that was the end of it.

THE CHAIRMAN: Did he seem uneasy about your view or your call?

A. Sorry?

THE CHAIRMAN: Did he seem uneasy that you were ringing him and that you were, in effect, expressing a different view to his?

A. No, I don't think he was concerned about my view.

THE CHAIRMAN: Okay.

MR WOLFE: I realise I might be pushing a little, but in terms of his declaration that he was satisfied with the report that he produced, did he offer any justification or explanation for his view that the fluids were appropriate?

A. No. No, we didn't go into great detail at all. I had phoned him, I suppose just hoping for further clarification, and he just said he was satisfied with his report.

Q. Thank you.

MR COUNSELL: I wonder if the witness can be asked whether she gave Dr Quinn any forewarning that she was going to call.

THE CHAIRMAN: Can you remember at the time when you rang him -- well, sorry, for you to ring him, having formed a view, you must have been well along the process of reading Lucy's notes, Dr Quinn's report and the post-mortem report.

A. Mm-hm.

THE CHAIRMAN: Was a fairly clear view emerging in your mind at that time? Did you say to him expressly or do you think you would have implied from your call that you were going to report something different to what he had reported?

A. I'm not sure that I said to him what was in the report. I just said that I had concerns about Lucy's fluid management, but I don't think I said to him what I was going to write or anything like that --

THE CHAIRMAN: Okay.

A. -- or even had written. I'm not sure of the timing of that call.

MR WOLFE: If I could just pick up on my learned friend's question, I think his point is: did you alert Dr Quinn to your views before participating in a discussion with him or was it, alternatively, picking up the phone, "Dr Quinn, it's me", and then explaining at that point, if you like, without warning that you were wishing to engage in this discussion?

A. Yes, it was without warning.
Q. I think in your witness statement to us, you said:
"I concluded that we had to agree to differ."
Do I infer from that that during this conversation, it was being made clear that really "we hold different views, which can't be reconciled", and he would have known that you were going to produce a report?
A. I mean, I think I must have told him that I'd been asked to review the cases from the point of view of Dr O'Donohoe's care and I must have said to him that I had concerns about fluid management. It really was -- I do remember it being a very, very short conversation. We didn't get into debate or details about the initial fluid, follow-on fluid, anything like that. It was a very brief conversation.
Q. Could I move on then to your report for the Trust? You will appreciate, doctor, that although you reported on a number of cases, the only interest of this inquiry is in the Lucy Crawford case and the rest of the material has been redacted. I'm going to bring up on the screen 036a-025-052.
I'm going to run through parts of this relatively quickly, but if there's anything that you feel the need to draw to our attention, please do so. On the opening several pages of your report, doctor, you have set out

your interpretation of the history and the background to this child coming into hospital and the various developments thereafter.
You set out the various blood samples that were taken and you note that:
"In or about 10.30 pm [this is towards the bottom of the page], the child was commenced on Solution No. 18."
Then if we go over the page, please, you reference the additional gastric losses that were suffered by the child upon her admission and then refer to the episode at 3 am and the description of it is set out. You then move through the various stages of resuscitation and the child's transfer to the Erne's intensive care unit and thereafter to PICU.
Over the page then again, please. Just following this structure of setting out the background, you refer to the post-mortem examination and then you say:
"The following comments have been made following careful examination of the nursing and medical records from the Erne Hospital, including the post-mortem report and the medical report from Dr Murray Quinn. They are necessarily limited to the information contained in the notes. It is apparent that Lucy's clinical deterioration was unpredicted, rapid and extremely distressing for all concerned. I appreciate that I may

have missed some facts and that my comments are made sometime after the events had occurred."
Just before we move from that introduction, doctor, what did you see as your role in analysing and providing comment on Lucy Crawford?
A. I primarily kept in mind the terms of reference of what I'd been asked to do, which was to comment on the clinical care provided by Dr O'Donohoe. As part of that, and going through the notes, it was obvious that there were deficiencies in care provided to Lucy, not just on the part of Dr O'Donohoe, but also involving other members of staff on duty that night. So I saw then my role as drawing attention to some of those deficiencies, even though they were outside the remit of what I was initially asked to do, in the hope that processes could be put in place that would prevent anything like this happening again.
Q. You did find yourself, as we will see, in the realms of commenting upon some possible explanations for the child's deterioration.
A. Yes.
Q. How did that sit with your view of your remit?
A. I think it fitted in that I was trying to be able to stand over the concerns I had that there were deficiencies in the fluid prescription and

administration to Lucy and, in order to do that, I was trying to go through possible aetiological factors which could have contributed to her deterioration. So it was really to try and provide a comprehensive report that was sufficient to allow me to make certain statements.
Q. Okay. Let's move forward. From the bottom of the page then, you comment on the fact that vomiting and fever are very common in young children:
"In most children these symptoms are self-limiting and require only supportive measures such as attention to fluid balance and antipyretic medication."
So you are explaining that these are normally straightforward conditions to managed, particularly in a hospital setting where you might have a lot of resources; is that fair?
A. That's fair.
Q. Moving on over the page to 055, you take the view that Lucy was probably quite ill on admission and you set out some factors that lead you to that view; is that right?
A. That's correct.
Q. You say about halfway down the page:
"The plan was to encourage feeding and commence intravenous fluids after cannulation."
Given that this is an expression of an opinion then on your part:

"Given the symptoms and signs, the prolonged capillary refill time (greater than 2 seconds), it would be appropriate to give an immediate fluid bolus of up to 20 ml/kg of normal saline and then reassess."

And clearly that hadn't happened in this case; is this right?

A. It didn't happen, yes.

Q. "It was several hours after admission before intravenous fluids were commenced."

And then you set out the difficulties, the well-recognised difficulties in securing access. But you make the point that the notes do not make clear the possible reasons for the delay in addressing the problem of restoration of circulatory blood volume.

Then if we can go over the page, please, you begin to set out, at 056, several possible explanations, having recognised:

"... the neurological decompensation that had occurred at around 3 am and the problems identified by the repeat urea and electrolytes."

The several possible explanations were that:

"Lucy had a febrile seizure, which continued, leading to hypoxia and cerebral oedema."

Is one to infer from your comment on that that most children who have febrile seizures suffer no long-term

sequelae? Do we read that as you suggesting that that is not a particularly strong possibility?

A. The reason I put is first is because, for seizure activity in young children of this age, the most common cause by far is a simple seizure associated with increased temperature, so that's why I put it first, but I was not convinced from the notes that Lucy had had this type of event. And as I say, it's extremely uncommon for children -- most children who have febrile seizures recover spontaneously, often not even needing any medication to terminate the seizure.

Q. You then move on to a second possibility, which was that:

"She had a seizure-like episode due to underlying biochemical abnormality."

You highlight the initial sodium, which was normal, and then you say:

"At 3 am, after administration of the Solution No. 18, the repeat sodium was 127 and potassium 2.5."

I'm not sure even yet, doctor, whether you're aware that that may well have been or in fact was a misreading of the notes in that the 127 was arrived at after this quantity or some quantity of normal saline had been run in, and it was only after the arrival at the hospital of

Dr O'Donohoe that bloods were ordered and it was the bloods at that point in time that identified the 127. Presumably that wasn't something that was clarified for you.

A. No. I'm aware of the debate around how much normal saline Lucy had received before the blood was taken. I mean, I've gone over and over the notes. The nursing notes state, I think, that normal saline was started at 3.15 and then that the bloods were ordered at 3.20. So it's not clear whether ordering and taking the bloods -- how much time elapsed between the two. I know that the bloods arrived in the lab just before 4 am, but again I don't know how long it took to get from the ward to the lab.

The other aspect of that is that I know the fluids were changed at around the time of her seizure-like episode, but again it's not clear from the notes when that occurred. And there were a lot of things happening at the one time. She was having a seizure, she was being given diazepam, fluids were being changed. So I just couldn't actually work out the sequence of events. But I appreciate that the blood tests could well have been taken after a quantity of normal saline was administered.

Q. Yes. Could we move over the page then to 058? You say:

"Biochemical changes are often well tolerated and easily corrected with appropriate fluid replacement, although these results do show a change over a relatively short period of time."

A. Mm-hm.

Q. Can you help us by unpacking that? What did you mean by drawing attention to the fact that the results, that is the change in electrolyte results, do show a change over a relatively short period of time?

A. I mean, a sodium level of 127 is by definition hyponatraemia, but we see many children admitted to hospital, particularly with gastroenteritis, with a sodium of 127. And prior to this, I had never known a child to suffer serious adverse outcomes with a sodium reading of that level. So what I was trying to draw attention to there was that it wasn't the absolute level which was important, whether it was 127 or whether it was even lower than that, but it was the change from the time that her bloods were taken when she was admitted until the time of her acute deterioration around 3 am.

Q. So you saw the, if you like, rapidity of the fall as of being potentially significant?

A. Yes.

Q. And then you move on to a third position. Does the third position relate to the second position? Are they

to be read together? Because obviously, you have the incident at 3 am, which was variously described as something akin to a seizure, and then you're moving on to the episode at 3.15 am, which was described, if you like, as the respiratory arrest:

"The episode at 3.15 was due to cerebral oedema and coning."

Is there a relationship between your observations at (ii) and then into (iii)?

A. Yes. I thought the fall in sodium was associated with retention of fluid and, in particular, cerebral oedema, which then in turn led to coning at around 3.20 am, and thereafter I felt that the situation, as far as Lucy was concerned, was irretrievable at that stage.

Q. You then move on to rule out rectal diazepam as being a contributory factor, and in that regard you agree with what Dr Quinn had observed in his report.

A. Yes.

Q. Then you move on to the fluid balance records, which you indicate are incomplete. Going over the page, you say:

"My interpretation of the chart is that she received 100 ml an hour of Solution No. 18 until around 3 am, when the adverse episode occurred."

At this point you get into dealing with the appropriateness of the fluid regime that had been

applied. As we noted earlier in your report, you'd dealt with the need, as you saw it, for the correction of shock, so once shock has been corrected you then pick up on what the APLS guidelines say, and we've looked at this this morning already.

So what you're saying is that for a child with moderate to severe dehydration, that's the calculation, 750 ml on a 10-kilogram child -- and you have explained that you round it up for ease of calculation -- it would be 750 ml, and then maintenance fluids in addition to the replacement. You then say:

"The volume given, therefore, does not appear excessive."

On the basis of a 7.5 per cent dehydration, the calculation comes to somewhere between 70 to 80, and that's allowing for a slightly higher weight than she actually was. She was 9 kilograms, not 10. The fluids in terms of total volume pre-seizure were certainly excessive.

A. Mm-hm.

Q. Why did you characterise the volume given as not appearing excessive?

A. The reason I did that was because I was counting in 200 ml of bolus resuscitation fluid in -- whenever I was working out if she had 200 ml and then if she had had

another 200 to 250 ml over 4 hours, the total volume would not be excessive. I think that's why I used the term "clumsy attempt", because obviously it is causing concern and debate, but that was my thinking about it: we need to factor in the bolus of resuscitation fluid in the amount that would be given over a 4 to 5-hour period.

Q. So where you say in your witness statement -- and I had it up on the screen earlier -- that this was a clumsy attempt to reconcile the volume of fluids Lucy received from 10.30 to 3 am, with recommendations for the various types of fluid --

A. Yes.

Q. -- just to be clear then, what you're accepting is that, in terms of how you have phrased this, you were at best somewhat ambiguous and what you really should have been saying is that the total volume given doesn't appear excessive --

A. That's right.

Q. -- but the types of fluids, the types and volume of each fluid, ought to have been identified?

A. Yes. The sentence -- I should have written the sentence:

"The total volume given including resuscitation, maintenance and rehydration fluids ..."

And I thought I had set that out clearly earlier on, but obviously it has caused confusion.

Q. Well, you go on to say that there is debate about the most appropriate fluid to use.

A. Mm-hm.

Q. You say:

"APLS guidelines indicate the deficit should be replaced with normal saline and maintenance with Solution No. 18."

A. Mm-hm.

Q. And then you explain how it's explained in the APLS guidelines that, for convenience, the two fluids can often be combined.

A. Mm-hm.

Q. In terms of the fluids necessary for replacement in a dehydrated child at that time there was no debate.

A. There was debate about how best to administer it: should there be two separate infusions, one with maintenance fluid and one with replacement fluid? And that is the ideal situation because then the replacement fluids can be tailored to ongoing losses. But due to the difficulty in getting venous access in young children and also just the practical details in trying to run two separate infusions, they're often combined as half-normal saline, 0.45 per cent. So that was what

I meant by the ongoing debate.
Q. We'll come to the discussion which you held with Dr Kelly on or about 31 May in just a moment. But in terms of how you have set this out and inviting the reader to consider that there could be a debate about the type of fluids that might be appropriate to use, could the reader be forgiven for interpreting that as saying there's a debate between, for example, whether to use Solution No. 18 for replacement or, for example, another fluid such as normal saline? Could your invitation to consider a debate be read in that way?
A. I thought I had been clear in setting out the guidelines for the different fluids to be used for different situations, resuscitation, maintenance and replacement. And I think that's why I had gone to such lengths earlier on to lay out the guidelines so that they were absolutely explicit.
Q. But just to be explicit for a moment, you were of the view that the fluid regimen for Lucy was wrong?
A. Yes, I was. But I also was very aware that the documentation in the notes was very poor. I had interpreted her getting 100 ml per hour of fifth-normal saline, but the nursing records were not clear about that, so I was taking the very worst possible scenario, but also aware that I was going on very limited

documentation and that I did not -- I wasn't there at the time and it was not clear from the notes just what fluids had been prescribed or given to Lucy.
Q. Yes. Let me talk about what you were thinking. You were thinking the following: if this child has received 100 ml per hour of Solution No. 18, then that is quite the wrong approach for a dehydrated child who required normal saline?
A. Yes.
Q. And Dr MacFaul's concern about your approach is that you failed to state clearly in your report that an excessive volume of Solution No. 18 had been administered?
A. Yes, and I think I kept coming back to what I'd been asked to do, which was not to prepare a medical report, and it was obvious to me that the problems around fluid prescription and administration were not solely on the part of Dr O'Donohoe, even though as consultant he retains overall responsibility. But usually, it's a junior member of staff who writes up fluids. There were problems with the recording of rates of fluid that were administered, so from the point of view of what I'd been asked to do, there were problems associated with other members of staff on duty that night.
THE CHAIRMAN: Sorry, doctor, surely the critical competence point is that Lucy was prescribed the wrong type of

fluid?
A. Yes.
THE CHAIRMAN: I think the concern expressed by Professor MacFaul is: at what point in your report is that explicit?
A. I don't think it's as explicit as it could be.
THE CHAIRMAN: Thank you.
MR WOLFE: His further concern is that while you have set out the various aetiological possibilities that were in play, you could and should have explained to the reader how a high volume of low-solute fluid could have caused the electrolyte change and led to the cerebral oedema.
A. Yes. I chose my words with care because, as I said, I hadn't been asked to do a medical report. As far as I was concerned at that stage, Lucy's case would have been referred to the coroner, there would have been a coroner's inquest and at that stage all relevant documentation, views of expert witnesses, and the opportunity to talk to members of staff on duty that night would have been taken into account. And at that stage conclusions would have been reached as to cause of her acute deterioration and then death.
Q. Moving on to the post-collapse fluids, you have explained that it would have been inappropriate, for a child in Lucy's condition, who had suffered

a seizure-like episode, suffered a respiratory arrest, whose pupils were fixed and dilated, it would have been inappropriate to run in a further bolus of 500 ml.
A. Yes.
Q. But again, Dr MacFaul's concern is that you failed to say anything about the inappropriateness of that post-seizure, post-collapse approach to fluid management.
A. Right. The reason I stopped at around 3.15/3.20 am, I think there were two main reasons. The first one is that I was sure in my own mind that she had coned at that stage and that no matter what had been done, there would have been the -- the outcome would not have been changed. I think that's in keeping with the views expressed by Dr Hanrahan in his statements. And the other reason was that, again, from the perspective of Dr O'Donohoe, it was apparent or fairly apparent that he had not requested the change in fluids to normal saline and that it was probably done by the junior member of staff on duty that night. And again, I wasn't asked to comment on his competency.
It was very unclear just what amount of normal saline Lucy received. I know that whenever she was admitted to intensive care, it was reported that there was still 250 ml left in the 500 ml of normal saline,

which is out of keeping with what Dr O'Donohoe had said whenever he arrived soon after her respiratory arrest. So I just could not work out what had gone on in that hour or hour-and-a-half until she was transferred from the ward in the Erne to the intensive care unit.

Q. Could I just move, to complete this section, over the page, please? In your witness statement when you're asked, doctor -- is it the last page? Move on to the next page, please. It's the summary.

When asked, doctor, in your witness statement to explain why you hadn't drawn attention to what was clearly in your view a mismanaged fluid situation, you draw attention to the conclusion or the summary section of your report where you say:

"There was a delay in implementing fluid resuscitation and there are deficiencies in the prescription and recording of volumes of fluids administered."

Were you suggesting that where you said that there are deficiencies in the prescription that the reader should draw some particular meaning from that?

A. There were obvious deficiencies. The fluids weren't prescribed in the first place. The records of the volumes that Lucy received were very difficult to work out. The observations during the administration of

those fluids were very poor. Again, I felt to draw firm conclusions as to cause of death was inappropriate for me to do in my report and, again, coming back to the fact that those conclusions needed to be made on the basis of all information that was available, and that would include her previous medical history, her subsequent care in RBHSC and any other information that staff on duty that night could provide.

Q. You had a meeting with Dr Kelly on 31 May --

MR GREEN: May I rise? Before we move away from the report --

THE CHAIRMAN: If there's a point about the report, I'll take it and we won't go on to the meeting until after a break.

MR GREEN: Thank you very much, sir.

The legal team for Dr Stewart have very helpfully provided a clutch of documents last week designed to deal with chronology. I don't know if they've got a reference on the inquiry website as yet. I don't see anybody ...

THE CHAIRMAN: We were given a two-page chronology yesterday.

MR GREEN: The letter I'm referring to is a letter dated 9 November 2000. It's addressed to Dr Kelly and it's from Patricia Hamilton.

MR WOLFE: That's a reference at 036a-010-019, I think.

MR DAVIES: Sir, can I assist? The difference between the two documents, the document that my learned friend is referring to as having been a document provided last week, is the handwritten note that has been added to the original document.

MR GREEN: That's very helpful, but there is also a redaction. I think, without compromising the purpose behind that redaction, I can read one sentence of the redacted part and if anybody is sensitive about it, I'm happy for them to jump up and stop me. It says:

"We did agree, however, that we would address the second question where specific instances of professional competency have been raised."

I just wondered if Mr Wolfe would be good enough to explore with Dr Stewart how easily or otherwise that sits with her assertion a moment ago that her remit didn't include questions of competency.

THE CHAIRMAN: Sorry, I thought the remit of this first report from Dr Stewart was specifically the area of competency.

MR GREEN: Absolutely, but she said a moment ago that she wasn't addressing issues of competency, and that's why she didn't get down to the nitty-gritty, the cause of death and being more explicit about the fluid

mismanagement.

MR WOLFE: I don't have the screen in front of me, nor did I hear you express yourself in quite that way, but my friend has obviously got it in front of him.

MR GREEN: I'll show my learned friend the reference in the break. If I have got the wrong end of the stick, I am happy for my hands to be taken off it.

THE CHAIRMAN: I'll tell you what we'll do: we'll take the break now because we're overdue the break and come back at 12.30. If you can sort it out on the screen in the meantime. Thank you.

(12.17 pm)

(A short break)

(12.35 pm)

MR DAVIES: Sir, can I assist in this way by referring to the passage, I think, which has caused confusion to my learned friend? It's at [draft] page 60, lines 1 to 8, and it reads as follows:

"And the other reason was that again, from the perspective of Dr O'Donohoe, it was fairly apparent that he had not requested the change in fluids to normal saline and that it was probably done by the junior member of staff on duty that night and again I wasn't asked to comment on his competency."

So it's the context, I'm afraid, that has caused the

confusion.
THE CHAIRMAN: The "him" for "his competency" is not Dr O'Donohoe, it's another doctor?
MR DAVIES: It's a junior doctor.
THE CHAIRMAN: Okay.
MR WOLFE: Does Mr Green share that view?
THE CHAIRMAN: He does now!
MR GREEN: Her evidence is as it stands. I'm sure she's perfectly capable of giving the evidence herself, but I'm grateful to Mr Davies in any event.
MR WOLFE: Doctor, could we move on, please, to the meeting which you had with Dr Kelly? You had submitted your report in or around the end of April. This meeting had been established by Dr Kelly, he tells us, because he wished to obtain, if you like, further clarification of the report that you had introduced. And no doubt there was discussion of other issues beyond simply the case of Lucy Crawford, but it's obviously Lucy's case that we are focused on. Could I bring up on the screen, please, the only record that appears to be available relating to that meeting? It's at 036a-027-067.
Just to orientate you, doctor, Dr Kelly has explained that in advance of the meeting he had prepared by identifying a number of specific questions that he would have liked to address with you, and then he went

back after the meeting and, just before the big black box, you can see "A1 to 5", a series of what he says were notes, the provenance of which was what was said or described by you at the meeting. So A1 to 5, that's answers 1 to 5:
"Capillary refill, raised urea and CO2 level point to circulatory failure. IV fluids were indicated earlier. Overall amount of fluids once started not a major problem, but rate of change of electrolytes may have been responsible for the cerebral oedema. RVH ward guidelines would recommend normal saline, not one-fifth normal, as the replacement fluid."
That's the note and we raised the note with you in your witness statement and, because Dr Kelly agrees with this perspective, you fairly say that this is a brief summary of a much longer conversation; is that fair?
A. That's fair.
Q. You went on to say in answer to one of the questions in the witness statement that you do remember him asking you if you really thought that the electrolyte disturbances had caused the seizure and you said in response to that an unequivocal yes. And from recall you then went on to elaborate on the guidelines for the type of fluid replacement that would be indicated in cases of dehydration and shock.

Let me ask you this: in the context of this meeting, were you more specific than you appear to have been in your written report about your view of the aetiology of this child's deterioration and death?
A. I was more specific because he asked me direct questions and I gave him direct answers. I hadn't been asked to provide that -- I hadn't been asked direct questions whenever I'd been asked to undertake the review.
Q. We asked you in your witness statement to explain, if you could, the line which says:
"Overall amount of fluids once started, not a major problem ..."
And maybe it's unfair to stop it there because it goes on to say:
"... but rate of change of electrolytes may have been responsible for the cerebral oedema."
A. Mm-hm.
Q. So just looking at this note, you've highlighted circulatory failure, which you've explained this morning indicates the need for treatment of shock, so you're saying, "IV fluids were indicated earlier", presumably for that reason. What did you mean then by:
"Overall amount of fluids once started not a major problem"?
A. I think it really is repeating what I said earlier on,

that if you add up what Lucy required from the point of view of resuscitation, maintenance and replacement, that the volume of fluids she received over that 4 to 5-hour period was appropriate, but it was the type of fluid that was inappropriate to be used as the sole infusion fluid.
Q. So what you have said in your witness statement is that the exclusive use of hypotonic fluids, that is Solution No. 18, was problematic?
A. Yes.
Q. Of course, it's important that we know what you think was said at the meeting as opposed to what you have now said in a witness statement. To what extent was there discussion at this meeting about the appropriateness or otherwise of the use of Solution No. 18 or the exclusive use of Solution No. 18 in these particular circumstances?
A. From recall, it was a detailed discussion, really going through what I had set out in the initial report on the APLS guidelines for fluid management in a child presenting with Lucy's symptoms and signs.
Q. We asked you in your witness statement to clarify whether you attached any significance to the use, the exclusive use, of Solution No. 18, in the change to this child's electrolytes. It's your recollection that you

said to Dr Kelly that the use of Solution No. 18 was implicated in this change of electrolytes.

A. I'm going from memory now. I don't have a record of this meeting, but I'm fairly sure that I was explicit when talking to him that Solution No. 18 should not have been used as the sole infusion fluid.

Q. The note that is up in front of you refers to "normal saline, not one-fifth normal" as being the replacement fluid indicated by the Royal Victoria Hospital ward guidelines. So it does appear that, in terms, the type of fluid that was appropriate was discussed. Can I ask you about the reference to the ward guidelines?

A. I'm fairly sure I didn't use this term. I never called Children's Hospital "RVH" and we didn't have ward guidelines at the time. So I think he has picked it up. I think I said APLS guidelines; I don't think I said RVH ward guidelines.

THE CHAIRMAN: Might you have said something like, "The APLS guidelines, which are typically followed in the RBHSC"? Something along those lines --

A. Yes, but --

THE CHAIRMAN: -- so the two run together in his mind perhaps?

A. They might have done. He wouldn't be familiar with -- as familiar as I was with APLS and most paediatricians

are, so I think he just misunderstood or misheard me.

MR WOLFE: One of the things that Dr Kelly says, by way of response, which I would invite you to comment upon, is that during this meeting you told him that there had been considerable recent debate about the best resuscitation and rehydration regimes and that the Royal Belfast Hospital for Sick Children had changed its guidelines in recent years; does that assist you?

A. I don't think that's correct. We certainly hadn't -- we were still using Solution No. 18 as maintenance fluid right through for probably another year to 18 months, and that was the standard infusion fluid across Northern Ireland and across most units in the UK. If I said there were any changes, it would have been in that we were more aggressive in our management of children that we suspected of being at risk of circulatory collapse. In other words, give bolus fluids early on at the start of an illness before starting an infusion fluid regime. But there hadn't been discussion or there hadn't been changes to guidelines issued in RBHSC at that time.

Q. Let me just address that issue. It means me departing from the content of the meeting for a short time, but it may be convenient to deal with it now.

You've said that you can't recollect speaking in the

terms that Dr Kelly has suggested. He's suggesting that you said to him there had been recent debate in relation to the appropriate rehydration replacement therapy and that the Royal had changed its guidelines in recent years. You have said something just now about when you think the approach to Solution No. 18 had changed; when do you think it had changed?

A. Well, I know that graphs have been produced to do with pharmacy purchase of Solution No. 18.

Q. Yes.

A. I'm going from memory now, but I'm fairly sure that it was really after Raychel's death that there were really growing concerns about implications of Solution No. 18 in causing hyponatraemia in children.

I knew about Adam Strain's case, but I only knew in very peripheral terms, and he was a very unique, complex little boy, a very specific set of circumstances. I never heard anything about Lucy's case until I got the notes and was asked to review them. So I had no prior knowledge at all of her being admitted to RBHSC and dying. But certainly, following Raychel's death, there was a lot more discussion and concerns about use of Solution No. 18. I think it was following Raychel's death.

Q. Could I just ask you to look at the graph you have

alluded to? It's 319-087d-003. You can see, doctor, that through most of the year 2000, the order in respect or supply in respect of Solution No. 18 was up at at least 400, sometimes dropping to about 350, but sometimes getting as high as 500 and beyond.

A. Mm-hm.

Q. But by the end of that year, there was a significant tailing off in the amounts ordered and throughout the year 2001, as is illustrated by the graph, the orders were at or less than 100 units. Building that into our chronology, you would know that Lucy died in April of 2000.

A. Mm-hm.

Q. Raychel died in June 2001. But it would appear that the decline in ordering had really commenced in advance of Raychel's death.

A. Mm-hm. Yes, I appreciate that. I'm just telling you what I remember.

THE CHAIRMAN: You see, what sparked this exercise, doctor, was the evidence from Altnagelvin is that when they were involved with the Children's Hospital over Raychel's death, they were told that the Royal had stopped using Solution No. 18 some months previously. I wouldn't be surprised if there was further discussion on the basis of Raychel's death, but the sequence, rightly or

wrongly, that was given from the Children's Hospital was that Solution No. 18 dropped off before Raychel died. And to a limited extent, that is supported by the fact that for the month of June 2001, which is the month Raychel died, there were only 42 batches of Solution No. 18 ordered and that the number of batches ordered in April and May 2001 was really a way down from the previous year.

A. Mm-hm.

THE CHAIRMAN: So maybe there was something which was confirmed by what happened to Raychel, but there seems to have been a trend just before that in any event.

A. Mm-hm. Yes, I mean, I recognise that. I just cannot remember any changes. The other thing is that it would be nice to see a breakdown by ward because I think that RBHSC is quite a big hospital and I know that PICU were much keener on normal saline than would have been used in the peripheral wards, and again there's a difference between medical and surgical wards. But from my recollection, I didn't hear any discussion about hyponatraemia and use of Solution No. 18 really until after Raychel's death.

THE CHAIRMAN: Thank you very much.

MR WOLFE: Well, in terms of the change in policy or approach which you, in your evidence just now, identify

with the period after Raychel's death, was the change a change in the use of Solution No. 18 for maintenance purposes or was it for replacement purposes?

A. Solution No. 18 was not ever the choice for replacement therapy. It was the subsequent change in maintenance recommendations.

Q. I asked the question in that way because, although you don't recall discussing matters in these terms with Dr Kelly, it was his evidence, and as contained in his witness statement, that so far as the recent debate which he alluded to was concerned and the change in the Royal's policy which he referred to, he says that there had been considerable recent debate with regard to the best resuscitation and rehydration regimes to use. And he says that that is what emerged from his conversation with you. The implication of that is that the Royal had been using Solution No. 18 for resuscitation and rehydration.

A. I can't recall saying that. I can't imagine that I would say that because that was not my knowledge of fluid balance in children.

Q. Very well.

A. And as I said earlier on, the juniors were all trained to follow the APLS guidelines right from the mid-1990s, so I can't understand that.

Q. Yes. Could we turn back to the meeting then? I want to put to you Dr Kelly's perspective because your perspective, I can summarise, is that arising out of this meeting you left Dr Kelly in no doubt that the inappropriate use of Solution No. 18 was implicated in the electrolyte derangement, seizure and cerebral oedema; is that fair?

A. I think so, yes.

Q. Whereas, if I can summarise his evidence -- and he gave evidence on 13 June -- he has said that he can recall you telling him that certainly you told him that the electrolyte or the serum sodium finding of 127, you wouldn't expect a seizure, but the rate of change of electrolytes could have caused a seizure or likely caused a seizure. And he knew your evidence, because I was putting it to him, but he says the point of departure between your perspective and his perspective is this: you were going through a number of possibilities during this conversation, one of which was the fluids, but other matters were discussed so that he was left with a range of possibilities rather than a specific declaration by you in terms of what you thought had happened.

Can you help us on that? Did you go through other possibilities with him?

A. Yes, I think I did. It was obvious that Dr Kelly had picked up from my report that I had concerns about the electrolytes and about fluids because he asked me a specific question about electrolytes. Now, obviously, even though I was fairly sure in my own mind that the cause of Lucy's deterioration was related to the changes in biochemistry, it was a very unusual situation and it was very difficult to completely exclude other causes that might have contributed to that deterioration. But I'm equally certain that, at the end of our discussion, he was left in no doubt that the most likely explanation for her deterioration was related to the change in sodium and the problems with fluid administration.

Q. Just coming back at you on that, your evidence is clear, but can I ask you: was bronchopneumonia discussed as a possible underlying cause for the brain oedema?

A. I can't remember that detail. My own view -- I was aware of Dr O'Hara's post-mortem report, I'm also aware that in children with bronchopneumonia you do get inappropriate ADH secretion and often we reduce the volume of fluids we give to children with pneumonia. But I was not convinced from her presentation that bronchopneumonia had been a major factor causing her deterioration. In my experience, post-mortem reports often include bronchopneumonia, but that's a terminal

event, and I did not think that that was a significant factor. But we may well have discussed it, but in those terms.

Q. Clearly, by your description, this conversation had taken things on a stage from your initial report, and you've given your evidence earlier in terms of where you saw the limitations or the constraints set by your remit. And in this conversation, you're saying you're being more explicit or more specific because you're being faced with direct questions. Was there any conclusion at the end of the meeting about what the implications of your view were for the Trust or for clinicians within the Trust?

A. I think there were two things which we discussed in the meeting -- and again I'm going from recall, but I do recall the meeting quite clearly. The first was that Dr Kelly did ask me if I was aware that the content of my report was rather different from that of Dr Quinn. And then I asked him what he was going to do next and he said he would have to take the reports and the comments from our meeting back to the Trust and then it would be up to the Trust to decide what to do next. The terms of reference from the Royal College were quite clear that once a report was handed over, subsequent actions were the responsibility of the Trust.

Now, the other question I put to Dr Kelly was -- I asked him specifically about a coroner's inquest. And again, from memory -- and I'm aware that this is not the same as Dr Kelly's recollection, but my recollection is he told me the coroner had been informed, but did not want to hold a coroner's inquest, did not feel it was necessary. And I remember that because I was surprised. Following on from that, by that stage I knew -- I had a telephone call from Sperrin Lakeland Trust to say that a medico-legal case was underway. I don't think Dr Kelly and I discussed medico-legal case at all in our meeting or, if we did, I can't remember it, but at no stage was I asked to contribute to medico-legal case or to coroner's inquest or to complaints procedure. So that's how I remember the meeting ending.

Q. You have made an important contribution in relation to the state of knowledge with regard to the need for an inquest. Was there any discussion about whether, in light of the views that you were expressing about fluid management, whether the coroner should be reintroduced to the case?

A. I think I was quite naive about coroner's role. Whenever I had made referrals to the coroner before and the coroner had made a decision, I had always made the assumption that the coroner's ruling would stand.

I would not have even thought of disagreeing with that. So that's ignorance on my part of the whole coroner's process. The other thing is that at that stage the medico-legal case was started then and in a way I sort of thought that will address issues and involve expert witnesses.

MR GREEN: Could I ask that witness statement 298/1 at page 14 be pulled up?

MR WOLFE: I'm going to go to that now.

MR GREEN: I was just going to invite my learned friend to ask the witness why she didn't deal with this in the exquisite level of detail that she's treating the inquiry to today.

MR WOLFE: Could I have up on the screen WS298/1, at page 14? You were asked, doctor:

"Did you discuss with the Trust whether there was a need to report Lucy's death to the coroner in light of the conclusion reached by you and Dr Boon that Lucy had died from hyponatraemia?"

So this is asked in the context of your second report. You answer that question by saying:

"I asked (from recall of my meeting with Dr Kelly) about the coroner's findings as to cause of death. From memory, I was surprised that the coroner had not requested a coroner's PM. I was aware at this time that

medico-legal action by the parents was underway. At the time of the external review, Dr Boon and I were aware that legal proceedings had still not been concluded, but assumed that expert witnesses were involved."

My learned friend has intervened and I think the point of his question -- I trust you were able to hear him okay. But the point of his question was: why, when asked a question by the inquiry, as you see set out here, why did you not see fit to address what you say you knew about what Dr Kelly told you during the meeting at the end of May 2001? Do you follow the point?

A. Um ...

THE CHAIRMAN: I think the point is this, doctor, that you have said something more explicit in your evidence a few moments ago when you say that you asked Dr Kelly about the coroner's inquest, he said the coroner had been informed, but did not want to hold an inquest and that you were surprised by this. In your answer to question 16, you say that you'd asked about the coroner's findings and you were surprised that the coroner had not requested a post-mortem. I think you've given us some additional information today, which isn't quite so clear from your written statement, or do you see it as being the same thing?

A. Sorry, I thought it was clear.

THE CHAIRMAN: Thought it was the same thing?
A. Yes, uh-huh.
THE CHAIRMAN: Okay. Thank you.
MR WOLFE: Could we move to the second Royal College report? The inquiry understands that the Royal College were called in for a second time because, if you like, the problems in the paediatric department of the Sperrin Lakeland Trust had not settled down, there was perhaps a further complaint or concern expressed about Dr O'Donohoe's competence, and you were asked to look at matters again, this time in a more elaborate way with a colleague, and involving a visit to the Trust itself.
A. That's correct. It was a much wider remit this time. It wasn't just about competency; there were issues to do with harassment, communication, so there was less focus on clinical competency than on other aspects of professional care delivered by Dr O'Donohoe.
Q. Could I ask you this: during this second visit, or second intervention, if I can put it in those terms, you're looking at a number of patients' cases, and again you're looking at Lucy Crawford's case. Now, whatever about the other cases, why are you looking again at a child's case when you've already expressed your view?
A. I'm not very sure. I don't think we -- I don't think Dr Boon and I specifically set out to look at Lucy's

case. But what happened during the course of interviews with other members of staff -- information was volunteered about Lucy rather than us seeking information. So in other words, I think during a conversation with one of the nursing staff, issues came up about fluid management. But I am clear that in the time we spent in the Erne Hospital, talking to people, there was very little time devoted to any one case, and it was much more general information gathering about Dr O'Donohoe's performance across a whole range of areas.
Q. Yes. Could I have up on the screen, please, 036a-149-306? This is the section of your report that makes brief mention of Lucy's case. You say:
"The prescription for the fluid therapy for Lucy Crawford was very poorly documented and it was not at all clear what fluid regime was being requested for this girl. With the benefit of hindsight, there seems to be little doubt that this girl died from unrecognised hyponatraemia, although at that time this was not so well recognised as at present."
When we asked you in your witness statement to explain what the benefit of hindsight had brought to the piece, you reflected the fact that you had access to materials and you had access to personnel, which were

not available to you at the time of your first report; is that fair?
A. Mm-hm.
Q. Can you remember what additional materials you might have received?
A. I can't and I went through the records and I don't have anything additional. I just know that I got a folder with information. I know that some of the -- I know at least the nursing staff, I'm not sure on the medical side, but I'm certainly sure that we had been given information from the nursing staff about Lucy's fluids, but I can't remember in any more detail than that.
Q. Yes. You have told us, doctor, if I correctly understand your evidence, that arising out of your first intervention, which led to report 1, which then led to a meeting with Dr Kelly, that at that time, a year earlier, you were of the view that the biochemistry had in essence killed the child -- the fluid management, leading to the biochemistry leading to the cerebral oedema; isn't that right?
A. I temper that with the inadequate documentation around the series of events whenever Lucy was admitted and also the fact that it's very difficult to exclude all other possible causes. But yes, I had felt that was the most likely cause of her acute deterioration and then death.

Q. Yes. I think you put it best when you say that, at the end of your meeting with Dr Kelly, you felt that he was left in no doubt as to your view. You couldn't rule out other possibilities, but you were sure as you could be that it was the fluid mismanagement leading to the biochemistry and then the seizure and the cerebral oedema. Why then, when it comes to writing this report, albeit with Dr Boon, are you reflecting the view that it's only with the benefit of hindsight, which you define as obtaining these other materials and access to other people?
A. I think the phrase "benefit of hindsight", it's a phrase that Dr Boon -- I'm not very keen on the phrase "benefit of hindsight". I think he was referring to the recognition of the factors leading to her deterioration at the time of her deterioration rather than at a later stage.
Q. Yes, he answers the question in a slightly different way to you. He says that he uses that phrasing to reflect the fact that by the time you're writing that report, the whole understanding of hyponatraemia had been opened up and he cites the article by Halberthal --
A. Yes.
Q. -- as indicating that while hyponatraemia as a problem here might not have been as clear to the clinicians

at the time of death as it should be now, but you, I think, as I understand your evidence, were clear about hyponatraemia and its role less than a year after Lucy's death. If that's right, then I'm not sure why you write the report in this way.

A. You're talking about the first report now?

Q. No, this report. Why do you, albeit as a co-author to the report, adopt that phraseology that it's only with the benefit of hindsight?

A. It's difficult to answer that without also referring back to the first report. But I think Dr Boon and I, we spent a lot of time -- we travelled back together from the Erne Hospital to the airport and we spent a lot of time discussing what had taken place in the Erne Hospital. It was a year on, over a year on, from the first report, which I'd done, and by that time there was the paper from Halberthal, which had been published just around the time of the first report, which was really a major paper in terms of raising awareness of hyponatraemia. And also, from my own personal perspective, I suppose being involved in a review of Lucy's notes, but also knowing about Raychel's death at that stage, it made the entity of hyponatraemia much -- I had never seen hyponatraemia used as a diagnostic entity or included in a death certificate. But

hyponatraemia was beginning to get into medical terminology as a diagnostic entity in itself with serious consequences.

There's no doubt Lucy had, by definition, hyponatraemia. In a way, I still think it wasn't the actual level of sodium which was the problem -- and I take on board all the reservations that it may have been lower at some stage -- but I think it was that rate of fall which was the important factor rather than the actual level. And there's a difference.

Q. Yes, but can I ask you this: Dr Kelly made the point quite strongly to the inquiry that arising out of receiving report 1 from you and arising out of the meeting, he was not getting from you a clear signal that the fluid management was to blame. Does this phrasing in your second report reflect the view that at the time of your first report you could not and were not sure?

A. I was fairly sure, but I was guarded in the way I wrote the report because I felt that her death would be investigated at a coroner's inquest and that I had only limited information, and to draw firm conclusions on the documentation that I had was inappropriate.

Q. But I thought you'd explained to us that you knew at the time of your first dealing with Dr Kelly that there wasn't to be a coroner's inquest.

A. Whenever I wrote the report, I thought that a coroner's inquest would be held.

Q. Yes.

A. Whenever I spoke to Dr Kelly at the meeting on 1 June, from memory, he told me that there wasn't going to be a coroner's inquest, but that was the first I knew of it, and at that stage I knew that a medico-legal case was underway and that I had not been asked to contribute to that.

Q. Can I bring you on to a slightly different point to finish? Between yourself and Dr Boon, a draft report was produced. Could we have on the screen, please,WS298/3, page 7? Under the heading "Poor documentation", it's the same layout as the ultimate report, but within the section in draft you add the finding:

"More careful attention to detail of the fluid therapy might possibly have avoided this girl's cerebral oedema and fatal outcome."

A. Mm-hm.

Q. You have explained and Dr Boon has explained within your witness statements why that conclusion wasn't ultimately included, and I emphasise that Dr MacFaul understands and accepts the reasoning you've advanced. But could you just explain to us the reason why that wasn't

included?

A. Dr Boon and I talked about this very carefully. The only reason -- the only child that we alluded to in our second report was Lucy and that was because of the tragic consequences following her admission to the Erne Hospital, and we felt in light of that we should include reference to her case. The main reason that we left out the last sentence in the final report was on the basis of our knowledge that medico-legal proceedings were underway and that expert witnesses would be involved and that we had not been asked to be part of that process or to contribute to it in any way.

Q. Nevertheless, it's a view that yourself and Dr Boon had held. It's a conclusion that you agreed with?

A. Yes.

Q. And that wasn't otherwise shared with the Trust?

A. No, it wasn't, but we had -- no, we had no discussion with the Trust following our visit. At least I didn't. But we felt that we had been -- the second sentence:

"Little doubt this little girl died from unrecognised hyponatraemia."

Was a sufficiently strong statement not to need any further recommendations, which really should come out of further medico-legal proceedings.

MR WOLFE: Well, I think that's fair because Dr Kelly and

indeed Mr Mills, in their evidence to the inquiry, say that they understood your report as implicating the fluid management of the child without the need necessarily for that final sentence.

Very well. I have no further questions.

THE CHAIRMAN: Could I pick up one point with you, doctor? When you were explaining a few moments ago the added certainty in your second report about -- or the reference to "with the benefit of hindsight", you said in relation to that that, by that point, when you were presenting this report, which I think was presented to the Trust in August 2002, the Halberthal paper was very significant and you knew about it, but you also knew about Raychel's case.

A. Yes.

THE CHAIRMAN: Although Raychel died in June 2001, her inquest wasn't held until, I think, February 2003. How did you know about her case in the summer of 2002?

A. She was transferred to RBHSC from Altnagelvin and, again, the circumstances surrounding her death were so unusual and unexpected -- a child admitted for fairly minor surgery, who subsequently had had a catastrophic event on the basis of cerebral oedema -- we talked about it within the hospital. It wasn't -- and that was different. I had never heard Lucy's case discussed

within the hospital or even Adam's, but there was no doubt that there was general discussion and concern that this had happened.

THE CHAIRMAN: I can entirely understand how there would be discussion about Raychel's case, given the circumstances in which she was admitted to Altnagelvin and then transferred to the Children's Hospital. I'm just a bit curious about why there would not be equivalent discussions about Lucy's case because Lucy's case was equally stark and awful, wasn't it? She was admitted with something, gastroenteritis plus perhaps something more, but the same sequence of events?

A. Yes. I mean, I can't really explain if ... You see from my CV, it was fairly busy. I wouldn't have ... I would have tended to be in the hospital and do work rather than -- I wouldn't have coffee or lunch or anything like that, so I wouldn't necessarily hear talk that was going on unless I happened to be in intensive care at the time. I think it was beginning to build on the fact that there had been Lucy and then there had been Raychel, both children who appeared to be previously well and then had catastrophic events and died. So I think it was beginning -- it was the accumulation of information over a relatively short period of time.

THE CHAIRMAN: Thank you very much.

Are there any questions from the floor before I come to Mr Davies?

MR DAVIES: No, thank you.

THE CHAIRMAN: Doctor, thank you very much for your contribution. That brings an end to your evidence, unless there's anything you particularly want to say before you leave the witness box, but you don't have to say anything more if you have said all you want.

A. Thank you very much.

(The witness withdrew)

THE CHAIRMAN: Okay. Ladies and gentlemen, we'll start at 2.15. Thank you.

(1.30 pm)

(The Short Adjournment)

(2.15 pm)

(Delay in proceedings)

(2.22 pm)

MR WOLFE: Good afternoon, sir. Mr Martin Bradley.

PROFESSOR MARTIN BRADLEY (called)

Questions from MR WOLFE

MR WOLFE: Good afternoon, Mr Bradley. You have provided the inquiry with a witness statement in writing; it's numbered WS307/1, dated 22 January 2013. We ask all of our witnesses this: do you wish to adopt that statement

to be read in addition to the evidence you give to the inquiry this afternoon?

A. Yes, I do.

Q. Very well. In addition to the witness statement, you have helpfully provided us with a curriculum vitae, which we can put up on the screen now, please. Let me go to the second page, 315-004-002.

As we can see from that document, sir, you engaged in nursing education from 1973 to 1976. You obtained a certificate in education between 1976 and 1977 and then moved on and obtained your degree in education and a master's degree in education?

A. That's right.

Q. Followed by a diploma in health economics?

A. Yes.

Q. As we can observe from your CV, you practised as a nurse between -- is it 1969 to 1976?

A. I was a student nurse from 1968 through to 1971, then practised as a general nurse from November 1971 until March 1972, and then as a post-registration student nurse from 1972 to 1973, and then worked in mental health from November 1973 through to September 1976.

Q. And moving forward in your career, you took up various positions in health sector/health service management;

is that right?
A. I think the early career would demonstrate a primary focus in nurse education and then moving into the Department of Health as a senior nursing officer in November 1991 and working there until 1997, and then moving to the Western Health and Social Services Board as a chief nurse in April 1997 until August 2000. And then as director of healthcare and chief nurse until March 2003.
Q. Yes. So it's that period, the period within that, which we want to address this afternoon. Could I ask you this: you, at the time of Lucy Crawford's death, which was April 2000, held the chief nursing officer post in the Western Board.
A. That's right, yes.
Q. Then at the end of August, start of September of that year, you took on another role, which was in addition to your nursing officer role; is that correct?
A. That's correct.
Q. So you performed both the chief nursing officer role and the director of healthcare role?
A. Yes.
Q. You left the Western Board in April 2003; is that correct?
A. That's right.

Q. To take up a position with the Royal College of Nursing?
A. Yes.
Q. You were director of that organisation for a little over two years?
A. Yes.
Q. And then you moved into the department?
A. Yes.
Q. And you worked there from November 2005 until June 2011, when you retired?
A. That's right.
Q. You now carry out some work for the Northern Ireland Association for Mental Health?
A. I do, yes.
Q. So looking at your CV, you are well placed, I think, sir, to assist the inquiry in its efforts to understand the nature of the relationships that existed, in or about 2000, between the Sperrin Lakeland Trust, the Western Board and, in turn, the Department of Health; is that fair?
A. Well, I hope so. We'll see.
Q. Just a little more about your role as the chief nursing officer for the Western Board --
THE CHAIRMAN: Sorry, is it Professor Bradley, Dr Bradley, Mr Bradley?
A. Well, I'm a visiting professor at the University of

Ulster. It's not doctor.
THE CHAIRMAN: It's "professor"? Thank you.
MR WOLFE: In your role as director of healthcare and chief nursing officer, professor, you had responsibility for commissioning services on behalf of the Western Board on the population within that area?
A. That's correct.
Q. And I think you've told us that in terms of your and the organisation's relationship with the Sperrin Lakeland Trust, you had no direct responsibility for the operation, management or supervision of anything that went on within the Trust?
A. Yes. I think we need to be clear that the operational responsibility for the day-to-day running of the Trust rested with Sperrin Lakeland Trust, not with the Western Health and Social Services Board.
Q. Yes. In terms of your responsibilities, I know that Mr Frawley left the Western Board in or about August or September 2000.
A. That's correct, yes.
Q. You have said something about how the Western Board was organised. It wasn't until you became the director of healthcare that you became part of the board of the Western Board; is that right?
A. Well, I would have attended meetings of the board in my

role as chief nursing officer. I didn't become an executive director of the board until I took up the position of director of healthcare.
Q. Mr Frawley was the general manager of the Western Board. You worked closely with the director of public health; is that right? That was Dr McConnell.
A. I would have done, yes.
Q. And in your role as chief nursing officer, before you took on the other role, you were accountable to Mr Frawley; is that right?
A. I would have been accountable to Mr Frawley on all matters relating to professional issues to do with nursing or midwifery practice. I would have been accountable to Dr McConnell for a range of commissioning activities to do with healthcare.
Q. So could you illustrate those two points for us by way of an example? So responsible to Mr Frawley on the professional side to do with nursing?
A. Well, responsible to Mr Frawley and to the board for being the principal adviser on professional matters to do with nursing or midwifery practice. I did have a role within the board over a period of time to lead on a range of commissioning initiatives and I would have related more to Dr McConnell around elements of those, but I think it would be fair to say that we worked very

much as a team. I think these distinctions probably become more pertinent if things were going wrong or there were challenges, but on a day-to-day basis we were working very closely as a team together.

Q. Could I move on and ask you directly about the relationship between the Western Board and the Sperrin Lakeland Trust? The trusts were formed or the Sperrin Lakeland Trust, at the very least, was formed pursuant to legislation in the mid-90s, 1996.

A. Yes.

Q. And it has been suggested by Professor Scally, the expert retained by the inquiry to examine this area, that there was no direct managerial responsibility between the Trust and the Western Board because of that, if you like, legal change leading to a realignment in how the Trust was constituted.

A. That's correct. I would say it reflected a change in policy in Northern Ireland where we were becoming more focused on introducing, for want of a better word, a market in healthcare. So there was an attempt to ensure that the existing Health & Social Care Boards focused more of their attention on identifying what were the needs of their local population and using the money that they had from the department, that was voted to them by the department, to meet those needs in a much

more what I would say was a dynamic commissioning role. It was the whole idea of the purchaser/provider split and the trusts were placed in the role of being the providers of services and responsible for managing their organisations to provide those services.

They would theoretically -- although this was less maybe in Northern Ireland than it might have been in other parts of the UK -- they would theoretically be in competition with each other around value for money and ensuring that they had the best services available for local populations. Ideally, the boards could choose where to place their contracts. The reality in a small market like Northern Ireland is that there was a very limited variation in how contracts were placed because Northern Ireland is not of a size, I think, where you can have a large health and social care market as the government in the UK might have envisaged it.

Q. So where Professor Scally characterised the relationship as having become one where the Western Board agrees with the Trust what services it required and the sums of money to be passed to the Trust in respect of those services, that, I suppose, in a nutshell, encapsulates the change that had been brought into place, by the mid-90s, by the change in policy?

A. That's correct.

THE CHAIRMAN: Does that mean that in Belfast there may have been some competition between, say, the Royal Trust and the City Trust, but that the real likelihood in the Western Board area of competition between Sperrin Lakeland and Altnagelvin, that was unlikely, was it?

A. Well, it would have been more limited, chairman, in the western area. My observation generally at that time within Northern Ireland is that the vast amount of money would have gone across anyway in a block contract and what you would have then had would have been discussions around the margins of that amount of money. But primarily trying to use that money for new and innovative services and that, I think, would have put a slight competitive edge into trusts across Northern Ireland to try and compete for that.

MR WOLFE: Could I ask you this, professor: did the change in formal or, should I say, legislative accountability, the basis for the accountability changed by legislation, did that affect the way that the Trust, which is, if you like, bits and pieces of hospitals and care homes and that kind of thing -- did that affect the way the management of those bodies related to the Western Board?

A. Well, my observation on this is that the relationship, I think, was different, particularly between the board

and Altnagelvin Trust and the board and Sperrin Lakeland Trust. Now, I didn't have the benefit or otherwise of having been subject to direct management from the old system. I came into the board more or less on the foot of these changes as trusts were being created. It would have been my observation that Sperrin Lakeland and the board would have had a much more, in some ways, dependent-type relationship with the Trust, I think, looking to the board for possibly more support than Altnagelvin might do.

Now, these are human factors, you know, and I'm doing this from my observation and this is my view of what I saw during that period of time. And I'm not saying that one is right and the other is wrong, but certainly the relationship, I think, with Sperrin Lakeland was much more of a dependent-type of relationship, much more. I would describe it as almost a parent/child relationship, without being insulting to anybody, while the relationship with Altnagelvin, I think, was much more business-like, much more in your face, and much more contested, but in a positive way, to get the best out of the system. And they would have challenged the board much more openly about the amount of money they were getting, their share of resources, and the board's support for their plans in relation to

developing services, particularly around the city of Derry.

I'm not saying that there wouldn't have been that with Sperrin Lakeland, but it was much more on the basis of continuous negotiation and being supportive, and my personal memory of all of this is that I would have spent much more time around Sperrin Lakeland issues than I would have around Altnagelvin-type issues.

Q. And dealing with what you have just said about the Sperrin Lakeland, are your observations applicable as much to the bigger strategic issues as they would be about, say, operational issues? And one of the operational issues, obviously, was the adverse incidents that occur from time to time.

A. I think dealing with the strategic issues, the context here is that Sperrin Lakeland in particular was in the middle of a public debate about the future of acute services in the south-west of Northern Ireland. Now, the rest of Northern Ireland was involved in that debate as well, but I think Sperrin Lakeland, in that context, found itself between two very strong local communities, one advocating for Omagh and the other advocating for Enniskillen, and I wouldn't underestimate the amount of energy and time that the Trust had to put in to trying to continue to maintain services for everybody during

that period while at the same time trying to deal with the strategic changes that they appeared to be heading into and having the debate with the public about how that might best be done.

So you know, the Trust will have been the subject to more or less continuous headlines every week in the local press around those sorts of issues.

Q. And as you indicate, they were issues that you were interacting with the Trust upon?

A. Yes. We as boards, around those strategic issues, had a role to play in trying to steer our way through that in conjunction with the department to try and get the best result.

Q. And operationally, an example I've given to you is interactions around adverse incidents. As appears from the Lucy Crawford case, which we'll look at in detail in a moment, the Trust, in a sense, felt obliged to be reporting that kind of issue to the Western Board, its commissioning body, but not necessarily just that point. In a general sense, was there this continued operational interaction with the board or on operational issues?

A. There would have been ongoing discussions around operational issues, primarily because of, I think, an ongoing difficulty in trying to maintain services: the recruitment of staff, in particular medical staff, comes

very much to mind; difficulty in staffing Accident & Emergency departments; difficulty maintaining some of the surgical services, particularly over holiday periods. All of these would have become issues that we would have had to engage with the Trust on.

Q. And they're presumably issues that emerge from its geographical remoteness?

A. Yes.

Q. And what you describe is by contrast, perhaps, with bigger centres such as Altnagelvin?

A. Yes. I think Altnagelvin were in a -- they may contest this of course. I think they were in a slightly better position in relation to their location and being close to a large population centre and also having ambitions to provide services on a wider basis because they were in a border area as well. So there were opportunities for them to want to develop around all of that. But I think at the same time, the management philosophy probably in Sperrin Lakeland was one of maybe sometimes looking too much, I think, to the board for some elements of this support. Even though we would want to have been supportive, I think the situation in Altnagelvin was one of much more robust management in the sense of wanting to deal with their own business. In other words, there would have been more sharing of

problems and issues between Sperrin Lakeland and the Western Board.

Q. Well, that's helpful. Professor Scally, of course, notes that in this, as a result of this change of policy, which was writ large in the legislation, accountability in strict terms was between the Trust and the Department of Health; isn't that right?

A. That's right.

Q. But whether it was a case of old habits die hard or the human factors that you allude to, it appears that notwithstanding the absence of an accountability relationship, the Trust continued to interact with the Western Board almost as if this accountability hadn't changed.

A. Well, I want to be careful not to make too much of this. I'm giving you my view in relation to how I perceived the differences between the two -- the two trusts. The caveat I would also have is that the development of this policy in Northern Ireland -- I think we were the last part of the UK to go to the purchaser/provider split and, from memory I think the western area was the last part of Northern Ireland to go to the purchaser/provider split. So there were a lot of factors there in relation to how you move from one way of working to a new way of working. And I think we would also need to caveat some

of these comments by the fact that, whether I like it or not, I'm not terribly sure that the department or the system generally had worked out some of the implications and consequences of these new accountability arrangements. In other words, they weren't, I think, backed up by good operational planning to allow it to happen in reality. In other words, I think we were having a debate or will be having a debate, I'm assuming, around whether there was any particular policy or guidance as to who was reporting to who around some of these issues.

Q. Let me be more specific. Let's get into the area of adverse incidents, and by that I mean, in this particular case, the situation where you had an unexpected and unexplained death. You, as chief nursing officer at the time of the death, would have expected the Trust to be reporting to the Western Board that this incident had occurred?

A. Yes, we would have had an expectation that they would have informed us that this incident had occurred.

Q. And where does that expectation derive from, if that's the appropriate question? It doesn't derive from legislation.

A. I think you might find in the service level agreement that we would have had with the Trust. There would have

been an expectation that there were governance arrangements in place, and it might go too far to say that they would have -- that they should have reported to us, but I think in relation to ongoing work we wanted to know if there was going to be an issue.

Q. In fairness, you're probably more familiar with this service level agreement than myself, but it's not explicit in the terms. This expectation that the adverse incident would be reported to the board, does it derive from an understanding that the board, that is the Western Board, had a responsibility to be assured that the health of the local populous for which it is responsible was being properly attended to by the organisations from whom you commissioned services?

A. Yes. We would have had an expectation that if there was an incident that was very unexpected and was going to give rise either to the need for a review or for major public concern, that we would be made aware of that. I don't want to be too blasé about it, but in principle we wanted to hear about it from the Trust before we read about it in the papers.

Q. If I can just bring you to something that Mr Mills has said. He has said that the Western Board would receive from the Trust and consider information about an adverse incident and would in turn advise the Trust on any

details they required or action they wished the Trust to take. As a statement of practice or principle, is that accurate?

A. Well, my experience of this situation is that that is not accurate in the sense that I think we were being informed about an incident and we were being told what the Trust was then going to do. Now, we would have, of course, had an expectation that in a case like Lucy Crawford, the incident would be properly investigated and that there would be a report at some stage in relation to what the outcome of that investigation had shown and then any recommendations or any points for learning that arose from that. We would have had an expectation that we would at least be made aware of that at some point.

Q. So the tension that I think your answer points up is that to the extent that the Trust is saying that the board and its officers should be prepared to offer a guiding hand, that would not be your understanding?

A. It wouldn't be my understanding in the sense that I think it becomes difficult if accountabilities become confused in that way. There's a line there between, let's say, being aware of the situation and making a comment or an observation that hopefully might be helpful to the Trust as opposed to maybe some sort of

expectation that the board was going to investigate the incident.

Q. Yes. I don't think Mr Mills puts it that far. Perhaps the position is otherwise better summed up by Dr McConnell, who in his witness statement has told us it was his responsibility to disseminate within colleagues within the Western Board any report and it would appear that he becomes, in this case, the person to whom the report was initially directed. And you would say that is quite appropriate because he wears the director of public health hat?

A. That's right.

Q. But moving on to what he says would be his role, he says that once a report is made to him, he reports it internally and then works with Western Board managerial and professional colleagues to ensure that the Trust had and were taking all appropriate steps to investigate the surrounding events. So it is a case of the report comes in and Dr McConnell, working with you and other colleagues, perhaps take a quick spot-check to ensure that you're satisfied that the Trust are doing what needs to be done to get to the bottom of this?

A. Yes, that's fair.

Q. There's then a second stage, if you like, the report has come in. If the board feels the need to comment, as

Dr McConnell suggests, to get the thing on the right track, then that might be done, but then you have, in this case -- but I want to keep it as general as possible before we move forward -- then you might have a review carried out, leading to a report, and of course that wouldn't be the approach necessarily in every adverse incident.

But can I ask you to comment on Mr Frawley's perspective? He said that where the investigation and its conclusions resulted in the preparation of a formal report, he would have had an expectation that the board, that is the Western Board, would initiate any action that is necessary arising out of that report. But before reaching a judgment on whether action was necessary, he would seek the views of the relevant professionals within his organisation and, in turn, then report back to the Trust if he thought any further steps were needed.

A. Yes, that sounds right.

THE CHAIRMAN: Is that because you're talking about two different sorts of reaction? One is if there's a review with a report, let's say in the Erne, then there are steps which may need to be taken in the Erne on foot of the review, but the Western Board also wants to know, because the steps taken in the Erne may have wider

significance? Is that the context in which the Western Board wants to know what's going on?

A. Yes. There would be a judgment call here in relation to what matters needed to be addressed let's say in the very local situation of one acute unit. But if there was learning or if there were issues that had a wider context that needed to be dealt with, then those would be escalated up to the department or to other boards. But in this system, we're also depending on the Trust reporting any of those issues as well to the department.

THE CHAIRMAN: Sorry, there's a whole lot of angles on this. Let's take it away from Lucy, let's say there was a serious adverse incident in the Erne, but it didn't result in a child's death. The Western Board is advised that the Sperrin Lakeland Trust is doing a review and the review comes up with some recommendations which are implemented within the Erne. Does the Western Board then want to know what that report says and what those recommendations are so that it can decide whether -- they are of broader significance than simply within Sperrin Lakeland?

A. My knowledge of this is that I think it would depend on the seriousness of the original incident because, healthcare being what it is, there will be a range of incidents that happen over a period of time, not all of

those would necessarily be escalated to the board's attention --

THE CHAIRMAN: Right.

A. -- but would be dealt with internally by the Trust.

THE CHAIRMAN: Is that a judgment call at the Trust's end?

A. Yes, I believe it is a judgment call at the Trust's end.

THE CHAIRMAN: So it's a judgment call of whether the issue leaves the Trust and goes to the board, even for information purposes?

A. Yes.

THE CHAIRMAN: Is it the same judgment call at the Trust's end as to whether that is also reported to the department?

A. It would be. And again, it would be on the basis of the seriousness of the event. Because you could have a whole range of incidents happening within a large Trust, not all of which necessarily require regional action, but can be dealt with on a 24/7 basis by the Trust and by talking to staff or by putting in place arrangements fairly quickly that will deal with that issue.

THE CHAIRMAN: So if an incident was sufficiently serious in the Erne to lead it to report that to the Western Board, then it would automatically follow that it would be sufficiently serious for the Trust to report

that to the department?

A. I would have thought so, yes. That would have been my expectation.

THE CHAIRMAN: So in your eyes, the Trust should be reporting serious incidents to both the Western Board and to the department?

A. Yes. To the board for information and for any consequences that we might see as a board in relation to the local population and things that might need to be dealt with sooner rather than later, and to the department in particular for regional learning and for any other business that might subsequently arise out of the report on that incident. I have to say these incidents, in my time in the Western Board, were very rare. If we were getting everything that potentially might be going on in a healthcare system, we would be dealing with that day in daily.

THE CHAIRMAN: I understand. We have the awful example, I'm afraid, in 2001 when Raychel died that there was a report made by Altnagelvin to the department. So whatever the precise ins and outs of that, I presume you would say that is an example of appropriate action being taken --

A. Yes.

THE CHAIRMAN: -- on foot of the death of a child?

A. Yes.
THE CHAIRMAN: We'll look at the end of the summer as to what else the Altnagelvin Trust did, but that's appropriate. And I also understand your point, which is that not everything goes because there has to be an element of discretion about what is worth reporting and what isn't.
A. Yes, and there may be some things that don't appear as if they need to be reported until they're investigated.
THE CHAIRMAN: But if I understand you right, there are different reasons for reporting to the department as opposed to the Western Board. One is, in reporting to the Western Board, that's because there may be something that the Western Board should know about and might then consider carrying over to other trusts within the board?
A. That's right.
THE CHAIRMAN: Or, even beyond that, to other boards. Whereas the report to the department is because the Trust is accountable to the department?
A. Accountable to the department and the department also ultimately is in a better position to influence policy and to pick up on regional learning that needs to be implemented. Now, I'm not saying that the board can't do that as well, but the department, you know, covers the whole of Northern Ireland. The board's primary

responsibility is to its local population and it would be good professional practice that, if there was something that we discovered that had relevance to other parts of Northern Ireland, we would communicate that. But the department is in the ideal position to be able to deal with those broader Northern Ireland-wide issues.
THE CHAIRMAN: Thank you.
MR WOLFE: Could I just pick up on that requirement to report to the department if the case is judged by the Trust to be sufficiently serious by whatever range of applicable factors? The counterpoint to that is the evidence of, for example, Mr Mills yesterday, who was resolute in his view that at that time, April 2000, not only was there no expectation that he should report such an incident as this death to the department, but there was no mechanism in place to permit that to happen. I think you've dealt with the first of those points, but what would you describe as the mechanism for the report? To whom should he be reporting?
A. I think I did allude to that earlier on, that it's one thing to change a system and to redefine some of the accountabilities; I think then it's another thing to make sure that you've got in place the mechanisms and the systems that allow that to happen. And I don't think, in the year that we're talking about, there was

clarity over how those reports should be made. My own experience, again, of this, just thinking this through -- and these would have been incidents, whether they were serious adverse incidents is open to interpretation -- but certainly in the public health arena we would have dealt with, let's say, an outbreak of tuberculosis that had gone undiagnosed, we would have related directly to the department on any issues such as that through the chief medical officer's office and also to other disease control specialists. So there were issues where we would have moved quickly from the local situation to the department to make them aware of issues such as that.
THE CHAIRMAN: I presume in that scenario you don't have to look for form 43B, you just lift the phone?
A. Yes.
THE CHAIRMAN: So a bit of common sense tells you not to get bogged down in what exactly the mechanism is; you ring the CMO or someone in her office. She doesn't work alone; there's a group of people around her, isn't there?
A. There is.
THE CHAIRMAN: You can ring the CMO and have a discussion about how exactly this is to be taken forward, but it's on the basis that it does need to be taken forward?

A. Yes.
THE CHAIRMAN: That all makes sense. Can we just go back a few years? You were in the department from 1991 to 1997 as senior nursing officer, weren't you?
A. Yes.
THE CHAIRMAN: And that was just as the trusts -- certainly on the eastern part of Northern Ireland -- were being established?
A. Mm-hm.
THE CHAIRMAN: In those days, would you have been contacted by the representatives of the Eastern Board, the Northern Board or Southern Board to say, "Look, we've got an incident here, how do we take it forward? Something has happened that we think you should know about"?
A. Well, first of all, I'm a senior nursing officer in the department, so my role and function is limited to the areas that I --
THE CHAIRMAN: Nursing issues?
A. Nursing issues and in my case it was primarily around education issues because I was moving the College of Nursing into higher education at that time. I just want to make that caveat. But it would be true to say that, certainly on the nursing lines, we would have had conversations with directors of nursing within

the four board areas and if there were areas of concern that were arising, we would become aware of those. But I'm not aware during that period of what the formal adverse incident reporting arrangements might have been because I wasn't actually dealing with those.

THE CHAIRMAN: Okay.

A. So my knowledge in that area is limited, I'm afraid.

THE CHAIRMAN: You see, part of the reason we're going over this is because it's essential to, but also because in Adam's case and in Claire's case, for that matter, William McKee, who as you know was the chief executive in the Royal Trust, was asserting the position that, up until 2003, the trusts had no legal responsibility for the quality of care provided to patients.

He said -- and there's a degree of support from Dr Ian Carson -- in terms that they say until the 2003 order, the people who were responsible for the quality of healthcare were the individual doctors and nurses, and their responsibility was to their professional bodies and to the GMC. Does that put it more starkly than you would put it?

A. Definitely, yes. It seems to me counter-intuitive that if you're running a healthcare organisation, you don't have any regard for what the professionals who are working for you, who are your employees, are doing.

I take maybe the legal point, which again, if I may just return for a moment to the previous conversation -- the reality was that the system eventually got round to producing guidance in relation to the -- it wasn't as if nobody ever felt there was any need for that. We eventually got round or the system got round to doing that. But, sorry, chairman, returning to your original proposition to me, I would find that difficult to live with.

THE CHAIRMAN: Mr McKee said it was both counter-intuitive and bizarre.

A. Well, we're on the same side then.

THE CHAIRMAN: But you don't agree with it?

A. Well, I don't agree with the reality of that.

THE CHAIRMAN: Are you saying he might be technically right on the effect of the 2003 order, but that doesn't mean that, in practice and in reality, each trust -- and before them the boards -- had a responsibility for the quality of care provided to patients?

A. Yes.

THE CHAIRMAN: Thank you.

MR WOLFE: I just want to go back a step, professor, to what I termed as a two-stage approach. The first stage is the board might get a report of an adverse incident, Dr McConnell would engage with professional colleagues

within the board and then satisfy himself that the Trust was on the right, if you like, investigative track and then the Trust would be left to get on with it. There would then, as you agreed with me, be Mr Frawley's assessment that the board would look at some point for that report to come back to the board so that the board could satisfy itself that the Trust had done its investigative job correctly and whether there were, if you like, any lessons to learn, going forward, that might be of relevance to the board.

Just on that -- and I see you grimace, so maybe you don't quite agree with how I have set it out.

A. My feeling would be that we would definitely want to see any recommendations arising from that review. I think we would -- and again this is my own comment. We would personally want to be very careful about second-guessing how that investigation was done. If there was obvious flaws in the investigation that the Trust weren't picking up, then I think we would have a responsibility to note those.

Q. Yes.

A. But if we were getting a report that said X, Y and Z has been investigated, here's what we found and here are the recommendations arising from that, we probably would accept that.

Q. Thank you for clarifying that. The question I was moving on to then was: was there in place within the Western Board a mechanism by which that judgment could be made? If a report becomes available to the board, there has to be some kind of facility by which it can be considered; was there such a facility?

A. Well, two points if I may. Number 1, this was not a frequent occurrence. The second point is that it is more than likely that a report such as that would have been discussed at the healthcare committee of the board and would have had input from a variety of professionals who had some competence in that area.

Q. Yes. Moving on then to the specifics, Mr Hugh Mills, the chief executive of the Sperrin Lakeland Trust, indicated in his evidence that he notified Dr McConnell of the adverse incident, which was the death of Lucy Crawford, and, as I understand it, you were notified via Dr McConnell that this had occurred?

A. That's correct.

Q. And at that point, at a very early stage in what was to become a process, did you have to take any action?

A. At that stage, no. I was informed through general conversation that an incident had happened in the Erne and that a child had died, and the death was unexpected.

Q. You did, at a slightly later point, but within a matter

of days, have an informal discussion with Mr Mills. You described this, to the best of your memory, as being a brief conversation that took place on a corridor?

A. That's correct.

Q. And by virtue of that conversation, you understood that the Trust was set to engage in a process of review and that -- I think as you describe it -- Mr Mills had asked Altnagelvin Trust to provide an independent view on the issue. And as we now know, a Dr Murray Quinn provided that input.

A. Yes.

Q. In terms of your understanding of what had happened, were you inquisitive as to the nature of the problem?

A. Well, yes, I mean, I was inquisitive. What I was -- my memory of that encounter with Mr Mills was that the child -- a child had died unexpectedly, that there was an issue over intravenous fluids and there seemed to be a disagreement between the medical and the nursing staff over the administration of those fluids. So that was an extra bit of information that I was being given at that time.

Q. Was the picture painted for you of the potential that the child had received incorrect fluid therapy and that was one of the question marks or one of the questions to be addressed during the review?

A. From memory, I cannot be clear that it was as explicit as that. What I noted was that there was a complication, a disagreement, between the medical and the nursing staff over the administration of this fluid.

Q. Just in terms of your own personal involvement in this, you, as I understand Mr Fee's evidence, met with him as part of the usual round of commissioning meetings that you had.

A. Yes.

Q. I think he refers to a meeting on 10 May, which was nothing other than one of these usual regular meetings, and he may have addressed the issue of the ongoing review with you. And then, on 12 May, you visited the Erne Hospital to speak to staff who had been involved in the care of Lucy.

A. Yes. This is all from memory. My memory of that encounter was that we took time aside at that meeting to discuss the incident and what Mr Fee was doing and some of the issues around it. Again, being aware of the piece of information that I had that there was a disagreement between the professionals involved over the administration of this fluid and also being aware that the staff had been very traumatised, as it was described to me, by the death of Lucy, I decided to go and have a look at the paediatric unit again and to meet

with whatever staff were there. Now, the staff that were there were mainly day staff rather than staff at night, and I don't, from memory, think any of the staff who had been involved in the situation were present. But I wanted to orientate myself to the layout of that ward. I think, from memory, that I met Sister Traynor, Etain Traynor, and just left myself open for any comments or anything that anybody wanted to talk to me about. I was also, being, I think, very careful about not second-guessing or interfering in any way with the inquiry that would be going on.

Q. Your visit --

MR COUNSELL: I wonder if the witness could be asked to sit a little closer to the microphone. We're struggling to hear him at the back.

THE CHAIRMAN: Of course.

MR WOLFE: The decision to visit the ward, an unusual action on your part. It's not something you would do regularly, I'm sure.

A. Well, if I was involved in the commissioning of a service or in the change in a service, I would quite frequently go into clinical areas and meet with clinicians and discuss issues. So I don't think either Sperrin Lakeland or Altnagelvin would have been surprised at me doing that. I had a tendency and

a desire to do that.

Q. Your decision to visit the ward and to familiarise yourself again with the layout, as you described it, was that in any sense with a view to enabling you to better understand what had happened?

A. I think two things. One, I wanted to be seen to be supporting the staff in the paediatric unit and then, secondly, yes, there was an opportunity to just orientate myself again to what that ward was like. As I say, where the layout -- I think I asked specifically, I think, where Lucy Crawford had been nursed and then left myself open to anybody who wanted to say anything to me.

Q. Were you seeking views as to what might have happened?

A. No, no, I wasn't. I was there primarily to offer support in the best way that I could.

Q. Yes. Could I have up on the screen, please, WS307/1, page 3? This is your witness statement. At the bottom of the page you're asked, at (e), a particular question:

"In circumstances where a Health and Social Services trust notified you or your office of an unexpected and unexplained death, what were your particular responsibilities and where did those derive from?"

And you start by telling us:

"In 2000, the reporting of adverse incidents was not

as well-organised as it is today."

You go on to say, presumably dealing with the situation in 2000:

"If a trust notified me of an unexpected or unexplained death, I would have asked the Trust to explain what action was being taken to investigate the circumstances, and also ask if the coroner had been informed. I would have suggested that the Trust considered making the DHSS aware of the situation if the death was giving cause for concern, could have implications for patient/public safety, or likely to be of public concern. I would also have requested that learning from the death or the circumstances surrounding the death would have been communicated to the board. I would also have shared such information with the director of public health and chief executive. I would have seen this as the responsible approach to take."

Can I take it that the answer that you've given there might be of more general application in the sense that if the director of public health in the Western Board is notified in the way that's premised in the question, that you would expect the director of public health to run through this checklist of items to do?

A. Yes. And if I may say, reading that again, I think

I was answering a very general question at the top.

Q. Let's --

A. I think what --

Q. There's usually a preface to the question. If we can have the full page, please.

A. I'm sorry, I'm talking about question (e).

Q. Indeed.

A. All I'm, I think, trying to point out here is that it would be unusual for a Trust to approach me as the chief nursing officer in the board to tell me all of this. It probably would have been possible for somebody like Mr Fee, who was also a nurse, to ask for or make me aware of an issue and to ask for advice on this. So I just want to be clear about that. I'm not taking over here from the chief executive or from the director of public health.

Q. Yes. Well, as appears from the description of your involvement, you had certain contacts, contact with Mr Mills, contact with Mr Fee, engagement internally with Dr McConnell. Can you help us on this? In terms of your own direct involvement, did you ask Mr Mills or Mr Fee whether the department had been notified?

A. My contact with Mr Mills on this issue was limited. I have memory of having a conversation at some stage, but I cannot remember when. I imagine it must have been

in the early stages of this, of asking Mr Fee will he consider that the department would need to know about this issue.

Q. Could I say Mr Mills has it that it was on Wednesday, 19 April, which was just under a week after the death. But go on, I interrupted you.

A. If you're referring to the meeting Mr Mills had with me in the corridor, that just did not -- this conversation would not have happened there because there would not have been enough detail to make me respond in that way. This is more likely to have been a conversation with Mr Fee on the back of him making me more aware of some of the details of this incident when we met in May.

Q. I'm not saying that you did mention it to the department. I suppose the question is: to the best of your recollection, doing the best you can, do you think you raised that query at any point with the Trust officers who you were meeting?

A. From memory, I raised that issue with Mr Fee, but I cannot remember when. But it would have been in the early -- it would have been in the early stages.

Q. And again, doing the best you can, what answer do you think you got?

A. I don't think I got an answer. It was a comment to him that he would need to consider whether or not this was

an issue that the department would need to be made aware of.

THE CHAIRMAN: Can I ask you: did it appear to you to be very obviously an issue that the department needed to be aware of?

A. I think, given the concern that there was about the death at that level, at the local level -- and I don't want to be misunderstood when I say this -- but also given the potential for publicity sooner rather than later around this, that wouldn't have been the only motivating factor here, it seemed to me to be a wise thing to make the department aware.

MR WOLFE: I suppose the next step on this is whether you took any action to ascertain whether the department was in fact made aware of the death.

A. No, I didn't do that. I probably would have felt that was beyond my remit. I mean, that -- I didn't do it.

Q. Professor Scally, who has looked at these things on our behalf, observes that notwithstanding the absence of direct accountability, he puts it on (a) a professional footing and (b) the fact that you had this responsibility for the local populous that there was arguably an onus on the board and its officers to assure themselves that a report had been made to the department.

A. Yes, I'm not disagreeing with that. I think in my role as chief nursing officer and also in the context probably of where this conversation took place, which was more of a one-to-one personal conversation, I didn't follow that through by checking with the Trust subsequently, "Have you reported this?"
Q. There is an observation made in Dr McConnell's statement that he formed the view, is the best way of putting it, I think, that arising out of what Mr Fee and Mr Mills were saying to them, he thought the death had been reported to the department. Can you help us on that, was that view shared with you?
A. I'm sorry, I can't. I have no recollection of that conversation.
Q. You've told us, I think, so far as the coroner is concerned, it would be one of the things that you should be doing or which the board should be doing is to ask the person reporting to you from the Trust whether the coroner has been informed. Was that an issue that you addressed in any of your contacts with the Trust?
A. Again, in my contact with Mr Fee, I again have a memory of asking, "Has the coroner been informed?", and my memory of the response back was that this was in hand.
Q. It may seem obvious, but how did you interpret that?
A. Well, I interpreted it as it was said, that this was in

hand. I assumed that they were waiting for some further information before they would approach the coroner, but I can't be sure. I can't be sure of ... I mean, that is my memory of the response back. If somebody had said to me, "The coroner has not been informed", then I would have remembered that. It seems to me that that is something then that I probably would have considered a little bit further.
Q. Can the inquiry infer from what you have said that you believed that it was appropriate for the Trust to be in contact with the coroner's office?
A. Well, you know, I'm sure this isn't very helpful to you, but this was intuitive on my part. This was an unexplained death and it did seem to me that it was the sort of death that would have been reported to the coroner. I subsequently have now seen the debate around this and was it Sperrin Lakeland's responsibility or was it RBHSC's responsibility. Those issues would not have occurred to me at that time.
Q. Could I ask you about your internal dealings, in other words with your colleagues in the board, in relation to the death of Lucy Crawford and the report that had been made to you by the Trust? At what level was this being handled within the Trust or within the board, I should say? In whose in-tray did it belong or did it belong in

everybody's in-tray?
A. Well, I've tried to reflect on that. Clearly, the communication came to the chief executive and to the director of public health and then to myself. We were aware that an investigation or review was underway and I think we were all waiting for something to emerge from Sperrin Lakeland in relation to the outcome of that. A report was produced eventually.
I have no memory of ever having received that formally. I do have a memory of Eugene Fee talking to me about it at one stage and I probably -- I'm sure I did see it, but I think it more in the context of within his office. But I have no memory of this report ever coming to the board in any formal way.
Q. I want to come to the delivery of the report just in a little bit. Could I draw your attention to an e-mail? WS308/1, page 94. This is an attachment to Mr Frawley's statement. The e-mail is coming from Carol Mooney, who is Mr Frawley's PA, is that correct, or was?
A. Yes.
Q. And it's to yourself and Bill McConnell:
"I am aware from brief conversations that you have received some background on the above from Hugh Mills. I think it is important that we get some definitive advice and I would be grateful if you could keep me

apprised. Many thanks."
So the chief executive or the general manager, Mr Frawley, is, if you like, coming across this issue now and he's writing out to his professional leads, yourself and Dr McConnell. How did you react to this? Did you take any steps to address this?
A. No, well, again, on reflection, I would have seen this in the context of an ongoing intermittent discussion with Bill McConnell and myself around how this was being progressed and what information, if any, we had at a particular moment in time. I would have seen this e-mail as being a marker for the fact that we would need, at some stage, to see the outcome of the review of this incident and then have a discussion around the outcome of that and any recommendations that there might have been. I wasn't picking up from this that there was a particular issue that now needed to be addressed with the Trust at that point in time.
Q. What did he mean or how did you interpret his use of the phrase "definitive advice"?
A. I'm truly not sure what that would have meant. It's obvious that he's had a conversation with somebody and we've received some background on the above from Hugh Mills. The only background I would have had from Hugh Mills was this conversation in the corridor. So

I'm not too sure really what was meant by this.
Q. I think you said a moment or two ago that, within the board, the position had been adopted that: we know that there's a review underway and I suppose we're waiting on the report coming in; is that an accurate description of the state of mind of those within the board who had been apprised of this case?
A. Yes, I think on 8 May 2000 that would have been the state of play, I would have thought.
Q. You have just said a moment or two ago that you have no personal recollections of receiving the report.
A. That's right. Receiving the report formally, yes.
Q. Yes.
THE CHAIRMAN: You thought you must have seen it at some point and you maybe saw it in Mr Fee's office?
A. Yes.
MR WOLFE: That suggests that it wasn't sent to you formally; is that your evidence?
A. Yes.
Q. In terms of the Western Board itself, as I've said to you earlier, Mr Frawley has explained what he saw as the next stage of the process once a report comes in arising out of a review. And to summarise, he says:
"[He] would speak to his professional leads to ascertain whether the report and its conclusions and

recommendations was a proportionate response to the incident."
Do you recall any attempt on the part of the boards -- that is the Western Board's general manager or anyone else within that board -- to bring you together as a group to work through the report and to make a judgment upon it?
A. I have no memory of there being an occasion when this report was officially received by the board. I've reflected on this and I don't know where we were, what we were thinking of. I just don't have any memory of that at all. I do have a memory of at some stage discussing with Bill McConnell some of the issues that were arising out of this report. That must have been on the basis of me having seen a copy of it at some stage, which I think was probably in Mr Fee's office, and I'm assuming Bill McConnell must have similarly seen the document. But I have no memory of us coming together as a corporate group within the board and having the document there in front of us. Now, I stand to be corrected, but that is my memory of this.
Q. I think, if I can interject, you're certainly right in what you imply, that certainly this inquiry has received no document or record, either from yourselves, that is the board, or from the Trust, to indicate that the

report was formally sent to the board and, for that matter, there is no record to indicate that the report was formally discussed or even informally discussed within the board. When you think back on it, professor, at least with regard to the board, did this report fall between the cracks?
A. Well, I think my observations are, first of all, I think it's quite extraordinary that here we have a Trust that seems to document and record everything and one of the most important elements of this would have been the end report and you would have thought we would have got that with a letter, saying, "This is it and these are the recommendations". On reflection -- and these are personal reflections and again I stand to be corrected in all of this, but my perception is that there never seemed to be an end to this inquiry in Sperrin Lakeland. They ended up with a report, which we've seen in the background papers for this inquiry, there were issues within that, which I certainly was picking up on in relation to the administration of medication or the administration of IV fluids and record keeping, which I subsequently discussed with other directors of nursing, about the need to sharpen up our record keeping and if there was any issues in relation to education and training around the IV fluids, that those would need to

be addressed.
But when I look now with hindsight at the whole thing, it seems to me that the Trust itself must have been thinking on the outcome of this review because, as far as I can see, within six to eight weeks, they were engaging with the Royal College of Paediatrics and Healthcare [sic] to take on a review of Dr O'Donohoe's practice.
And again, from my memory of the report and its recommendations, it did seem to me that maybe we became too focused on the whole element of professional practice and the errors that there may have been in both the prescription and the administration of IV fluids. I'm saying that because I think that if anybody was looking to learn something about the actual fluid that was being administered, we went off in a different direction, and I think the issue, I'm assuming, became much more of an issue around professional competence and maybe possibly disciplinary action of some kind.
Q. Yes.
A. So that's my only rationalisation as to why there never seemed to be a conclusion to all of this.
Q. Yes, but could I make this observation to you, professor: the board was clearly aware that a review was in train, its officers had reached a decision that

they would await the outcome of this review before taking any action or reaching any further decision in relation to it, but there seems to have been a failure to recognise that this report had not arrived with the board as a corporation to then be discussed by the board. That just seems not to have happened; is that fair?

A. I think that's fair, yes.

Q. And of course, given your professional obligations and your obligations to the local populous, that was a significant omission.

A. It does seem extraordinary, I have to say, that we didn't get ourselves to a point where we would have had a more open debate about that. Now, I, at some stage, was aware of the recommendations in the report that we've seen and began to deal with those in my own capacity as chief nursing officer.

Q. I'm going to bring you to those in just a moment. In fairness to you, we'll deal with those in some detail.

But just on this, Dr McConnell has observed to the inquiry -- and I ask you this because I think you've just told us that yourself and Dr McConnell, possibly arising out of the communication of the report to you from Mr Fee, had a conversation. So yourself and Dr McConnell are conversing about the report. What

Dr McConnell has told us is that any review of a medical event such as this needs to have credibility in the eyes of the public, in the eyes of the family. He tells us that he expressed his reservations to Mr Mills about the fact that there might well be a perception that Dr Quinn, who had been retained to carry out a case note review for the Trust, and that perception of a lack of independence or perhaps perception of bias would have arisen, in Dr McConnell's view, from the fact that Dr Quinn had had, if you like, a relationship with the organisation with which he was charged with investigating or reviewing. Was that expression of concern ever made known to you?

A. From memory, that concern wasn't articulated in that way. Again, I have a memory of a conversation or conversations around elements of the adequacy of this report, which I am never totally sure came to any real conclusion other than more work needed to be done. And I think from what I've seen and in relation to the background evidence that I've been party to now, it seems to me that Dr McConnell probably was more aware of some of the background to this than I was.

I've been listening to Dr Stewart this morning and I've seen the papers or the reports that have been produced, all of that is new to me in relation to the

amount of detail that there is there. That would explain, I think, the ongoing engagement with the Royal College of Paediatricians, which, on reflection, seems to be a way of trying to progress that report from where it was.

Q. Can I just come in on that? I don't intend cutting you short. It's the end piece of Dr McConnell's analysis, by reference to concerns about the perception of a lack of independence in the person of Dr Quinn, that he was of the view that a broader report or broader review should be carried out. But equally, there might have been another reason for a broader review to be carried out, and that was the fact that the review report commissioned by the Trust had not led to any firm conclusions about why this child had died. Did you pick up on that when you were shown the report or the report was discussed with you?

A. I don't think I was picking up on the independence of Dr Quinn.

Q. It's the second point I'm asking you to focus on, whether the absence of conclusiveness was -- did it bear upon you as a reason for going down the route of conducting a broader review?

A. Yes, I would have been concerned about the fact that we weren't really coming to any conclusions. Even the

fact of the mistakes, as I would see, human factors again in relation to the prescription of the fluids and the administration of those fluids and the confusion around all of that, was a matter for some more investigation, which I didn't really see there.

Q. You were aware, as you've told us, that the Royal College had been engaged quite quickly after this review was produced. As you would have heard from Dr Stewart's evidence this morning -- and I think you said you heard it -- she had it in mind -- and indeed her terms of reference said so -- that she was conducting a performance and competence review, as opposed to engaging in a medical report process. Were you aware that that was the distinction in the review that was being taken forward after this first review?

A. My knowledge of this review is very limited. I don't think I was engaged in any real discussions at board level around that review. But it would have been reasonable in my state of mind at the time where I was really, I think, focusing on the competence of the medical staff and the nursing staff in the management of this case, so a review around competence would have seemed to me at that time as being a logical step forward.

THE CHAIRMAN: And it would be particularly important for

you, wouldn't it, because you're a director of the body which commissions services from this Trust? So if it is the case that a consultant in the Trust is not competent to provide those services, that is something that the Western Board would be very, very interested in?

A. Yes.

THE CHAIRMAN: And in fact, you would want, at the Western Board, to be reassured that the outcome of the competency review is that the consultant is actually competent or, if he isn't, if he's got weaknesses or gaps in his knowledge, that some training or support is going to be put in place to make sure that his imperfections do not put local children at risk?

A. Yes, I agree.

THE CHAIRMAN: Right.

MR WOLFE: That's the competence issue and we have your evidence on that. But should the board have been seeking assurances from the Trust that with regard to the clinical outcome for this child that further work would be done by it in order to get, if you like, to the bottom of what had happened?

A. Yes -- I mean, that, of course, is a reasonable approach to take. From my own personal point of view, I think I became distracted by what I would have perceived to be the competency issues, regretfully, but I did become

distracted by that. If I may say so, there is a logic that if you can get to the bottom of the competency issues, you might also get to the bottom of what exactly happened here in relation to the death of Lucy.

THE CHAIRMAN: Did you ever get the reassurance about competence?

A. I personally don't think I did, really.

THE CHAIRMAN: Okay. Do you know of anybody in the Western Board who got reassurance about competence?

A. I'm assuming that Dr McConnell did.

THE CHAIRMAN: Do you know if he saw Dr Stewart's reports?

A. I don't know.

THE CHAIRMAN: Did you see Dr Stewart's reports?

A. No.

MR WOLFE: I promised to go back to the steps that you did take and if we could just have up on the screen, as an aide memoire for you, what you said in your witness statement. It's WS307/1 at page 11. We asked you at 23:

"Did you give any consideration to whether any of the issues arising out of Lucy Crawford's case warranted dissemination to a wider audience in the NHS in Northern Ireland? If so, explain the consideration you gave to this matter, the conclusions which you reached and any action that you took."

Just before we get into the steps that you took, question 22, I think, it's helpful perhaps to start there. You are asked to:

"Outline the criteria or factors which you would have taken into account when determining whether issues identified as a result of a critical incident needed to be disseminated to others in the NHS in Northern Ireland."

And really, it's a professional judgment call and what you've explained is you would need to work out:

"... whether the incident was unique or likely to occur again, particularly if there were conditions within the clinical environment which might lead to a recurrence."

So if you like, that's the test. And you say that among local directors of nursing, you brought up a number of points. Is that, professor, because, if you like, the test had been met? There were issues emerging from your understanding of what had happened in the case of Lucy Crawford, which were of sufficient either uniqueness or held the characteristic that they could recur again that caused you to bring them forward to a wider audience?

A. Initially, I was bringing those forward to the local directors of nursing. Those would be the directors of

nursing within the Western Trust. And then I did raise the issues with my other colleagues in the other three area boards as a matter of information. These issues, however, are not unique in the sense that if you look at things that go wrong in healthcare, I'm afraid -- with the exception maybe of the final indent -- maintaining accurate clinical records, fluid balance and ensuring accuracy in administration of intravenous fluids and making sure that prescriptions are not ambiguous, all of those are recurring themes right up to today. Even as we speak, the National Clinical Standards Authority in England are consulting on the same administration of intravenous fluids because it still remains an ongoing issue for us.

Q. Yes.

A. In relation to the need for maintaining good observations of a sick child and being aware of the early signs of deterioration, the first part of that in relation to good observations is obviously again something that we continue to struggle with and make sure that that happens as and when it is required.

I think the issue with Lucy Crawford was the apparent suddenness of her deterioration, and I think just being aware of the need to be really, really aware of such deterioration in a young child, which can

actually happen very quickly.
Q. You say you addressed these issues in the first instance with local directors, that's the directors within the Western Board?
A. Yes.
Q. Is that Mr Fee, his counterpart in --
A. It would be Mr Fee -- Irene Duddy, from memory in Altnagelvin, and Phil Mahon in Foyle Trust, although it would have been of maybe less concern to her since it was primarily a community trust.
Q. And what was the mechanism for bringing this information or these lessons learned to their attention?
A. I would have had regular meetings with the directors of nursing, usually every five to six weeks, and it would have been at one of those meetings that I would have outlined these issues. I didn't put them in a letter to them, which in retrospect maybe I should have thought of doing so. But none of this is new. I mean, this is really old lessons having to be learned again and again.
Q. You say you didn't put it in a letter, and therefore no document exists?
A. No.
Q. But can I pick up on one thing? The inquiry made a call for documentation from all of the relevant participants as far back as 2005, I believe it was, and in terms of

what we received from the Western Board, we received documentation which, broadly speaking, related to events that occurred after the inquest in 2004, but save the e-mail which I referred you to issued by Mr Frawley to yourself and Dr McConnell, I think it's safe to say that we haven't received a jot of documentation arising from the period when you first were notified of the death in April 2000 all the way through to the point at which the inquest concluded, three years later. You presumably would have made some records, professor, in terms of your dealings with various people from time to time during that early period?
A. To be honest, I mean, I think in relation to this issue, I have no records at all, and I think that also reflects the fact that we seem to have been waiting for events to emerge, which does -- took an inordinate length of time. I can't explain that.
Q. Could I ask you finally -- and it's rather a hypothetical question -- but if it had been recognised by the Sperrin Lakeland Trust during their review into Lucy's death in April, May and June 2000 that the approach to replacement fluid therapy which, to their eyes, involved using Solution No. 18, a low-sodium fluid, if that had been recognised as being an erroneous practice, which was regarded as a normal practice

because that's what the report said nursing staff had concluded, so if that had been recognised as being a widespread but erroneous practice within that Trust, is that something that the Western Board would have been interested in addressing?
A. Absolutely. It would be a matter for immediate escalation to the system generally that this was an inherent danger that was unrecognised. And belatedly, after the death of Raychel Ferguson, you can see that those issues were escalated at that time. So, yes is the answer to that.
Q. And would the Western Board, seized of that information that I've outlined hypothetically, you will understand, would, as I understand your previous answers, have provided a forum or a vehicle to get that message out, not only within its local area but more broadly?
A. Yes. I mean, you know, that would have been a matter for a phone call to the chief medical officer.
MR WOLFE: I have no more questions.
THE CHAIRMAN: Can I just check with you one thing? Was there any local publicity immediately after Lucy died that you can remember?
A. I can't remember.
THE CHAIRMAN: I'm not sure that we've ever heard about any, and of course, with hindsight, it would have been far

better if there was.
Any questions from the floor before I come to Mr Lockhart? No? Mr Lockhart?
MR LOCKHART: No, thank you.
THE CHAIRMAN: Professor, thank you very much for coming. We're grateful to you and to the other Western Board witnesses who we'll hear over the next day or two.
You don't have to say anything more, but I'm giving you this opportunity to add anything if there is something that you haven't had the chance to say already.
A. Well, chairman, I suppose really all I'd like to say is that clearly this wasn't our finest hour in relation to how elements of this were dealt with. I don't want to overplay this, but I do think there was a range of human factors involved here, as there are with many serious adverse incidents, and I'm conscious that nothing that I can say is going to bring Lucy Crawford or Raychel Ferguson back again, but I'm sincerely sorry if there's been anything in relation to our practice or omissions that may have contributed to this situation, but I hope we have all learned from this.
THE CHAIRMAN: Thank you very much, professor.
(The witness withdrew)
Ladies and gentlemen, 10 o'clock tomorrow morning.

(4.07 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X