1 Tuesday, 18 June 2013
2 (10.00 am)
3 (Delay in proceedings)
4 (10.11 am)
5 THE CHAIRMAN: Good morning. Mr Wolfe?
6 MR WOLFE: Good morning, sir. The next witness is
7 Dr Moira Stewart.
8 DR MOIRA STEWART (called)
9 Questions from MR WOLFE
10 MR WOLFE: Good morning, doctor. The first thing I want to
11 ask you about this morning is in relation to your
12 contribution to the inquiry to date. You've provided
13 the inquiry with three witness statements; isn't that
14 correct?
15 A. That's correct.
16 Q. They are numbered 298/1, 298/2 and 298/3, and dated
17 19 November 2012, 18 January 2013 and 21 March 2013
18 respectively; isn't that right?
19 A. That's correct.
20 Q. We ask witnesses who come along whether they wish to
21 adopt their written evidence and to be read and
22 supplemented by what they say today in evidence before
23 the inquiry. Would you like to adopt your witness
24 statements?
25 A. Yes.

1 Q. In addition to your witness statements, you have
2 recently and helpfully provided us with an updated CV.
3 If we could have that up on the screen, please.
4 315-023-001. The first thing to note, doctor, are your
5 current appointments, which we see at the bottom of that
6 page. You're a senior lecturer in child health at the
7 Queen's University of Belfast and a consultant
8 paediatrician in the Belfast Trust.
9 A. I have retired from Queen's at the end of March this
10 year. I continue my five NHS sessions under
11 Belfast Trust.
12 THE CHAIRMAN: Thank you.
13 MR WOLFE: We note on this page your qualifications. You
14 graduated with a medical degree in 1977, you obtained --
15 is that a diploma in child health?
16 A. That's correct.
17 Q. In 1981 from Dublin. A member of the Royal College of
18 -- is that Physicians?
19 A. Yes.
20 Q. In 1982. Is that a fellow of the Royal College of
21 Physicians then?
22 A. That's correct.
23 Q. In July 1994. A fellow of the Royal College of
24 Paediatrics and Child Health in 1996. And then working
25 back, I think, ten years to 1986, you obtained

1 a doctorate in medicine?
2 A. That's right.
3 Q. From the Queen's University of Belfast?
4 A. Yes.
5 Q. If we could just go over the page, please, that
6 helpfully lists all of your various posts through your
7 career. It appears from a reading of that that having
8 gone through the normal rotations of a trainee doctor,
9 you began to specialise in paediatrics in the early
10 1980s; is that fair?
11 A. I actually did my first job as an SHO in paediatrics in
12 1979, 1 February 1979, through to July 1979.
13 Q. And that was followed by an SHO in medicine and then
14 everything after that has been in the paediatric field?
15 A. That's right, yes.
16 Q. If we could just go over the page, please, to 003.
17 Leading to your appointment as consultant paediatrician
18 in July 1990, and that's a post that you have held, no
19 doubt with changes along the way, but it's a post that
20 you've held until the present day?
21 A. Yes, until the end of March this year, when I retired
22 from the Queen's half of the job and continue in my NHS
23 post.
24 Q. So in understanding that post, it was very much -- there
25 was a clinical -- I hesitate to say clinical half of it,

1 but a clinical part of it and an academic part of it;
2 is that fair?
3 A. Yes. I've always had five sessions of clinical work --
4 in fact more than five sessions because of commitments
5 to the on-call rota, weekend working, so there was
6 actually more clinical work than there was academic
7 work.
8 Q. You describe at the bottom of the page a little bit
9 about the consultant post that you held. You've
10 described it as:
11 "The first consultant community paediatrics post
12 in the island of Ireland."
13 Is that correct?
14 A. That's correct.
15 THE CHAIRMAN: Dr Steen gave evidence in Claire's case and
16 she was working outside the Children's Hospital in
17 Cupar Street. Is that something similar to what you
18 were doing as a community paediatrician?
19 A. Yes. I actually obtained my accreditation as a general
20 paediatrician, but our professor of paediatrics at that
21 time was very keen that we begin to develop community
22 paediatrics as a sub-specialty within Northern Ireland,
23 so I did additional training in community paediatrics
24 and then came back to this post. But I've always worked
25 across community and acute services, and then the other

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

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

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

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

1 needs. Could I bring you to something you've said in
2 your witness statement? If we could have up on the
3 screen, please, WS298/1, at page 8, and have alongside
4 that page 9.
5 At the bottom of the page, Dr Stewart, question 11,
6 if I could take you there on the left-hand side, is
7 raising with you a series of enquiries with regard to
8 the appropriate fluid regime for Lucy. At question (c)
9 we ask:
10 "Was it appropriate to treat Lucy with
11 Solution No. 18 at a rate of 100 ml per hour between
12 10.30 pm and 3 am?"
13 And we ask you to fully explain your view and
14 specify the rate, type and volume of fluids which Lucy
15 should have received during that period. And we have
16 your answer at the top of the page. You introduce your
17 answer by saying:
18 "This was a clumsy attempt to reconcile volume of
19 fluids received."
20 Can I leave that just for the moment? That is you,
21 I think, going back to something you said in your report
22 to the Trust, and you were attempting to explain how you
23 had expressed yourself in that way. But what I want to
24 come to is the next bit, which is the direct answer to
25 the question. If I could take up with:

1 "Solution No. 18 would have been an inappropriate
2 solution according to accepted practice at this time."
3 Could I just stop there? Was that because Lucy was
4 a child with a background of gastroenteritis, who,
5 properly assessed, should have been identified as having
6 moderate dehydration?
7 A. Yes. I always find it difficult to interpret symptoms
8 and signs without actually seeing a child, but my
9 impression from the notes -- and the notes were very
10 poorly documented -- was this was a little girl who was
11 really quite ill whenever she was admitted. And
12 certainly nowadays, it's almost certain that she should
13 have been given an initial bolus of normal saline, 20 ml
14 per kilo, and that would have been really taken as
15 initial resuscitation fluid to try and restore
16 circulating blood volume. And then thereafter, the
17 calculations move into maintenance fluid and into
18 rehydration fluid.
19 Q. Yes.
20 A. At that time, Solution No. 18 was still the solution
21 that was in general use, not just in
22 Children's Hospital, but also across the UK as
23 maintenance fluid for children, but it was really
24 the ... I felt she was really quite sick whenever she
25 came into hospital and that she needed a bolus of normal

1 saline at that time.
2 Q. Yes, and you helpfully say in your answer, if I can
3 underline the phrase, "the accepted practice at that
4 time", so you're saying because of her condition, she
5 was really quite ill, she was dehydrated --
6 A. Yes.
7 Q. -- Solution No. 18 would have been an inappropriate
8 solution by reference to the practice of the time, and
9 then you go on to tell us what she should have received
10 according to you. That is:
11 "Initial treatment with a bolus of normal saline
12 given over a short period of time."
13 So that would have been, what, over a period of 20
14 to 30 minutes?
15 A. Whenever you give it, you give it as quickly as you can.
16 Q. You push it in?
17 A. You push it in, so it's given as quickly as you can,
18 which usually means in practice about 20 minutes.
19 Q. And as I say, the 20 ml per kilogram would have been, in
20 round numbers, for 200 ml, although to do it precisely
21 would have been a little over 9 kilograms multiplied by
22 20.
23 A. Mm-hm, yes.
24 Q. And then, having achieved that -- and the purpose of
25 that, doctor, was to address imminent or actual

1 circulatory shock?
2 A. Yes, imminent. She wasn't in established shock, but
3 certainly from the information I had, I felt that she
4 was in imminent circulatory shock.
5 Q. And then having treated the shock issue, you move on to
6 the next stage, which is to work out the degree of
7 dehydration and select the appropriate fluid for that.
8 That's when we talk about replacement fluids; isn't that
9 right?
10 A. That's correct, yes.
11 Q. And we realise, I think, that because you weren't
12 treating the child, didn't see the child, you're having
13 to make your best assessment of the degree of
14 dehydration; is that fair?
15 A. That's correct.
16 Q. And the inquiry knows that the various doctors who have
17 looked at this have come up with different figures.
18 I think Dr Sumner, when he looked at it, may have
19 considered that she was not in moderate dehydration,
20 other doctors share your view. But you've plumped, if
21 that's not too unkind a word, for 7.5 per cent bearing
22 in mind all the information. The important thing is the
23 type of fluid. Can you help us with that? You have
24 said normal saline.
25 A. Yes. I very much referred to the Advanced Paediatric

1 Life Support guidelines on fluid management, but even
2 without those guidelines, as a paediatrician I know that
3 if you're replacing losses, you do it with normal
4 saline, certainly a solution that is a much higher
5 sodium concentration than Solution No. 18.
6 Q. I'm going to bring you to the APLS guidelines just now.
7 Then, of course, a child -- or any patient, I suppose --
8 requires fluids for ongoing or, if you like, normal
9 losses, and that's when maintenance fluids are
10 necessary. So you refer to that in your answer as well.
11 And by the standards of the time in the management of
12 the maintenance needs of a child, Solution No. 18 would
13 have been accepted practice; is that fair?
14 A. It was, it was still accepted practice in the early
15 2000s.
16 Q. You've referred to the APLS guidelines. You were an
17 instructor on the APLS course.
18 A. That's correct.
19 Q. Can you help us a little just with a bit of background?
20 APLS is what? Presumably it's not just focused on the
21 fluid needs of children.
22 A. No. Advanced Paediatric Life Support is a three-day
23 course. It started running in Northern Ireland in
24 really the early to mid-1990s. By that stage, we
25 expected all our trainee paediatricians to have become

1 certified in APLS before they got to registrar or middle
2 grade standard.
3 APLS covers a whole range of assessment and
4 management strategies for acutely-ill children, right
5 through from medical emergencies to trauma, surgery,
6 burns, poisoning. And because we expected our juniors
7 to be certified in APLS, I felt that I also should do
8 the course. It wasn't in existence at the time that
9 I was training, but I felt that if we expected the
10 juniors to be certified, then I should also be
11 certified.
12 Then, depending on how you get on in the course,
13 then some people are invited to become instructors and
14 do a further instructor's course, which I did, and then
15 I taught. You have to teach on -- I think it was
16 a minimum of two courses a year in order to keep up your
17 accreditation. So I continued to do that through to the
18 mid-2000s.
19 Q. I think you've said in your CV you did it over the
20 period 1999 to 2006.
21 A. Yes.
22 Q. So what you're telling us is that you did the course as
23 a participant, you then took on the role of instructor,
24 and as I understand it from your CV, when you are an
25 instructor you have to do an instructor's course to

1 equip you to deliver the course?
2 A. Yes, that's right.
3 Q. We can pull it up on the screen. There was an APLS
4 second edition. There was manual; isn't that right?
5 A. Yes.
6 Q. Would that have been on the shelf of most paediatric
7 units or how would practitioners access the manual?
8 A. Well, everybody who does the course at that time got
9 a hard copy of the manual, which is the one I worked
10 from whenever I was checking the guidelines on fluids.
11 I'm not sure that otherwise there would have been a copy
12 of the guidelines in each ward. I don't think so.
13 There may have been in intensive care, I can't remember.
14 Q. Okay.
15 A. But most of us had our own copy.
16 Q. Would paediatric consultants be expected to be
17 knowledgable as to the contents of the APLS manual?
18 A. I think all consultants would have known about APLS.
19 Not all consultants would have decided to do the course.
20 Q. Yes. Could we take a look then at --
21 THE CHAIRMAN: Sorry. But that means the manual is more
22 likely to be found in the children's ward in the RBHSC
23 than it is in Craigavon or Daisy Hill or the Erne, does
24 it?
25 A. I don't think that's the case. There were just as many

1 instructors from outside Belfast as there were -- in
2 fact, I think there were more instructors in
3 Northern Ireland who were outside Belfast than within
4 Belfast.
5 THE CHAIRMAN: Thank you.
6 MR WOLFE: Could we have up on the screen, please,
7 250-004-037? You may be familiar with it, doctor, but
8 what I've got up on the screen here is the section of
9 the APLS manual from 1997/98. It's referred to by
10 Dr MacFaul as the second edition, and the pages that
11 we're going to look at concern the management of
12 dehydration.
13 There is a description here of dehydration, it tells
14 us that it is:
15 "The result of abnormal fluid losses from the body
16 which are greater than the amount for which the kidneys
17 can compensate. The natural mechanisms for compensation
18 have the primary aim of maintaining concentrating volume
19 and blood pressure at all cost. Thus the majority of
20 patients with dehydration maintain their central
21 circulation satisfactorily. Loss of central circulatory
22 homoeostasis constitutes hypovolemic shock and is dealt
23 with [in another part of the manual]."
24 But it was your concern in Lucy's case, or at least
25 it was your interpretation of the data that was

1 available to you, limited though you say it was, that
2 she was at risk or at danger of developing this kind of
3 shock?
4 A. Mm-hm.
5 Q. And it's for that reason that you, in the answer
6 I looked at with you earlier, were suggesting a bolus of
7 normal saline. It goes on to say:
8 "The major causes of dehydration in children are
9 gastrointestinal disorders and diabetic ketoacidosis."
10 Lucy's background, it seemed, was of
11 a gastrointestinal disorder, isn't that right? And the
12 manual goes on then in this paragraph to say:
13 "Depending on the source of fluid losses and the
14 quantities of electrolytes lost [and it refers back to
15 table B3] dehydration can be divided into three types."
16 And it refers to, if we go over the page:
17 "Isotonic dehydration, hyponatraemic dehydration or
18 hypernatraemic dehydration."
19 I'm not sure we need to concern ourselves with the
20 minutiae of that, but it goes on to say:
21 "In all three types, there is usually a total body
22 deficit of salt and water."
23 Can you help us, doctor, with this: is it by reason
24 of the fact that there is a total body deficit of salt
25 and water that the need in terms of replacement fluids

1 is to move in the direction of selecting a type of fluid
2 which has a relatively high sodium content?
3 A. Sorry, I don't quite follow the question.
4 Q. Is the problem that you're trying to correct, in
5 a dehydration situation, the loss of salt and water?
6 A. Usually it's a combination of salt and water.
7 Q. And in terms of the appropriate fluid for replacement
8 purposes, given the nature of the problem, that is why
9 a fluid that's relatively high in sodium is selected?
10 A. Yes. If you have a child who is becoming dehydrated
11 because of ongoing losses such as diarrhoea and
12 vomiting, usually those losses are relatively high in
13 sodium and, in that case, you would be replacing with
14 a fluid which was relatively high in sodium. Now, you
15 do see the other situation where children become
16 dehydrated simply because they're unwell and not
17 drinking with no ongoing losses. Sometimes in those
18 children, the sodium is actually too high. Now, again,
19 that's a very specific circumstance and we're all very
20 aware and we were all taught in great detail about this
21 as students about the dangers of hypernatraemic
22 dehydration and the need to bring down sodium very
23 slowly in that situation. But certainly dehydration can
24 be associated with low sodium or with high sodium or
25 with normal sodium, and the fluids have to be tailored

1 to take account of that.
2 Q. Yes.
3 THE CHAIRMAN: In Lucy's case, her initial sodium reading on
4 admission was 137, so although she was dehydrated to
5 some extent, her sodium reading was not particularly
6 a cause of concern, was it?
7 A. I think ... I mean, my interpretation of Lucy is that
8 she had gastroenteritis, but she also hadn't been eating
9 or drinking for four or five days, which may be why her
10 sodium was relatively well maintained, even though she
11 was -- in my opinion she was clinically dehydrated with
12 signs of imminent shock.
13 THE CHAIRMAN: Okay, thank you.
14 MR WOLFE: So notwithstanding the normal electrolyte results
15 that emerged from testing at the point of admission to
16 the hospital, you would nevertheless select in her case
17 a fluid for replacement which was relatively high in
18 sodium?
19 A. The initial resuscitation fluid would still be isotonic
20 normal saline unless you got a U&E back which showed
21 that her sodium was high. In that case, you would still
22 probably -- I think I may be going too far here, but
23 you'd probably still use an intravenous solution like
24 normal saline, but you would do it very, very slowly.
25 THE CHAIRMAN: And when you say unless her reading was high,

1 a high reading would be, what, 140 plus or even higher?
2 A. Whenever I'm talking about high, I'd be talking about
3 150/160, that sort of level, and then you'd take it
4 very, very slowly.
5 MR WOLFE: I think that point is dealt with over the page in
6 the manual and we'll come to that in a moment. Just
7 looking to the section on down the page in front of you,
8 "Management of dehydration":
9 "Mild dehydration can usually be managed with oral
10 rehydration if vomiting is not a major problem."
11 But of course, you have, if you like, put Lucy into
12 the moderate-to-severe category, so we'll turn to that.
13 The manual tells the practitioner that:
14 "Moderate and severe dehydration will require more
15 accurate replacement of fluid loss and although oral
16 rehydration may sometimes be possible, intravenous
17 therapy may be needed."
18 There's then an example given of how you work out or
19 approach the calculation for dehydration. So the first
20 question is how much fluid will the child need for
21 rehydration and what sodium concentration will be
22 required? And then a step-by-step approach is set out
23 for the practitioner. So step 1:
24 "What is the fluid deficit?"
25 And in Lucy's case, the appropriate calculation

1 would have been, if she was 7.5 per cent, her weight
2 multiplied by 7.5 multiplied by 10; is that correct?
3 A. Mm-hm.
4 Q. And then if we go over the page, please, to 039. That's
5 the formula that I have just rehearsed. It goes on to
6 say in that case:
7 "Thus the fluid deficit ..."
8 It's almost a like-for-like example comparison with
9 Lucy, albeit her weight is a little lower, a kilogram
10 lower. Let's assume for the sake of argument is
11 10 kilograms. It goes on:
12 "Thus the fluid deficit is 750 ml. The fluid
13 deficit is essentially made up from roughly 0.9 per cent
14 saline."
15 It uses the words "made up". Is that to be
16 interpreted as: this is what you do to make up the fluid
17 deficit?
18 A. That's my interpretation of it, yes.
19 Q. So you make up or you replace the fluid deficit from
20 roughly 0.9 per cent saline?
21 A. Mm-hm.
22 Q. "Since it is mainly extracellular fluid that has been
23 lost, which has a sodium concentration of approximately
24 140 millimoles."
25 It goes on to say:

1 "Step 2. The child also has maintenance fluid
2 needs."
3 And we discussed that a little earlier. Then in
4 terms of the practice of how you would approach and
5 manage a child who has both these replacement needs and
6 maintenance needs and, as the doctors found in Lucy's
7 case, it's not always easy to fix intravenous drips to
8 children, and the suggestion here is that rather than
9 have two drips, it's possible to select a fluid that
10 finds a middle ground. That was the teaching at the
11 time, that you might select half normal saline as, if
12 you like, a compromise --
13 A. Mm-hm.
14 Q. -- or as an approach which marries both the maintenance
15 and the replacement needs. Could I ask you, doctor, in
16 your approach to Lucy's case -- and we'll come to look
17 at your report in a moment -- did you have this kind of
18 teaching or instruction in mind?
19 A. Yes, very much so.
20 Q. The teaching or instruction that's contained within this
21 is replicated in other paediatric literature of the
22 time; isn't that right? You would be familiar with the
23 publication, Forfar & Arneil?
24 A. Mm-hm.
25 Q. It, in its description, illustrates a very similar

1 approach. Could I just ask you to look at the sentence
2 beginning:
3 "In patients with a low or normal sodium ..."
4 Do you see that? The first sentence of that
5 paragraph:
6 "In patients with a low or normal sodium [which was
7 of course Lucy's case upon admission] lost fluid can be
8 replaced over 24 hours."
9 Can you help with us that? First of all, what does
10 that mean in terms of the type of fluid?
11 A. What it means is that you'd calculate the maintenance
12 fluids for the child based on weight, and each day the
13 child would get that amount of maintenance fluid. At
14 that time, if you had a child, as it says, with low or
15 normal sodium, the deficit in this case -- my estimate
16 was about 750 ml -- that could be added to the
17 maintenance fluid during the first 24 hours.
18 Nowadays -- and just recently, the guidelines are
19 changing in that that deficit, even for children with
20 low or normal saline, there would be a slower correction
21 of the rehydration. But at that time, the teaching was
22 that all that deficit could be added on to the
23 maintenance in the first 24 hours.
24 Q. Could I just briefly refer you to a passage from
25 Forfar & Arneil, please? It's 250-004-047. This is the

1 section of Forfar & Arneil that is dealing with
2 gastroenteritis. You can see at the bottom left hand
3 paragraph under the heading "Treatment":
4 "Prevention of infantile gastroenteritis ..."
5 So that's the area we're dealing with. It goes on
6 then to say, if we look over the right-hand side:
7 "Moderate or severe cases. When the dehydration is
8 moderate or severe, the infant should be hospitalised as
9 parenteral fluid therapy will be necessary. Fluids
10 should be given intravenously."
11 The point I want then to turn to is this:
12 "There are three main aspects of fluid therapy in
13 infantile gastroenteritis, namely the type of repair
14 fluid, the amount, and the rate at which it is
15 administered. There are many regimes in use, but
16 there's little substantial difference between them."
17 It says:
18 "The following regime is simple and has been used
19 for many years and found to be satisfactory."
20 It's this reference to the regime, which is then
21 described, which mirrors what is said in the APLS
22 manual. It's this point about the regime or this
23 approach being in place for many years, the approach
24 being you assess the degree of dehydration, and if
25 there's shock, you correct the shock, and then you move

1 to replacement and maintenance, selecting, if
2 appropriate, a high-sodium solution for replacement.
3 In terms of this approach being in place for many
4 years, over your career, was this the approach that was
5 in place?
6 A. I think what has changed over the years is that we are
7 more --
8 Q. If we could take it up, first of all, up to the year
9 2000, first of all.
10 A. Okay. I think up until then or -- no, it was before
11 then, but certainly at the time that I was training and
12 up until I became a consultant, there was much less
13 aggressive approach to management of fluids. So in
14 other words, we would not have been as quick to commence
15 children on intravenous fluids and we would not have
16 given such large quantities of fluid. We now use
17 boluses of fluid, boluses of resuscitation, much more
18 commonly in sick children than we did whenever I was
19 a junior doctor.
20 I think we tried very hard to use oral replacement
21 therapy, particularly for children with gastroenteritis.
22 I think the trend has now moved to introducing
23 intravenous fluids at an earlier stage.
24 THE CHAIRMAN: By the time you get to 2000, had you moved on
25 from that? I think you described that as your training

1 years and your early years, fewer boluses and less fluid
2 by IV. By the time you got to the late 1990s, around
3 2000, had the era of boluses and IV fluids arrived?
4 I think it must have.
5 A. Yes. I think by that stage we were using bolus fluids
6 more commonly than certainly 15 years earlier.
7 THE CHAIRMAN: And that would be why the APLS guidelines are
8 written in the way that they are and the way
9 Forfar & Arneil is written in the way that it is?
10 A. I know I've sort of stressed APLS, but I think it was --
11 that was the first time that there had been very
12 specific teaching on acutely-ill children and certainly
13 it was just introduced in the early 1990s as an adjunct
14 to training.
15 THE CHAIRMAN: Okay.
16 MR WOLFE: In terms of the, if you like, instruction
17 contained within the manual and indeed within
18 Forfar & Arneil -- which seems to direct that, if you
19 like, gastric losses which are high in sodium should be
20 replaced on a like-for-like basis with a concentration
21 that's high in sodium -- was that fundament of that
22 teaching recognised for, if you like, years, as it's
23 suggested here?
24 A. I think I had always been taught that, that ongoing
25 losses -- vomiting, diarrhoea -- were likely to be high

1 in sodium and that therefore had to be replaced with
2 appropriate solutions that were also high in sodium.
3 I think, right back to the days when I was a medical
4 student, that was standard teaching at the time.
5 Q. Just moving on from that -- I think you've alluded to it
6 in your witness statement -- if a child is suffering
7 heavy losses of sodium-rich fluid, but is receiving
8 a fluid which is inappropriate in that it doesn't
9 contain sufficient salt, were the dangers of that
10 appreciated by the paediatric sector at that time?
11 A. Yes, I think so.
12 Q. And the dangers were that a depletion of sodium in the
13 blood can lead to electrolyte derangement, seizures and
14 cerebral problems?
15 A. Yes.
16 Q. Could I ask you to look at the guidelines that were
17 developed in the Royal in or about the late 1990s? You
18 had some input, I understand, in the development of the
19 Paediatric Medical Guidelines at the Royal Hospital.
20 There's a section in the guidelines dealing with the
21 management of diarrhoea, which I would ask you to look
22 at. Could we go to, just to orientate ourselves,
23 please, 319-067a-089? This is the section we're in. If
24 we could move over and have up alongside each other
25 pages 090 and 091, please.

1 On the left hand page, first of all, doctor, it
2 describes the various investigations, I suppose, that
3 you might conduct after admission in a case of moderate
4 to severe dehydration. There's a series of dos and
5 don'ts underneath that: "Don't suggest flat Coke", that
6 old wives' tale, I think, is a pointer. But moving on
7 to the right-hand side, there is a description of the
8 management of moderate to severe dehydration. There's
9 a description of the proper approach to maintenance
10 fluids in terms of the calculation and then
11 a description of the proper approach to calculating, for
12 example, 5 per cent, 10 per cent or 15 per cent
13 dehydration.
14 Then it says:
15 "Try oral rehydration therapy by mouth, although
16 naso-gastric or intravenous fluids may be necessary."
17 Then it says:
18 "With a situation of normal serum sodium, treat
19 shock if present."
20 So that's treated with a bolus; that would have been
21 the appropriate treatment of the time, a bolus of normal
22 saline?
23 A. Yes.
24 Q. And then it says:
25 "Use 0.18 saline plus 4 per cent dextrose as the

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

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

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

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

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

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

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

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

1 doctor, the point at which you were able to sit down and
2 start was at the end of January?
3 A. Yes.
4 Q. And presumably, in addition to your day job, you got on
5 with the task of looking at these four cases?
6 A. Yes.
7 Q. And you were in a position to report -- I think it says
8 here 28 April. I think I have another reference to
9 26 April, but certainly by the end of April you had
10 reported. So that was a period of approximately
11 12 weeks or so?
12 A. Yes. I had completed the three reviews, review of three
13 sets of case notes, by the end of March, but we were
14 still -- I was still waiting for Dr Carson's report,
15 which came at the beginning of April. There was further
16 delay because the deeds of indemnity had not been signed
17 for Dr Carson by Sperrin Lakeland Trust. So that was
18 the delay during that month.
19 Q. Can you help us, doctor, in terms of whether you think
20 there was anything that was within your power to achieve
21 that could have speeded up this whole process through to
22 the provision of a report?
23 A. I really don't think so. I mean, there's been delay at
24 all stages from the initial contact, that telephone
25 contact, which I can't remember, but I'm sure did take

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

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

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

1 a child who had died. And also, on looking through the
2 notes, even though the documentation was extremely poor,
3 but even so, it seemed to me that there were problems
4 associated with fluid prescription and administration.
5 I'd read Dr Quinn's report and knew that he didn't share
6 my concerns. I had worked for Dr Quinn in Altnagelvin
7 as his registrar and I had the highest regard for his
8 clinical knowledge and skills, and therefore I felt it
9 was a courtesy to telephone him.
10 I think I was also hoping in some way that maybe
11 he had further information than I had that could explain
12 the sequence of events on the night that Lucy was
13 admitted to hospital.
14 Q. Can you recall, doctor, what particularly jarred with
15 you in terms of Dr Quinn's report? You say that you
16 realised that he had reached a different view to you.
17 What was it that concerned you and prompted the phone
18 call?
19 A. It was his conclusion that the fluids used were
20 appropriate.
21 Q. He went through the fluid regime and with regard to
22 Lucy's fluid needs, he, within his report, looked at
23 various permutations with regard to the extent of
24 dehydration and he described the type of fluid which was
25 used, which everybody knew to be Solution No. 18, at

1 least initially, he described that as appropriate. Was
2 that what you were thinking about?
3 A. Yes.
4 Q. In fairness to Dr Quinn, who was asked about this, his
5 only memory of the discussion, he told us on Friday last
6 when he gave evidence, his only memory of his discussion
7 with you was you telling him of the low carbon dioxide,
8 he told us a reading of 16 was what you were explaining
9 to him, from which each of you could conclude that the
10 child was acidotic -- is that the word? --
11 A. Yes, acidotic, yes.
12 Q. -- and really quite sick. Help us if you can. Your
13 recollection of the conversation with him, did it
14 include a discussion of the competing views, if you
15 like, of the appropriateness of the fluids?
16 A. Yes. From memory -- and it was a telephone
17 conversation, it was a long time ago, but there were two
18 aspects. One was that I really thought Lucy was a very
19 sick little girl whenever she was admitted to the
20 Erne Hospital and we went through the various -- I went
21 through the various reasons for coming to those
22 conclusions. Then I said that I felt that her fluid
23 management had been sub-optimal at that time. I just
24 asked him, was he satisfied with the report that he had
25 produced for Sperrin Lakeland Trust, and he said yes,

1 he was. It was a very, very brief conversation and
2 I have no idea, I may have caught him in the middle of
3 clinic or something like that, but it was very brief and
4 that was the end of it.
5 THE CHAIRMAN: Did he seem uneasy about your view or your
6 call?
7 A. Sorry?
8 THE CHAIRMAN: Did he seem uneasy that you were ringing him
9 and that you were, in effect, expressing a different
10 view to his?
11 A. No, I don't think he was concerned about my view.
12 THE CHAIRMAN: Okay.
13 MR WOLFE: I realise I might be pushing a little, but in
14 terms of his declaration that he was satisfied with the
15 report that he produced, did he offer any justification
16 or explanation for his view that the fluids were
17 appropriate?
18 A. No. No, we didn't go into great detail at all. I had
19 phoned him, I suppose just hoping for further
20 clarification, and he just said he was satisfied with
21 his report.
22 Q. Thank you.
23 MR COUNSELL: I wonder if the witness can be asked whether
24 she gave Dr Quinn any forewarning that she was going to
25 call.

1 THE CHAIRMAN: Can you remember at the time when you rang
2 him -- well, sorry, for you to ring him, having formed
3 a view, you must have been well along the process of
4 reading Lucy's notes, Dr Quinn's report and the
5 post-mortem report.
6 A. Mm-hm.
7 THE CHAIRMAN: Was a fairly clear view emerging in your mind
8 at that time? Did you say to him expressly or do you
9 think you would have implied from your call that you
10 were going to report something different to what he had
11 reported?
12 A. I'm not sure that I said to him what was in the report.
13 I just said that I had concerns about Lucy's fluid
14 management, but I don't think I said to him what I was
15 going to write or anything like that --
16 THE CHAIRMAN: Okay.
17 A. -- or even had written. I'm not sure of the timing of
18 that call.
19 MR WOLFE: If I could just pick up on my learned friend's
20 question, I think his point is: did you alert Dr Quinn
21 to your views before participating in a discussion with
22 him or was it, alternatively, picking up the phone,
23 "Dr Quinn, it's me", and then explaining at that point,
24 if you like, without warning that you were wishing to
25 engage in this discussion?

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

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

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

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

1 "Given the symptoms and signs, the prolonged
2 capillary refill time (greater than 2 seconds), it would
3 be appropriate to give an immediate fluid bolus of up to
4 20 ml/kg of normal saline and then reassess."
5 And clearly that hadn't happened in this case; is
6 this right?
7 A. It didn't happen, yes.
8 Q. "It was several hours after admission before intravenous
9 fluids were commenced."
10 And then you set out the difficulties, the
11 well-recognised difficulties in securing access. But
12 you make the point that the notes do not make clear the
13 possible reasons for the delay in addressing the problem
14 of restoration of circulatory blood volume.
15 Then if we can go over the page, please, you begin
16 to set out, at 056, several possible explanations,
17 having recognised:
18 "... the neurological decompensation that had
19 occurred at around 3 am and the problems identified by
20 the repeat urea and electrolytes."
21 The several possible explanations were that:
22 "Lucy had a febrile seizure, which continued,
23 leading to hypoxia and cerebral oedema."
24 Is one to infer from your comment on that that most
25 children who have febrile seizures suffer no long-term

1 sequelae? Do we read that as you suggesting that that
2 is not a particularly strong possibility?
3 A. The reason I put is first is because, for seizure
4 activity in young children of this age, the most common
5 cause by far is a simple seizure associated with
6 increased temperature, so that's why I put it first, but
7 I was not convinced from the notes that Lucy had had
8 this type of event. And as I say, it's extremely
9 uncommon for children -- most children who have febrile
10 seizures recover spontaneously, often not even needing
11 any medication to terminate the seizure.
12 Q. You then move on to a second possibility, which was
13 that:
14 "She had a seizure-like episode due to underlying
15 biochemical abnormality."
16 You highlight the initial sodium, which was normal,
17 and then you say:
18 "At 3 am, after administration of the
19 Solution No. 18, the repeat sodium was 127 and potassium
20 2.5."
21 I'm not sure even yet, doctor, whether you're aware
22 that that may well have been or in fact was a misreading
23 of the notes in that the 127 was arrived at after this
24 quantity or some quantity of normal saline had been run
25 in, and it was only after the arrival at the hospital of

1 Dr O'Donohoe that bloods were ordered and it was the
2 bloods at that point in time that identified the 127.
3 Presumably that wasn't something that was clarified for
4 you.
5 A. No. I'm aware of the debate around how much normal
6 saline Lucy had received before the blood was taken.
7 I mean, I've gone over and over the notes. The nursing
8 notes state, I think, that normal saline was started at
9 3.15 and then that the bloods were ordered at 3.20. So
10 it's not clear whether ordering and taking the bloods --
11 how much time elapsed between the two. I know that the
12 bloods arrived in the lab just before 4 am, but again
13 I don't know how long it took to get from the ward to
14 the lab.
15 The other aspect of that is that I know the fluids
16 were changed at around the time of her seizure-like
17 episode, but again it's not clear from the notes when
18 that occurred. And there were a lot of things happening
19 at the one time. She was having a seizure, she was
20 being given diazepam, fluids were being changed. So
21 I just couldn't actually work out the sequence of
22 events. But I appreciate that the blood tests could
23 well have been taken after a quantity of normal saline
24 was administered.
25 Q. Yes. Could we move over the page then to 058? You say:

1 "Biochemical changes are often well tolerated and
2 easily corrected with appropriate fluid replacement,
3 although these results do show a change over
4 a relatively short period of time."
5 A. Mm-hm.
6 Q. Can you help us by unpacking that? What did you mean by
7 drawing attention to the fact that the results, that is
8 the change in electrolyte results, do show a change over
9 a relatively short period of time?
10 A. I mean, a sodium level of 127 is by definition
11 hyponatraemia, but we see many children admitted to
12 hospital, particularly with gastroenteritis, with
13 a sodium of 127. And prior to this, I had never known
14 a child to suffer serious adverse outcomes with a sodium
15 reading of that level. So what I was trying to draw
16 attention to there was that it wasn't the absolute level
17 which was important, whether it was 127 or whether it
18 was even lower than that, but it was the change from the
19 time that her bloods were taken when she was admitted
20 until the time of her acute deterioration around 3 am.
21 Q. So you saw the, if you like, rapidity of the fall as of
22 being potentially significant?
23 A. Yes.
24 Q. And then you move on to a third position. Does the
25 third position relate to the second position? Are they

1 to be read together? Because obviously, you have the
2 incident at 3 am, which was variously described as
3 something akin to a seizure, and then you're moving on
4 to the episode at 3.15 am, which was described, if you
5 like, as the respiratory arrest:
6 "The episode at 3.15 was due to cerebral oedema and
7 coning."
8 Is there a relationship between your observations at
9 (ii) and then into (iii)?
10 A. Yes. I thought the fall in sodium was associated with
11 retention of fluid and, in particular, cerebral oedema,
12 which then in turn led to coning at around 3.20 am, and
13 thereafter I felt that the situation, as far as Lucy was
14 concerned, was irretrievable at that stage.
15 Q. You then move on to rule out rectal diazepam as being
16 a contributory factor, and in that regard you agree with
17 what Dr Quinn had observed in his report.
18 A. Yes.
19 Q. Then you move on to the fluid balance records, which you
20 indicate are incomplete. Going over the page, you say:
21 "My interpretation of the chart is that she received
22 100 ml an hour of Solution No. 18 until around 3 am,
23 when the adverse episode occurred."
24 At this point you get into dealing with the
25 appropriateness of the fluid regime that had been

1 applied. As we noted earlier in your report, you'd
2 dealt with the need, as you saw it, for the correction
3 of shock, so once shock has been corrected you then pick
4 up on what the APLS guidelines say, and we've looked at
5 this this morning already.
6 So what you're saying is that for a child with
7 moderate to severe dehydration, that's the calculation,
8 750 ml on a 10-kilogram child -- and you have explained
9 that you round it up for ease of calculation -- it would
10 be 750 ml, and then maintenance fluids in addition to
11 the replacement. You then say:
12 "The volume given, therefore, does not appear
13 excessive."
14 On the basis of a 7.5 per cent dehydration, the
15 calculation comes to somewhere between 70 to 80, and
16 that's allowing for a slightly higher weight than she
17 actually was. She was 9 kilograms, not 10. The fluids
18 in terms of total volume pre-seizure were certainly
19 excessive.
20 A. Mm-hm.
21 Q. Why did you characterise the volume given as not
22 appearing excessive?
23 A. The reason I did that was because I was counting in
24 200 ml of bolus resuscitation fluid in -- whenever I was
25 working out if she had 200 ml and then if she had had

1 another 200 to 250 ml over 4 hours, the total volume
2 would not be excessive. I think that's why I used the
3 term "clumsy attempt", because obviously it is causing
4 concern and debate, but that was my thinking about it:
5 we need to factor in the bolus of resuscitation fluid
6 in the amount that would be given over a 4 to 5-hour
7 period.
8 Q. So where you say in your witness statement -- and I had
9 it up on the screen earlier -- that this was a clumsy
10 attempt to reconcile the volume of fluids Lucy received
11 from 10.30 to 3 am, with recommendations for the various
12 types of fluid --
13 A. Yes.
14 Q. -- just to be clear then, what you're accepting is that,
15 in terms of how you have phrased this, you were at best
16 somewhat ambiguous and what you really should have been
17 saying is that the total volume given doesn't appear
18 excessive --
19 A. That's right.
20 Q. -- but the types of fluids, the types and volume of each
21 fluid, ought to have been identified?
22 A. Yes. The sentence -- I should have written the
23 sentence:
24 "The total volume given including resuscitation,
25 maintenance and rehydration fluids ..."

1 And I thought I had set that out clearly earlier on,
2 but obviously it has caused confusion.
3 Q. Well, you go on to say that there is debate about the
4 most appropriate fluid to use.
5 A. Mm-hm.
6 Q. You say:
7 "APLS guidelines indicate the deficit should be
8 replaced with normal saline and maintenance with
9 Solution No. 18."
10 A. Mm-hm.
11 Q. And then you explain how it's explained in the APLS
12 guidelines that, for convenience, the two fluids can
13 often be combined.
14 A. Mm-hm.
15 Q. In terms of the fluids necessary for replacement in
16 a dehydrated child at that time there was no debate.
17 A. There was debate about how best to administer it: should
18 there be two separate infusions, one with maintenance
19 fluid and one with replacement fluid? And that is the
20 ideal situation because then the replacement fluids can
21 be tailored to ongoing losses. But due to the
22 difficulty in getting venous access in young children
23 and also just the practical details in trying to run two
24 separate infusions, they're often combined as
25 half-normal saline, 0.45 per cent. So that was what

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

1 documentation and that I did not -- I wasn't there
2 at the time and it was not clear from the notes just
3 what fluids had been prescribed or given to Lucy.
4 Q. Yes. Let me talk about what you were thinking. You
5 were thinking the following: if this child has received
6 100 ml per hour of Solution No. 18, then that is quite
7 the wrong approach for a dehydrated child who required
8 normal saline?
9 A. Yes.
10 Q. And Dr MacFaul's concern about your approach is that you
11 failed to state clearly in your report that an excessive
12 volume of Solution No. 18 had been administered?
13 A. Yes, and I think I kept coming back to what I'd been
14 asked to do, which was not to prepare a medical report,
15 and it was obvious to me that the problems around fluid
16 prescription and administration were not solely on the
17 part of Dr O'Donohoe, even though as consultant he
18 retains overall responsibility. But usually, it's
19 a junior member of staff who writes up fluids. There
20 were problems with the recording of rates of fluid that
21 were administered, so from the point of view of what I'd
22 been asked to do, there were problems associated with
23 other members of staff on duty that night.
24 THE CHAIRMAN: Sorry, doctor, surely the critical competence
25 point is that Lucy was prescribed the wrong type of

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

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

1 which is out of keeping with what Dr O'Donohoe had said
2 whenever he arrived soon after her respiratory arrest.
3 So I just could not work out what had gone on in that
4 hour or hour-and-a-half until she was transferred from
5 the ward in the Erne to the intensive care unit.
6 Q. Could I just move, to complete this section, over the
7 page, please? In your witness statement when you're
8 asked, doctor -- is it the last page? Move on to the
9 next page, please. It's the summary.
10 When asked, doctor, in your witness statement to
11 explain why you hadn't drawn attention to what was
12 clearly in your view a mismanaged fluid situation, you
13 draw attention to the conclusion or the summary section
14 of your report where you say:
15 "There was a delay in implementing fluid
16 resuscitation and there are deficiencies in the
17 prescription and recording of volumes of fluids
18 administered."
19 Were you suggesting that where you said that there
20 are deficiencies in the prescription that the reader
21 should draw some particular meaning from that?
22 A. There were obvious deficiencies. The fluids weren't
23 prescribed in the first place. The records of the
24 volumes that Lucy received were very difficult to work
25 out. The observations during the administration of

1 those fluids were very poor. Again, I felt to draw firm
2 conclusions as to cause of death was inappropriate for
3 me to do in my report and, again, coming back to the
4 fact that those conclusions needed to be made on the
5 basis of all information that was available, and that
6 would include her previous medical history, her
7 subsequent care in RBHSC and any other information that
8 staff on duty that night could provide.
9 Q. You had a meeting with Dr Kelly on 31 May --
10 MR GREEN: May I rise? Before we move away from the
11 report --
12 THE CHAIRMAN: If there's a point about the report, I'll
13 take it and we won't go on to the meeting until after
14 a break.
15 MR GREEN: Thank you very much, sir.
16 The legal team for Dr Stewart have very helpfully
17 provided a clutch of documents last week designed to
18 deal with chronology. I don't know if they've got
19 a reference on the inquiry website as yet. I don't see
20 anybody ...
21 THE CHAIRMAN: We were given a two-page chronology
22 yesterday.
23 MR GREEN: The letter I'm referring to is a letter dated
24 9 November 2000. It's addressed to Dr Kelly and it's
25 from Patricia Hamilton.

1 MR WOLFE: That's a reference at 036a-010-019, I think.
2 MR DAVIES: Sir, can I assist? The difference between the
3 two documents, the document that my learned friend is
4 referring to as having been a document provided last
5 week, is the handwritten note that has been added to the
6 original document.
7 MR GREEN: That's very helpful, but there is also
8 a redaction. I think, without compromising the purpose
9 behind that redaction, I can read one sentence of the
10 redacted part and if anybody is sensitive about it, I'm
11 happy for them to jump up and stop me. It says:
12 "We did agree, however, that we would address the
13 second question where specific instances of professional
14 competency have been raised."
15 I just wondered if Mr Wolfe would be good enough to
16 explore with Dr Stewart how easily or otherwise that
17 sits with her assertion a moment ago that her remit
18 didn't include questions of competency.
19 THE CHAIRMAN: Sorry, I thought the remit of this first
20 report from Dr Stewart was specifically the area of
21 competency.
22 MR GREEN: Absolutely, but she said a moment ago that she
23 wasn't addressing issues of competency, and that's why
24 she didn't get down to the nitty-gritty, the cause of
25 death and being more explicit about the fluid

1 mismanagement.
2 MR WOLFE: I don't have the screen in front of me, nor did
3 I hear you express yourself in quite that way, but my
4 friend has obviously got it in front of him.
5 MR GREEN: I'll show my learned friend the reference in the
6 break. If I have got the wrong end of the stick, I am
7 happy for my hands to be taken off it.
8 THE CHAIRMAN: I'll tell you what we'll do: we'll take the
9 break now because we're overdue the break and come back
10 at 12.30. If you can sort it out on the screen in the
11 meantime. Thank you.
12 (12.17 pm)
13 (A short break)
14 (12.35 pm)
15 MR DAVIES: Sir, can I assist in this way by referring to
16 the passage, I think, which has caused confusion to my
17 learned friend? It's at [draft] page 60, lines 1 to 8,
18 and it reads as follows:
19 "And the other reason was that again, from the
20 perspective of Dr O'Donohoe, it was fairly apparent that
21 he had not requested the change in fluids to normal
22 saline and that it was probably done by the junior
23 member of staff on duty that night and again I wasn't
24 asked to comment on his competency."
25 So it's the context, I'm afraid, that has caused the

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

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

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

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

1 said to Dr Kelly that the use of Solution No. 18 was
2 implicated in this change of electrolytes.
3 A. I'm going from memory now. I don't have a record of
4 this meeting, but I'm fairly sure that I was explicit
5 when talking to him that Solution No. 18 should not have
6 been used as the sole infusion fluid.
7 Q. The note that is up in front of you refers to "normal
8 saline, not one-fifth normal" as being the replacement
9 fluid indicated by the Royal Victoria Hospital ward
10 guidelines. So it does appear that, in terms, the type
11 of fluid that was appropriate was discussed. Can I ask
12 you about the reference to the ward guidelines?
13 A. I'm fairly sure I didn't use this term. I never called
14 Children's Hospital "RVH" and we didn't have ward
15 guidelines at the time. So I think he has picked it up.
16 I think I said APLS guidelines; I don't think I said RVH
17 ward guidelines.
18 THE CHAIRMAN: Might you have said something like, "The APLS
19 guidelines, which are typically followed in the RBHSC"?
20 Something along those lines --
21 A. Yes, but --
22 THE CHAIRMAN: -- so the two run together in his mind
23 perhaps?
24 A. They might have done. He wouldn't be familiar with --
25 as familiar as I was with APLS and most paediatricians

1 are, so I think he just misunderstood or misheard me.
2 MR WOLFE: One of the things that Dr Kelly says, by way of
3 response, which I would invite you to comment upon,
4 is that during this meeting you told him that there had
5 been considerable recent debate about the best
6 resuscitation and rehydration regimes and that the Royal
7 Belfast Hospital for Sick Children had changed its
8 guidelines in recent years; does that assist you?
9 A. I don't think that's correct. We certainly hadn't --
10 we were still using Solution No. 18 as maintenance fluid
11 right through for probably another year to 18 months,
12 and that was the standard infusion fluid across
13 Northern Ireland and across most units in the UK. If
14 I said there were any changes, it would have been
15 in that we were more aggressive in our management of
16 children that we suspected of being at risk of
17 circulatory collapse. In other words, give bolus fluids
18 early on at the start of an illness before starting an
19 infusion fluid regime. But there hadn't been discussion
20 or there hadn't been changes to guidelines issued in
21 RBHSC at that time.
22 Q. Let me just address that issue. It means me departing
23 from the content of the meeting for a short time, but it
24 may be convenient to deal with it now.
25 You've said that you can't recollect speaking in the

1 terms that Dr Kelly has suggested. He's suggesting that
2 you said to him there had been recent debate in relation
3 to the appropriate rehydration replacement therapy and
4 that the Royal had changed its guidelines in recent
5 years. You have said something just now about when you
6 think the approach to Solution No. 18 had changed; when
7 do you think it had changed?
8 A. Well, I know that graphs have been produced to do with
9 pharmacy purchase of Solution No. 18.
10 Q. Yes.
11 A. I'm going from memory now, but I'm fairly sure that it
12 was really after Raychel's death that there were really
13 growing concerns about implications of Solution No. 18
14 in causing hyponatraemia in children.
15 I knew about Adam Strain's case, but I only knew in
16 very peripheral terms, and he was a very unique, complex
17 little boy, a very specific set of circumstances.
18 I never heard anything about Lucy's case until I got the
19 notes and was asked to review them. So I had no prior
20 knowledge at all of her being admitted to RBHSC and
21 dying. But certainly, following Raychel's death, there
22 was a lot more discussion and concerns about use of
23 Solution No. 18. I think it was following Raychel's
24 death.
25 Q. Could I just ask you to look at the graph you have

1 alluded to? It's 319-087d-003. You can see, doctor,
2 that through most of the year 2000, the order in respect
3 or supply in respect of Solution No. 18 was up at at
4 least 400, sometimes dropping to about 350, but
5 sometimes getting as high as 500 and beyond.
6 A. Mm-hm.
7 Q. But by the end of that year, there was a significant
8 tailing off in the amounts ordered and throughout the
9 year 2001, as is illustrated by the graph, the orders
10 were at or less than 100 units. Building that into our
11 chronology, you would know that Lucy died in April of
12 2000.
13 A. Mm-hm.
14 Q. Raychel died in June 2001. But it would appear that the
15 decline in ordering had really commenced in advance of
16 Raychel's death.
17 A. Mm-hm. Yes, I appreciate that. I'm just telling you
18 what I remember.
19 THE CHAIRMAN: You see, what sparked this exercise, doctor,
20 was the evidence from Altnagelvin is that when they were
21 involved with the Children's Hospital over Raychel's
22 death, they were told that the Royal had stopped using
23 Solution No. 18 some months previously. I wouldn't be
24 surprised if there was further discussion on the basis
25 of Raychel's death, but the sequence, rightly or

1 wrongly, that was given from the Children's Hospital was
2 that Solution No. 18 dropped off before Raychel died.
3 And to a limited extent, that is supported by the fact
4 that for the month of June 2001, which is the month
5 Raychel died, there were only 42 batches of
6 Solution No. 18 ordered and that the number of batches
7 ordered in April and May 2001 was really a way down from
8 the previous year.
9 A. Mm-hm.
10 THE CHAIRMAN: So maybe there was something which was
11 confirmed by what happened to Raychel, but there seems
12 to have been a trend just before that in any event.
13 A. Mm-hm. Yes, I mean, I recognise that. I just cannot
14 remember any changes. The other thing is that it would
15 be nice to see a breakdown by ward because I think that
16 RBHSC is quite a big hospital and I know that PICU were
17 much keener on normal saline than would have been used
18 in the peripheral wards, and again there's a difference
19 between medical and surgical wards. But from my
20 recollection, I didn't hear any discussion about
21 hyponatraemia and use of Solution No. 18 really until
22 after Raychel's death.
23 THE CHAIRMAN: Thank you very much.
24 MR WOLFE: Well, in terms of the change in policy or
25 approach which you, in your evidence just now, identify

1 with the period after Raychel's death, was the change
2 a change in the use of Solution No. 18 for maintenance
3 purposes or was it for replacement purposes?
4 A. Solution No. 18 was not ever the choice for replacement
5 therapy. It was the subsequent change in maintenance
6 recommendations.
7 Q. I asked the question in that way because, although you
8 don't recall discussing matters in these terms with
9 Dr Kelly, it was his evidence, and as contained in his
10 witness statement, that so far as the recent debate
11 which he alluded to was concerned and the change in the
12 Royal's policy which he referred to, he says that there
13 had been considerable recent debate with regard to the
14 best resuscitation and rehydration regimes to use. And
15 he says that that is what emerged from his conversation
16 with you. The implication of that is that the Royal had
17 been using Solution No. 18 for resuscitation and
18 rehydration.
19 A. I can't recall saying that. I can't imagine that
20 I would say that because that was not my knowledge of
21 fluid balance in children.
22 Q. Very well.
23 A. And as I said earlier on, the juniors were all trained
24 to follow the APLS guidelines right from the mid-1990s,
25 so I can't understand that.

1 Q. Yes. Could we turn back to the meeting then? I want to
2 put to you Dr Kelly's perspective because your
3 perspective, I can summarise, is that arising out of
4 this meeting you left Dr Kelly in no doubt that the
5 inappropriate use of Solution No. 18 was implicated
6 in the electrolyte derangement, seizure and cerebral
7 oedema; is that fair?
8 A. I think so, yes.
9 Q. Whereas, if I can summarise his evidence -- and he gave
10 evidence on 13 June -- he has said that he can recall
11 you telling him that certainly you told him that the
12 electrolyte or the serum sodium finding of 127, you
13 wouldn't expect a seizure, but the rate of change of
14 electrolytes could have caused a seizure or likely
15 caused a seizure. And he knew your evidence, because
16 I was putting it to him, but he says the point of
17 departure between your perspective and his perspective
18 is this: you were going through a number of
19 possibilities during this conversation, one of which was
20 the fluids, but other matters were discussed so that he
21 was left with a range of possibilities rather than
22 a specific declaration by you in terms of what you
23 thought had happened.
24 Can you help us on that? Did you go through other
25 possibilities with him?

1 A. Yes, I think I did. It was obvious that Dr Kelly had
2 picked up from my report that I had concerns about the
3 electrolytes and about fluids because he asked me
4 a specific question about electrolytes. Now, obviously,
5 even though I was fairly sure in my own mind that the
6 cause of Lucy's deterioration was related to the changes
7 in biochemistry, it was a very unusual situation and it
8 was very difficult to completely exclude other causes
9 that might have contributed to that deterioration. But
10 I'm equally certain that, at the end of our discussion,
11 he was left in no doubt that the most likely explanation
12 for her deterioration was related to the change in
13 sodium and the problems with fluid administration.
14 Q. Just coming back at you on that, your evidence is clear,
15 but can I ask you: was bronchopneumonia discussed as
16 a possible underlying cause for the brain oedema?
17 A. I can't remember that detail. My own view -- I was
18 aware of Dr O'Hara's post-mortem report, I'm also aware
19 that in children with bronchopneumonia you do get
20 inappropriate ADH secretion and often we reduce the
21 volume of fluids we give to children with pneumonia.
22 But I was not convinced from her presentation that
23 bronchopneumonia had been a major factor causing her
24 deterioration. In my experience, post-mortem reports
25 often include bronchopneumonia, but that's a terminal

1 event, and I did not think that that was a significant
2 factor. But we may well have discussed it, but in those
3 terms.
4 Q. Clearly, by your description, this conversation had
5 taken things on a stage from your initial report, and
6 you've given your evidence earlier in terms of where you
7 saw the limitations or the constraints set by your
8 remit. And in this conversation, you're saying you're
9 being more explicit or more specific because you're
10 being faced with direct questions. Was there any
11 conclusion at the end of the meeting about what the
12 implications of your view were for the Trust or for
13 clinicians within the Trust?
14 A. I think there were two things which we discussed in the
15 meeting -- and again I'm going from recall, but I do
16 recall the meeting quite clearly. The first was that
17 Dr Kelly did ask me if I was aware that the content of
18 my report was rather different from that of Dr Quinn.
19 And then I asked him what he was going to do next and he
20 said he would have to take the reports and the comments
21 from our meeting back to the Trust and then it would be
22 up to the Trust to decide what to do next. The terms of
23 reference from the Royal College were quite clear that
24 once a report was handed over, subsequent actions were
25 the responsibility of the Trust.

1 Now, the other question I put to Dr Kelly was --
2 I asked him specifically about a coroner's inquest. And
3 again, from memory -- and I'm aware that this is not the
4 same as Dr Kelly's recollection, but my recollection is
5 he told me the coroner had been informed, but did not
6 want to hold a coroner's inquest, did not feel it was
7 necessary. And I remember that because I was surprised.
8 Following on from that, by that stage I knew -- I had
9 a telephone call from Sperrin Lakeland Trust to say that
10 a medico-legal case was underway. I don't think
11 Dr Kelly and I discussed medico-legal case at all in our
12 meeting or, if we did, I can't remember it, but at no
13 stage was I asked to contribute to medico-legal case or
14 to coroner's inquest or to complaints procedure. So
15 that's how I remember the meeting ending.
16 Q. You have made an important contribution in relation to
17 the state of knowledge with regard to the need for an
18 inquest. Was there any discussion about whether, in
19 light of the views that you were expressing about fluid
20 management, whether the coroner should be reintroduced
21 to the case?
22 A. I think I was quite naive about coroner's role.
23 Whenever I had made referrals to the coroner before and
24 the coroner had made a decision, I had always made the
25 assumption that the coroner's ruling would stand.

1 I would not have even thought of disagreeing with that.
2 So that's ignorance on my part of the whole coroner's
3 process. The other thing is that at that stage the
4 medico-legal case was started then and in a way I sort
5 of thought that will address issues and involve expert
6 witnesses.
7 MR GREEN: Could I ask that witness statement 298/1 at
8 page 14 be pulled up?
9 MR WOLFE: I'm going to go to that now.
10 MR GREEN: I was just going to invite my learned friend to
11 ask the witness why she didn't deal with this in the
12 exquisite level of detail that she's treating the
13 inquiry to today.
14 MR WOLFE: Could I have up on the screen WS298/1, at
15 page 14? You were asked, doctor:
16 "Did you discuss with the Trust whether there was
17 a need to report Lucy's death to the coroner in light of
18 the conclusion reached by you and Dr Boon that Lucy had
19 died from hyponatraemia?"
20 So this is asked in the context of your second
21 report. You answer that question by saying:
22 "I asked (from recall of my meeting with Dr Kelly)
23 about the coroner's findings as to cause of death. From
24 memory, I was surprised that the coroner had not
25 requested a coroner's PM. I was aware at this time that

1 medico-legal action by the parents was underway. At the
2 time of the external review, Dr Boon and I were aware
3 that legal proceedings had still not been concluded, but
4 assumed that expert witnesses were involved."
5 My learned friend has intervened and I think the
6 point of his question -- I trust you were able to hear
7 him okay. But the point of his question was: why, when
8 asked a question by the inquiry, as you see set out
9 here, why did you not see fit to address what you say
10 you knew about what Dr Kelly told you during the meeting
11 at the end of May 2001? Do you follow the point?
12 A. Um ...
13 THE CHAIRMAN: I think the point is this, doctor, that
14 you have said something more explicit in your evidence
15 a few moments ago when you say that you asked Dr Kelly
16 about the coroner's inquest, he said the coroner had
17 been informed, but did not want to hold an inquest and
18 that you were surprised by this. In your answer to
19 question 16, you say that you'd asked about the
20 coroner's findings and you were surprised that
21 the coroner had not requested a post-mortem. I think
22 you've given us some additional information today, which
23 isn't quite so clear from your written statement, or
24 do you see it as being the same thing?
25 A. Sorry, I thought it was clear.

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

1 case. But what happened during the course of interviews
2 with other members of staff -- information was
3 volunteered about Lucy rather than us seeking
4 information. So in other words, I think during
5 a conversation with one of the nursing staff, issues
6 came up about fluid management. But I am clear that in
7 the time we spent in the Erne Hospital, talking to
8 people, there was very little time devoted to any one
9 case, and it was much more general information gathering
10 about Dr O'Donohoe's performance across a whole range of
11 areas.
12 Q. Yes. Could I have up on the screen, please,
13 036a-149-306? This is the section of your report that
14 makes brief mention of Lucy's case. You say:
15 "The prescription for the fluid therapy for
16 Lucy Crawford was very poorly documented and it was not
17 at all clear what fluid regime was being requested for
18 this girl. With the benefit of hindsight, there seems
19 to be little doubt that this girl died from unrecognised
20 hyponatraemia, although at that time this was not so
21 well recognised as at present."
22 When we asked you in your witness statement to
23 explain what the benefit of hindsight had brought to the
24 piece, you reflected the fact that you had access to
25 materials and you had access to personnel, which were

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

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

1 at the time of death as it should be now, but you,
2 I think, as I understand your evidence, were clear about
3 hyponatraemia and its role less than a year after Lucy's
4 death. If that's right, then I'm not sure why you write
5 the report in this way.
6 A. You're talking about the first report now?
7 Q. No, this report. Why do you, albeit as a co-author to
8 the report, adopt that phraseology that it's only with
9 the benefit of hindsight?
10 A. It's difficult to answer that without also referring
11 back to the first report. But I think Dr Boon and I, we
12 spent a lot of time -- we travelled back together from
13 the Erne Hospital to the airport and we spent a lot of
14 time discussing what had taken place in the
15 Erne Hospital. It was a year on, over a year on, from
16 the first report, which I'd done, and by that time there
17 was the paper from Halberthal, which had been published
18 just around the time of the first report, which was
19 really a major paper in terms of raising awareness of
20 hyponatraemia. And also, from my own personal
21 perspective, I suppose being involved in a review of
22 Lucy's notes, but also knowing about Raychel's death at
23 that stage, it made the entity of hyponatraemia much --
24 I had never seen hyponatraemia used as a diagnostic
25 entity or included in a death certificate. But

1 hyponatraemia was beginning to get into medical
2 terminology as a diagnostic entity in itself with
3 serious consequences.
4 There's no doubt Lucy had, by definition,
5 hyponatraemia. In a way, I still think it wasn't the
6 actual level of sodium which was the problem -- and
7 I take on board all the reservations that it may have
8 been lower at some stage -- but I think it was that rate
9 of fall which was the important factor rather than the
10 actual level. And there's a difference.
11 Q. Yes, but can I ask you this: Dr Kelly made the point
12 quite strongly to the inquiry that arising out of
13 receiving report 1 from you and arising out of the
14 meeting, he was not getting from you a clear signal that
15 the fluid management was to blame. Does this phrasing
16 in your second report reflect the view that at the time
17 of your first report you could not and were not sure?
18 A. I was fairly sure, but I was guarded in the way I wrote
19 the report because I felt that her death would be
20 investigated at a coroner's inquest and that I had only
21 limited information, and to draw firm conclusions on the
22 documentation that I had was inappropriate.
23 Q. But I thought you'd explained to us that you knew at the
24 time of your first dealing with Dr Kelly that there
25 wasn't to be a coroner's inquest.

1 A. Whenever I wrote the report, I thought that a coroner's
2 inquest would be held.
3 Q. Yes.
4 A. Whenever I spoke to Dr Kelly at the meeting on 1 June,
5 from memory, he told me that there wasn't going to be
6 a coroner's inquest, but that was the first I knew of
7 it, and at that stage I knew that a medico-legal case
8 was underway and that I had not been asked to contribute
9 to that.
10 Q. Can I bring you on to a slightly different point to
11 finish? Between yourself and Dr Boon, a draft report
12 was produced. Could we have on the screen,
13 please,WS298/3, page 7? Under the heading "Poor
14 documentation", it's the same layout as the ultimate
15 report, but within the section in draft you add the
16 finding:
17 "More careful attention to detail of the fluid
18 therapy might possibly have avoided this girl's cerebral
19 oedema and fatal outcome."
20 A. Mm-hm.
21 Q. You have explained and Dr Boon has explained within your
22 witness statements why that conclusion wasn't ultimately
23 included, and I emphasise that Dr MacFaul understands
24 and accepts the reasoning you've advanced. But
25 could you just explain to us the reason why that wasn't

1 included?
2 A. Dr Boon and I talked about this very carefully. The
3 only reason -- the only child that we alluded to in our
4 second report was Lucy and that was because of the
5 tragic consequences following her admission to the
6 Erne Hospital, and we felt in light of that we should
7 include reference to her case. The main reason that we
8 left out the last sentence in the final report was on
9 the basis of our knowledge that medico-legal proceedings
10 were underway and that expert witnesses would be
11 involved and that we had not been asked to be part of
12 that process or to contribute to it in any way.
13 Q. Nevertheless, it's a view that yourself and Dr Boon had
14 held. It's a conclusion that you agreed with?
15 A. Yes.
16 Q. And that wasn't otherwise shared with the Trust?
17 A. No, it wasn't, but we had -- no, we had no discussion
18 with the Trust following our visit. At least I didn't.
19 But we felt that we had been -- the second sentence:
20 "Little doubt this little girl died from
21 unrecognised hyponatraemia."
22 Was a sufficiently strong statement not to need any
23 further recommendations, which really should come out of
24 further medico-legal proceedings.
25 MR WOLFE: Well, I think that's fair because Dr Kelly and

1 indeed Mr Mills, in their evidence to the inquiry, say
2 that they understood your report as implicating the
3 fluid management of the child without the need
4 necessarily for that final sentence.
5 Very well. I have no further questions.
6 THE CHAIRMAN: Could I pick up one point with you, doctor?
7 When you were explaining a few moments ago the added
8 certainty in your second report about -- or the
9 reference to "with the benefit of hindsight", you said
10 in relation to that that, by that point, when you were
11 presenting this report, which I think was presented to
12 the Trust in August 2002, the Halberthal paper was very
13 significant and you knew about it, but you also knew
14 about Raychel's case.
15 A. Yes.
16 THE CHAIRMAN: Although Raychel died in June 2001, her
17 inquest wasn't held until, I think, February 2003. How
18 did you know about her case in the summer of 2002?
19 A. She was transferred to RBHSC from Altnagelvin and,
20 again, the circumstances surrounding her death were so
21 unusual and unexpected -- a child admitted for fairly
22 minor surgery, who subsequently had had a catastrophic
23 event on the basis of cerebral oedema -- we talked about
24 it within the hospital. It wasn't -- and that was
25 different. I had never heard Lucy's case discussed

1 within the hospital or even Adam's, but there was no
2 doubt that there was general discussion and concern that
3 this had happened.
4 THE CHAIRMAN: I can entirely understand how there would be
5 discussion about Raychel's case, given the circumstances
6 in which she was admitted to Altnagelvin and then
7 transferred to the Children's Hospital. I'm just a bit
8 curious about why there would not be equivalent
9 discussions about Lucy's case because Lucy's case was
10 equally stark and awful, wasn't it? She was admitted
11 with something, gastroenteritis plus perhaps something
12 more, but the same sequence of events?
13 A. Yes. I mean, I can't really explain if ... You see
14 from my CV, it was fairly busy. I wouldn't have ...
15 I would have tended to be in the hospital and do work
16 rather than -- I wouldn't have coffee or lunch or
17 anything like that, so I wouldn't necessarily hear talk
18 that was going on unless I happened to be in intensive
19 care at the time. I think it was beginning to build on
20 the fact that there had been Lucy and then there had
21 been Raychel, both children who appeared to be
22 previously well and then had catastrophic events and
23 died. So I think it was beginning -- it was the
24 accumulation of information over a relatively short
25 period of time.

1 THE CHAIRMAN: Thank you very much.
2 Are there any questions from the floor before I come
3 to Mr Davies?
4 MR DAVIES: No, thank you.
5 THE CHAIRMAN: Doctor, thank you very much for your
6 contribution. That brings an end to your evidence,
7 unless there's anything you particularly want to say
8 before you leave the witness box, but you don't have to
9 say anything more if you have said all you want.
10 A. Thank you very much.
11 (The witness withdrew)
12 THE CHAIRMAN: Okay. Ladies and gentlemen, we'll start at
13 2.15. Thank you.
14 (1.30 pm)
15 (The Short Adjournment)
16 (2.15 pm)
17 (Delay in proceedings)
18 (2.22 pm)
19 MR WOLFE: Good afternoon, sir. Mr Martin Bradley.
20 PROFESSOR MARTIN BRADLEY (called)
21 Questions from MR WOLFE
22 MR WOLFE: Good afternoon, Mr Bradley. You have provided
23 the inquiry with a witness statement in writing; it's
24 numbered WS307/1, dated 22 January 2013. We ask all of
25 our witnesses this: do you wish to adopt that statement

1 to be read in addition to the evidence you give to the
2 inquiry this afternoon?
3 A. Yes, I do.
4 Q. Very well. In addition to the witness statement,
5 you have helpfully provided us with a curriculum vitae,
6 which we can put up on the screen now, please. Let me
7 go to the second page, 315-004-002.
8 As we can see from that document, sir, you engaged
9 in nursing education from 1973 to 1976. You obtained
10 a certificate in education between 1976 and 1977 and
11 then moved on and obtained your degree in education and
12 a master's degree in education?
13 A. That's right.
14 Q. Followed by a diploma in health economics?
15 A. Yes.
16 Q. As we can observe from your CV, you practised as a nurse
17 between -- is it 1969 to 1976?
18 A. I was a student nurse from 1968 through to 1971, then
19 practised as a general nurse from November 1971
20 until March 1972, and then as a post-registration
21 student nurse from 1972 to 1973, and then worked in
22 mental health from November 1973 through
23 to September 1976.
24 Q. And moving forward in your career, you took up various
25 positions in health sector/health service management;

1 is that right?
2 A. I think the early career would demonstrate a primary
3 focus in nurse education and then moving into the
4 Department of Health as a senior nursing officer
5 in November 1991 and working there until 1997, and then
6 moving to the Western Health and Social Services Board
7 as a chief nurse in April 1997 until August 2000. And
8 then as director of healthcare and chief nurse
9 until March 2003.
10 Q. Yes. So it's that period, the period within that, which
11 we want to address this afternoon. Could I ask you
12 this: you, at the time of Lucy Crawford's death, which
13 was April 2000, held the chief nursing officer post
14 in the Western Board.
15 A. That's right, yes.
16 Q. Then at the end of August, start of September of that
17 year, you took on another role, which was in addition to
18 your nursing officer role; is that correct?
19 A. That's correct.
20 Q. So you performed both the chief nursing officer role and
21 the director of healthcare role?
22 A. Yes.
23 Q. You left the Western Board in April 2003; is that
24 correct?
25 A. That's right.

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

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

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

1 much as a team. I think these distinctions probably
2 become more pertinent if things were going wrong or
3 there were challenges, but on a day-to-day basis we were
4 working very closely as a team together.
5 Q. Could I move on and ask you directly about the
6 relationship between the Western Board and the Sperrin
7 Lakeland Trust? The trusts were formed or the Sperrin
8 Lakeland Trust, at the very least, was formed pursuant
9 to legislation in the mid-90s, 1996.
10 A. Yes.
11 Q. And it has been suggested by Professor Scally, the
12 expert retained by the inquiry to examine this area,
13 that there was no direct managerial responsibility
14 between the Trust and the Western Board because of that,
15 if you like, legal change leading to a realignment in
16 how the Trust was constituted.
17 A. That's correct. I would say it reflected a change in
18 policy in Northern Ireland where we were becoming more
19 focused on introducing, for want of a better word,
20 a market in healthcare. So there was an attempt to
21 ensure that the existing Health & Social Care Boards
22 focused more of their attention on identifying what were
23 the needs of their local population and using the money
24 that they had from the department, that was voted to
25 them by the department, to meet those needs in a much

1 more what I would say was a dynamic commissioning role.
2 It was the whole idea of the purchaser/provider split
3 and the trusts were placed in the role of being the
4 providers of services and responsible for managing their
5 organisations to provide those services.
6 They would theoretically -- although this was less
7 maybe in Northern Ireland than it might have been in
8 other parts of the UK -- they would theoretically be in
9 competition with each other around value for money and
10 ensuring that they had the best services available for
11 local populations. Ideally, the boards could choose
12 where to place their contracts. The reality in a small
13 market like Northern Ireland is that there was a very
14 limited variation in how contracts were placed because
15 Northern Ireland is not of a size, I think, where you
16 can have a large health and social care market as the
17 government in the UK might have envisaged it.
18 Q. So where Professor Scally characterised the relationship
19 as having become one where the Western Board agrees with
20 the Trust what services it required and the sums of
21 money to be passed to the Trust in respect of those
22 services, that, I suppose, in a nutshell, encapsulates
23 the change that had been brought into place, by the
24 mid-90s, by the change in policy?
25 A. That's correct.

1 THE CHAIRMAN: Does that mean that in Belfast there may have
2 been some competition between, say, the Royal Trust and
3 the City Trust, but that the real likelihood in the
4 Western Board area of competition between
5 Sperrin Lakeland and Altnagelvin, that was unlikely, was
6 it?
7 A. Well, it would have been more limited, chairman, in the
8 western area. My observation generally at that time
9 within Northern Ireland is that the vast amount of money
10 would have gone across anyway in a block contract and
11 what you would have then had would have been discussions
12 around the margins of that amount of money. But
13 primarily trying to use that money for new and
14 innovative services and that, I think, would have put
15 a slight competitive edge into trusts across
16 Northern Ireland to try and compete for that.
17 MR WOLFE: Could I ask you this, professor: did the change
18 in formal or, should I say, legislative accountability,
19 the basis for the accountability changed by legislation,
20 did that affect the way that the Trust, which is, if you
21 like, bits and pieces of hospitals and care homes and
22 that kind of thing -- did that affect the way the
23 management of those bodies related to the Western Board?
24 A. Well, my observation on this is that the relationship,
25 I think, was different, particularly between the board

1 and Altnagelvin Trust and the board and Sperrin Lakeland
2 Trust. Now, I didn't have the benefit or otherwise of
3 having been subject to direct management from the old
4 system. I came into the board more or less on the foot
5 of these changes as trusts were being created. It would
6 have been my observation that Sperrin Lakeland and the
7 board would have had a much more, in some ways,
8 dependent-type relationship with the Trust, I think,
9 looking to the board for possibly more support than
10 Altnagelvin might do.
11 Now, these are human factors, you know, and I'm
12 doing this from my observation and this is my view of
13 what I saw during that period of time. And I'm not
14 saying that one is right and the other is wrong, but
15 certainly the relationship, I think, with
16 Sperrin Lakeland was much more of a dependent-type of
17 relationship, much more. I would describe it as almost
18 a parent/child relationship, without being insulting to
19 anybody, while the relationship with Altnagelvin,
20 I think, was much more business-like, much more in your
21 face, and much more contested, but in a positive way, to
22 get the best out of the system. And they would have
23 challenged the board much more openly about the amount
24 of money they were getting, their share of resources,
25 and the board's support for their plans in relation to

1 developing services, particularly around the city of
2 Derry.
3 I'm not saying that there wouldn't have been that
4 with Sperrin Lakeland, but it was much more on the basis
5 of continuous negotiation and being supportive, and my
6 personal memory of all of this is that I would have
7 spent much more time around Sperrin Lakeland issues than
8 I would have around Altnagelvin-type issues.
9 Q. And dealing with what you have just said about the
10 Sperrin Lakeland, are your observations applicable as
11 much to the bigger strategic issues as they would be
12 about, say, operational issues? And one of the
13 operational issues, obviously, was the adverse incidents
14 that occur from time to time.
15 A. I think dealing with the strategic issues, the context
16 here is that Sperrin Lakeland in particular was in the
17 middle of a public debate about the future of acute
18 services in the south-west of Northern Ireland. Now,
19 the rest of Northern Ireland was involved in that debate
20 as well, but I think Sperrin Lakeland, in that context,
21 found itself between two very strong local communities,
22 one advocating for Omagh and the other advocating for
23 Enniskillen, and I wouldn't underestimate the amount of
24 energy and time that the Trust had to put in to trying
25 to continue to maintain services for everybody during

1 that period while at the same time trying to deal with
2 the strategic changes that they appeared to be heading
3 into and having the debate with the public about how
4 that might best be done.
5 So you know, the Trust will have been the subject to
6 more or less continuous headlines every week in the
7 local press around those sorts of issues.
8 Q. And as you indicate, they were issues that you were
9 interacting with the Trust upon?
10 A. Yes. We as boards, around those strategic issues, had
11 a role to play in trying to steer our way through that
12 in conjunction with the department to try and get the
13 best result.
14 Q. And operationally, an example I've given to you is
15 interactions around adverse incidents. As appears from
16 the Lucy Crawford case, which we'll look at in detail in
17 a moment, the Trust, in a sense, felt obliged to be
18 reporting that kind of issue to the Western Board, its
19 commissioning body, but not necessarily just that point.
20 In a general sense, was there this continued operational
21 interaction with the board or on operational issues?
22 A. There would have been ongoing discussions around
23 operational issues, primarily because of, I think, an
24 ongoing difficulty in trying to maintain services: the
25 recruitment of staff, in particular medical staff, comes

1 very much to mind; difficulty in staffing Accident &
2 Emergency departments; difficulty maintaining some of
3 the surgical services, particularly over holiday
4 periods. All of these would have become issues that
5 we would have had to engage with the Trust on.
6 Q. And they're presumably issues that emerge from its
7 geographical remoteness?
8 A. Yes.
9 Q. And what you describe is by contrast, perhaps, with
10 bigger centres such as Altnagelvin?
11 A. Yes. I think Altnagelvin were in a -- they may contest
12 this of course. I think they were in a slightly better
13 position in relation to their location and being close
14 to a large population centre and also having ambitions
15 to provide services on a wider basis because they were
16 in a border area as well. So there were opportunities
17 for them to want to develop around all of that. But
18 I think at the same time, the management philosophy
19 probably in Sperrin Lakeland was one of maybe sometimes
20 looking too much, I think, to the board for some
21 elements of this support. Even though we would want to
22 have been supportive, I think the situation in
23 Altnagelvin was one of much more robust management
24 in the sense of wanting to deal with their own business.
25 In other words, there would have been more sharing of

1 problems and issues between Sperrin Lakeland and the
2 Western Board.
3 Q. Well, that's helpful. Professor Scally, of course,
4 notes that in this, as a result of this change of
5 policy, which was writ large in the legislation,
6 accountability in strict terms was between the Trust and
7 the Department of Health; isn't that right?
8 A. That's right.
9 Q. But whether it was a case of old habits die hard or the
10 human factors that you allude to, it appears that
11 notwithstanding the absence of an accountability
12 relationship, the Trust continued to interact with the
13 Western Board almost as if this accountability hadn't
14 changed.
15 A. Well, I want to be careful not to make too much of this.
16 I'm giving you my view in relation to how I perceived
17 the differences between the two -- the two trusts. The
18 caveat I would also have is that the development of this
19 policy in Northern Ireland -- I think we were the last
20 part of the UK to go to the purchaser/provider split
21 and, from memory I think the western area was the last
22 part of Northern Ireland to go to the purchaser/provider
23 split. So there were a lot of factors there in relation
24 to how you move from one way of working to a new way of
25 working. And I think we would also need to caveat some

1 of these comments by the fact that, whether I like it or
2 not, I'm not terribly sure that the department or the
3 system generally had worked out some of the implications
4 and consequences of these new accountability
5 arrangements. In other words, they weren't, I think,
6 backed up by good operational planning to allow it to
7 happen in reality. In other words, I think we were
8 having a debate or will be having a debate, I'm
9 assuming, around whether there was any particular policy
10 or guidance as to who was reporting to who around some
11 of these issues.
12 Q. Let me be more specific. Let's get into the area of
13 adverse incidents, and by that I mean, in this
14 particular case, the situation where you had an
15 unexpected and unexplained death. You, as chief nursing
16 officer at the time of the death, would have expected
17 the Trust to be reporting to the Western Board that this
18 incident had occurred?
19 A. Yes, we would have had an expectation that they would
20 have informed us that this incident had occurred.
21 Q. And where does that expectation derive from, if that's
22 the appropriate question? It doesn't derive from
23 legislation.
24 A. I think you might find in the service level agreement
25 that we would have had with the Trust. There would have

1 been an expectation that there were governance
2 arrangements in place, and it might go too far to say
3 that they would have -- that they should have reported
4 to us, but I think in relation to ongoing work we wanted
5 to know if there was going to be an issue.
6 Q. In fairness, you're probably more familiar with this
7 service level agreement than myself, but it's not
8 explicit in the terms. This expectation that the
9 adverse incident would be reported to the board, does it
10 derive from an understanding that the board, that is the
11 Western Board, had a responsibility to be assured that
12 the health of the local populous for which it is
13 responsible was being properly attended to by the
14 organisations from whom you commissioned services?
15 A. Yes. We would have had an expectation that if there was
16 an incident that was very unexpected and was going to
17 give rise either to the need for a review or for major
18 public concern, that we would be made aware of that.
19 I don't want to be too blasé about it, but in principle
20 we wanted to hear about it from the Trust before we read
21 about it in the papers.
22 Q. If I can just bring you to something that Mr Mills has
23 said. He has said that the Western Board would receive
24 from the Trust and consider information about an adverse
25 incident and would in turn advise the Trust on any

1 details they required or action they wished the Trust to
2 take. As a statement of practice or principle, is that
3 accurate?
4 A. Well, my experience of this situation is that that is
5 not accurate in the sense that I think we were being
6 informed about an incident and we were being told what
7 the Trust was then going to do. Now, we would have,
8 of course, had an expectation that in a case like
9 Lucy Crawford, the incident would be properly
10 investigated and that there would be a report at some
11 stage in relation to what the outcome of that
12 investigation had shown and then any recommendations or
13 any points for learning that arose from that. We would
14 have had an expectation that we would at least be made
15 aware of that at some point.
16 Q. So the tension that I think your answer points up
17 is that to the extent that the Trust is saying that the
18 board and its officers should be prepared to offer
19 a guiding hand, that would not be your understanding?
20 A. It wouldn't be my understanding in the sense that
21 I think it becomes difficult if accountabilities become
22 confused in that way. There's a line there between,
23 let's say, being aware of the situation and making
24 a comment or an observation that hopefully might be
25 helpful to the Trust as opposed to maybe some sort of

1 expectation that the board was going to investigate the
2 incident.
3 Q. Yes. I don't think Mr Mills puts it that far. Perhaps
4 the position is otherwise better summed up by
5 Dr McConnell, who in his witness statement has told us
6 it was his responsibility to disseminate within
7 colleagues within the Western Board any report and
8 it would appear that he becomes, in this case, the
9 person to whom the report was initially directed. And
10 you would say that is quite appropriate because he wears
11 the director of public health hat?
12 A. That's right.
13 Q. But moving on to what he says would be his role, he says
14 that once a report is made to him, he reports it
15 internally and then works with Western Board managerial
16 and professional colleagues to ensure that the Trust had
17 and were taking all appropriate steps to investigate the
18 surrounding events. So it is a case of the report comes
19 in and Dr McConnell, working with you and other
20 colleagues, perhaps take a quick spot-check to ensure
21 that you're satisfied that the Trust are doing what
22 needs to be done to get to the bottom of this?
23 A. Yes, that's fair.
24 Q. There's then a second stage, if you like, the report has
25 come in. If the board feels the need to comment, as

1 Dr McConnell suggests, to get the thing on the right
2 track, then that might be done, but then you have, in
3 this case -- but I want to keep it as general as
4 possible before we move forward -- then you might have
5 a review carried out, leading to a report, and of course
6 that wouldn't be the approach necessarily in every
7 adverse incident.
8 But can I ask you to comment on Mr Frawley's
9 perspective? He said that where the investigation and
10 its conclusions resulted in the preparation of a formal
11 report, he would have had an expectation that the board,
12 that is the Western Board, would initiate any action
13 that is necessary arising out of that report. But
14 before reaching a judgment on whether action was
15 necessary, he would seek the views of the relevant
16 professionals within his organisation and, in turn, then
17 report back to the Trust if he thought any further steps
18 were needed.
19 A. Yes, that sounds right.
20 THE CHAIRMAN: Is that because you're talking about two
21 different sorts of reaction? One is if there's a review
22 with a report, let's say in the Erne, then there are
23 steps which may need to be taken in the Erne on foot of
24 the review, but the Western Board also wants to know,
25 because the steps taken in the Erne may have wider

1 significance? Is that the context in which the
2 Western Board wants to know what's going on?
3 A. Yes. There would be a judgment call here in relation to
4 what matters needed to be addressed let's say in the
5 very local situation of one acute unit. But if there
6 was learning or if there were issues that had a wider
7 context that needed to be dealt with, then those would
8 be escalated up to the department or to other boards.
9 But in this system, we're also depending on the Trust
10 reporting any of those issues as well to the department.
11 THE CHAIRMAN: Sorry, there's a whole lot of angles on this.
12 Let's take it away from Lucy, let's say there was
13 a serious adverse incident in the Erne, but it didn't
14 result in a child's death. The Western Board is advised
15 that the Sperrin Lakeland Trust is doing a review and
16 the review comes up with some recommendations which are
17 implemented within the Erne. Does the Western Board
18 then want to know what that report says and what those
19 recommendations are so that it can decide whether --
20 they are of broader significance than simply within
21 Sperrin Lakeland?
22 A. My knowledge of this is that I think it would depend on
23 the seriousness of the original incident because,
24 healthcare being what it is, there will be a range of
25 incidents that happen over a period of time, not all of

1 those would necessarily be escalated to the board's
2 attention --
3 THE CHAIRMAN: Right.
4 A. -- but would be dealt with internally by the Trust.
5 THE CHAIRMAN: Is that a judgment call at the Trust's end?
6 A. Yes, I believe it is a judgment call at the Trust's end.
7 THE CHAIRMAN: So it's a judgment call of whether the issue
8 leaves the Trust and goes to the board, even for
9 information purposes?
10 A. Yes.
11 THE CHAIRMAN: Is it the same judgment call at the Trust's
12 end as to whether that is also reported to the
13 department?
14 A. It would be. And again, it would be on the basis of the
15 seriousness of the event. Because you could have
16 a whole range of incidents happening within a large
17 Trust, not all of which necessarily require regional
18 action, but can be dealt with on a 24/7 basis by the
19 Trust and by talking to staff or by putting in place
20 arrangements fairly quickly that will deal with that
21 issue.
22 THE CHAIRMAN: So if an incident was sufficiently serious
23 in the Erne to lead it to report that to the
24 Western Board, then it would automatically follow that
25 it would be sufficiently serious for the Trust to report

1 that to the department?
2 A. I would have thought so, yes. That would have been my
3 expectation.
4 THE CHAIRMAN: So in your eyes, the Trust should be
5 reporting serious incidents to both the Western Board
6 and to the department?
7 A. Yes. To the board for information and for any
8 consequences that we might see as a board in relation to
9 the local population and things that might need to be
10 dealt with sooner rather than later, and to the
11 department in particular for regional learning and for
12 any other business that might subsequently arise out of
13 the report on that incident. I have to say these
14 incidents, in my time in the Western Board, were very
15 rare. If we were getting everything that potentially
16 might be going on in a healthcare system, we would be
17 dealing with that day in daily.
18 THE CHAIRMAN: I understand. We have the awful example, I'm
19 afraid, in 2001 when Raychel died that there was
20 a report made by Altnagelvin to the department. So
21 whatever the precise ins and outs of that, I presume you
22 would say that is an example of appropriate action being
23 taken --
24 A. Yes.
25 THE CHAIRMAN: -- on foot of the death of a child?

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

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

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

1 A. Yes.
2 THE CHAIRMAN: That all makes sense. Can we just go back
3 a few years? You were in the department from 1991 to
4 1997 as senior nursing officer, weren't you?
5 A. Yes.
6 THE CHAIRMAN: And that was just as the trusts -- certainly
7 on the eastern part of Northern Ireland -- were being
8 established?
9 A. Mm-hm.
10 THE CHAIRMAN: In those days, would you have been contacted
11 by the representatives of the Eastern Board, the
12 Northern Board or Southern Board to say, "Look, we've
13 got an incident here, how do we take it forward?
14 Something has happened that we think you should know
15 about"?
16 A. Well, first of all, I'm a senior nursing officer in the
17 department, so my role and function is limited to the
18 areas that I --
19 THE CHAIRMAN: Nursing issues?
20 A. Nursing issues and in my case it was primarily around
21 education issues because I was moving the
22 College of Nursing into higher education at that time.
23 I just want to make that caveat. But it would be true
24 to say that, certainly on the nursing lines, we would
25 have had conversations with directors of nursing within

1 the four board areas and if there were areas of concern
2 that were arising, we would become aware of those. But
3 I'm not aware during that period of what the formal
4 adverse incident reporting arrangements might have been
5 because I wasn't actually dealing with those.
6 THE CHAIRMAN: Okay.
7 A. So my knowledge in that area is limited, I'm afraid.
8 THE CHAIRMAN: You see, part of the reason we're going over
9 this is because it's essential to, but also because in
10 Adam's case and in Claire's case, for that matter,
11 William McKee, who as you know was the chief executive
12 in the Royal Trust, was asserting the position that, up
13 until 2003, the trusts had no legal responsibility for
14 the quality of care provided to patients.
15 He said -- and there's a degree of support from
16 Dr Ian Carson -- in terms that they say until the 2003
17 order, the people who were responsible for the quality
18 of healthcare were the individual doctors and nurses,
19 and their responsibility was to their professional
20 bodies and to the GMC. Does that put it more starkly
21 than you would put it?
22 A. Definitely, yes. It seems to me counter-intuitive that
23 if you're running a healthcare organisation, you don't
24 have any regard for what the professionals who are
25 working for you, who are your employees, are doing.

1 I take maybe the legal point, which again, if I may just
2 return for a moment to the previous conversation -- the
3 reality was that the system eventually got round to
4 producing guidance in relation to the -- it wasn't as if
5 nobody ever felt there was any need for that. We
6 eventually got round or the system got round to doing
7 that. But, sorry, chairman, returning to your original
8 proposition to me, I would find that difficult to live
9 with.
10 THE CHAIRMAN: Mr McKee said it was both counter-intuitive
11 and bizarre.
12 A. Well, we're on the same side then.
13 THE CHAIRMAN: But you don't agree with it?
14 A. Well, I don't agree with the reality of that.
15 THE CHAIRMAN: Are you saying he might be technically right
16 on the effect of the 2003 order, but that doesn't mean
17 that, in practice and in reality, each trust -- and
18 before them the boards -- had a responsibility for the
19 quality of care provided to patients?
20 A. Yes.
21 THE CHAIRMAN: Thank you.
22 MR WOLFE: I just want to go back a step, professor, to what
23 I termed as a two-stage approach. The first stage is
24 the board might get a report of an adverse incident,
25 Dr McConnell would engage with professional colleagues

1 within the board and then satisfy himself that the Trust
2 was on the right, if you like, investigative track and
3 then the Trust would be left to get on with it. There
4 would then, as you agreed with me, be Mr Frawley's
5 assessment that the board would look at some point for
6 that report to come back to the board so that the board
7 could satisfy itself that the Trust had done its
8 investigative job correctly and whether there were, if
9 you like, any lessons to learn, going forward, that
10 might be of relevance to the board.
11 Just on that -- and I see you grimace, so maybe you
12 don't quite agree with how I have set it out.
13 A. My feeling would be that we would definitely want to see
14 any recommendations arising from that review. I think
15 we would -- and again this is my own comment. We would
16 personally want to be very careful about second-guessing
17 how that investigation was done. If there was obvious
18 flaws in the investigation that the Trust weren't
19 picking up, then I think we would have a responsibility
20 to note those.
21 Q. Yes.
22 A. But if we were getting a report that said X, Y and Z has
23 been investigated, here's what we found and here are the
24 recommendations arising from that, we probably would
25 accept that.

1 Q. Thank you for clarifying that. The question I was
2 moving on to then was: was there in place within the
3 Western Board a mechanism by which that judgment could
4 be made? If a report becomes available to the board,
5 there has to be some kind of facility by which it can be
6 considered; was there such a facility?
7 A. Well, two points if I may. Number 1, this was not
8 a frequent occurrence. The second point is that it is
9 more than likely that a report such as that would have
10 been discussed at the healthcare committee of the board
11 and would have had input from a variety of professionals
12 who had some competence in that area.
13 Q. Yes. Moving on then to the specifics, Mr Hugh Mills,
14 the chief executive of the Sperrin Lakeland Trust,
15 indicated in his evidence that he notified Dr McConnell
16 of the adverse incident, which was the death of
17 Lucy Crawford, and, as I understand it, you were
18 notified via Dr McConnell that this had occurred?
19 A. That's correct.
20 Q. And at that point, at a very early stage in what was to
21 become a process, did you have to take any action?
22 A. At that stage, no. I was informed through general
23 conversation that an incident had happened in the Erne
24 and that a child had died, and the death was unexpected.
25 Q. You did, at a slightly later point, but within a matter

1 of days, have an informal discussion with Mr Mills. You
2 described this, to the best of your memory, as being
3 a brief conversation that took place on a corridor?
4 A. That's correct.
5 Q. And by virtue of that conversation, you understood that
6 the Trust was set to engage in a process of review and
7 that -- I think as you describe it -- Mr Mills had asked
8 Altnagelvin Trust to provide an independent view on the
9 issue. And as we now know, a Dr Murray Quinn provided
10 that input.
11 A. Yes.
12 Q. In terms of your understanding of what had happened,
13 were you inquisitive as to the nature of the problem?
14 A. Well, yes, I mean, I was inquisitive. What I was -- my
15 memory of that encounter with Mr Mills was that the
16 child -- a child had died unexpectedly, that there was
17 an issue over intravenous fluids and there seemed to be
18 a disagreement between the medical and the nursing staff
19 over the administration of those fluids. So that was an
20 extra bit of information that I was being given at that
21 time.
22 Q. Was the picture painted for you of the potential that
23 the child had received incorrect fluid therapy and that
24 was one of the question marks or one of the questions to
25 be addressed during the review?

1 A. From memory, I cannot be clear that it was as explicit
2 as that. What I noted was that there was
3 a complication, a disagreement, between the medical and
4 the nursing staff over the administration of this fluid.
5 Q. Just in terms of your own personal involvement in this,
6 you, as I understand Mr Fee's evidence, met with him as
7 part of the usual round of commissioning meetings that
8 you had.
9 A. Yes.
10 Q. I think he refers to a meeting on 10 May, which was
11 nothing other than one of these usual regular meetings,
12 and he may have addressed the issue of the ongoing
13 review with you. And then, on 12 May, you visited the
14 Erne Hospital to speak to staff who had been involved in
15 the care of Lucy.
16 A. Yes. This is all from memory. My memory of that
17 encounter was that we took time aside at that meeting to
18 discuss the incident and what Mr Fee was doing and some
19 of the issues around it. Again, being aware of the
20 piece of information that I had that there was
21 a disagreement between the professionals involved over
22 the administration of this fluid and also being aware
23 that the staff had been very traumatised, as it was
24 described to me, by the death of Lucy, I decided to go
25 and have a look at the paediatric unit again and to meet

1 with whatever staff were there. Now, the staff that
2 were there were mainly day staff rather than staff at
3 night, and I don't, from memory, think any of the staff
4 who had been involved in the situation were present.
5 But I wanted to orientate myself to the layout of that
6 ward. I think, from memory, that I met Sister Traynor,
7 Etain Traynor, and just left myself open for any
8 comments or anything that anybody wanted to talk to me
9 about. I was also, being, I think, very careful about
10 not second-guessing or interfering in any way with the
11 inquiry that would be going on.
12 Q. Your visit --
13 MR COUNSELL: I wonder if the witness could be asked to sit
14 a little closer to the microphone. We're struggling to
15 hear him at the back.
16 THE CHAIRMAN: Of course.
17 MR WOLFE: The decision to visit the ward, an unusual action
18 on your part. It's not something you would do
19 regularly, I'm sure.
20 A. Well, if I was involved in the commissioning of
21 a service or in the change in a service, I would quite
22 frequently go into clinical areas and meet with
23 clinicians and discuss issues. So I don't think either
24 Sperrin Lakeland or Altnagelvin would have been
25 surprised at me doing that. I had a tendency and

1 a desire to do that.
2 Q. Your decision to visit the ward and to familiarise
3 yourself again with the layout, as you described it, was
4 that in any sense with a view to enabling you to better
5 understand what had happened?
6 A. I think two things. One, I wanted to be seen to be
7 supporting the staff in the paediatric unit and then,
8 secondly, yes, there was an opportunity to just
9 orientate myself again to what that ward was like. As
10 I say, where the layout -- I think I asked specifically,
11 I think, where Lucy Crawford had been nursed and then
12 left myself open to anybody who wanted to say anything
13 to me.
14 Q. Were you seeking views as to what might have happened?
15 A. No, no, I wasn't. I was there primarily to offer
16 support in the best way that I could.
17 Q. Yes. Could I have up on the screen, please, WS307/1,
18 page 3? This is your witness statement. At the bottom
19 of the page you're asked, at (e), a particular question:
20 "In circumstances where a Health and Social Services
21 trust notified you or your office of an unexpected and
22 unexplained death, what were your particular
23 responsibilities and where did those derive from?"
24 And you start by telling us:
25 "In 2000, the reporting of adverse incidents was not

1 as well-organised as it is today."
2 You go on to say, presumably dealing with the
3 situation in 2000:
4 "If a trust notified me of an unexpected or
5 unexplained death, I would have asked the Trust to
6 explain what action was being taken to investigate the
7 circumstances, and also ask if the coroner had been
8 informed. I would have suggested that the Trust
9 considered making the DHSS aware of the situation if the
10 death was giving cause for concern, could have
11 implications for patient/public safety, or likely to be
12 of public concern. I would also have requested that
13 learning from the death or the circumstances surrounding
14 the death would have been communicated to the board.
15 I would also have shared such information with the
16 director of public health and chief executive. I would
17 have seen this as the responsible approach to take."
18 Can I take it that the answer that you've given
19 there might be of more general application in the sense
20 that if the director of public health in the
21 Western Board is notified in the way that's premised
22 in the question, that you would expect the director of
23 public health to run through this checklist of items to
24 do?
25 A. Yes. And if I may say, reading that again, I think

1 I was answering a very general question at the top.
2 Q. Let's --
3 A. I think what --
4 Q. There's usually a preface to the question. If we can
5 have the full page, please.
6 A. I'm sorry, I'm talking about question (e).
7 Q. Indeed.
8 A. All I'm, I think, trying to point out here is that
9 it would be unusual for a Trust to approach me as the
10 chief nursing officer in the board to tell me all of
11 this. It probably would have been possible for somebody
12 like Mr Fee, who was also a nurse, to ask for or make me
13 aware of an issue and to ask for advice on this. So
14 I just want to be clear about that. I'm not taking over
15 here from the chief executive or from the director of
16 public health.
17 Q. Yes. Well, as appears from the description of your
18 involvement, you had certain contacts, contact with
19 Mr Mills, contact with Mr Fee, engagement internally
20 with Dr McConnell. Can you help us on this? In terms
21 of your own direct involvement, did you ask Mr Mills or
22 Mr Fee whether the department had been notified?
23 A. My contact with Mr Mills on this issue was limited.
24 I have memory of having a conversation at some stage,
25 but I cannot remember when. I imagine it must have been

1 in the early stages of this, of asking Mr Fee will he
2 consider that the department would need to know about
3 this issue.
4 Q. Could I say Mr Mills has it that it was on Wednesday,
5 19 April, which was just under a week after the death.
6 But go on, I interrupted you.
7 A. If you're referring to the meeting Mr Mills had with me
8 in the corridor, that just did not -- this conversation
9 would not have happened there because there would not
10 have been enough detail to make me respond in that way.
11 This is more likely to have been a conversation with
12 Mr Fee on the back of him making me more aware of some
13 of the details of this incident when we met in May.
14 Q. I'm not saying that you did mention it to the
15 department. I suppose the question is: to the best of
16 your recollection, doing the best you can, do you think
17 you raised that query at any point with the Trust
18 officers who you were meeting?
19 A. From memory, I raised that issue with Mr Fee, but
20 I cannot remember when. But it would have been in the
21 early -- it would have been in the early stages.
22 Q. And again, doing the best you can, what answer do you
23 think you got?
24 A. I don't think I got an answer. It was a comment to him
25 that he would need to consider whether or not this was

1 an issue that the department would need to be made aware
2 of.
3 THE CHAIRMAN: Can I ask you: did it appear to you to be
4 very obviously an issue that the department needed to be
5 aware of?
6 A. I think, given the concern that there was about the
7 death at that level, at the local level -- and I don't
8 want to be misunderstood when I say this -- but also
9 given the potential for publicity sooner rather than
10 later around this, that wouldn't have been the only
11 motivating factor here, it seemed to me to be a wise
12 thing to make the department aware.
13 MR WOLFE: I suppose the next step on this is whether you
14 took any action to ascertain whether the department was
15 in fact made aware of the death.
16 A. No, I didn't do that. I probably would have felt that
17 was beyond my remit. I mean, that -- I didn't do it.
18 Q. Professor Scally, who has looked at these things on our
19 behalf, observes that notwithstanding the absence of
20 direct accountability, he puts it on (a) a professional
21 footing and (b) the fact that you had this
22 responsibility for the local populous that there was
23 arguably an onus on the board and its officers to assure
24 themselves that a report had been made to the
25 department.

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

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

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

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

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

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

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

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

1 they would await the outcome of this review before
2 taking any action or reaching any further decision
3 in relation to it, but there seems to have been
4 a failure to recognise that this report had not arrived
5 with the board as a corporation to then be discussed by
6 the board. That just seems not to have happened;
7 is that fair?
8 A. I think that's fair, yes.
9 Q. And of course, given your professional obligations and
10 your obligations to the local populous, that was
11 a significant omission.
12 A. It does seem extraordinary, I have to say, that we
13 didn't get ourselves to a point where we would have had
14 a more open debate about that. Now, I, at some stage,
15 was aware of the recommendations in the report that
16 we've seen and began to deal with those in my own
17 capacity as chief nursing officer.
18 Q. I'm going to bring you to those in just a moment. In
19 fairness to you, we'll deal with those in some detail.
20 But just on this, Dr McConnell has observed to the
21 inquiry -- and I ask you this because I think you've
22 just told us that yourself and Dr McConnell, possibly
23 arising out of the communication of the report to you
24 from Mr Fee, had a conversation. So yourself and
25 Dr McConnell are conversing about the report. What

1 Dr McConnell has told us is that any review of a medical
2 event such as this needs to have credibility in the eyes
3 of the public, in the eyes of the family. He tells us
4 that he expressed his reservations to Mr Mills about the
5 fact that there might well be a perception that
6 Dr Quinn, who had been retained to carry out a case note
7 review for the Trust, and that perception of a lack of
8 independence or perhaps perception of bias would have
9 arisen, in Dr McConnell's view, from the fact that
10 Dr Quinn had had, if you like, a relationship with the
11 organisation with which he was charged with
12 investigating or reviewing. Was that expression of
13 concern ever made known to you?
14 A. From memory, that concern wasn't articulated in that
15 way. Again, I have a memory of a conversation or
16 conversations around elements of the adequacy of this
17 report, which I am never totally sure came to any real
18 conclusion other than more work needed to be done. And
19 I think from what I've seen and in relation to the
20 background evidence that I've been party to now, it
21 seems to me that Dr McConnell probably was more aware of
22 some of the background to this than I was.
23 I've been listening to Dr Stewart this morning and
24 I've seen the papers or the reports that have been
25 produced, all of that is new to me in relation to the

1 amount of detail that there is there. That would
2 explain, I think, the ongoing engagement with the Royal
3 College of Paediatricians, which, on reflection, seems
4 to be a way of trying to progress that report from where
5 it was.
6 Q. Can I just come in on that? I don't intend cutting you
7 short. It's the end piece of Dr McConnell's analysis,
8 by reference to concerns about the perception of a lack
9 of independence in the person of Dr Quinn, that he was
10 of the view that a broader report or broader review
11 should be carried out. But equally, there might have
12 been another reason for a broader review to be carried
13 out, and that was the fact that the review report
14 commissioned by the Trust had not led to any firm
15 conclusions about why this child had died. Did you pick
16 up on that when you were shown the report or the report
17 was discussed with you?
18 A. I don't think I was picking up on the independence of
19 Dr Quinn.
20 Q. It's the second point I'm asking you to focus on,
21 whether the absence of conclusiveness was -- did it bear
22 upon you as a reason for going down the route of
23 conducting a broader review?
24 A. Yes, I would have been concerned about the fact that
25 we weren't really coming to any conclusions. Even the

1 fact of the mistakes, as I would see, human factors
2 again in relation to the prescription of the fluids and
3 the administration of those fluids and the confusion
4 around all of that, was a matter for some more
5 investigation, which I didn't really see there.
6 Q. You were aware, as you've told us, that the Royal
7 College had been engaged quite quickly after this review
8 was produced. As you would have heard from Dr Stewart's
9 evidence this morning -- and I think you said you heard
10 it -- she had it in mind -- and indeed her terms of
11 reference said so -- that she was conducting
12 a performance and competence review, as opposed to
13 engaging in a medical report process. Were you aware
14 that that was the distinction in the review that was
15 being taken forward after this first review?
16 A. My knowledge of this review is very limited. I don't
17 think I was engaged in any real discussions at board
18 level around that review. But it would have been
19 reasonable in my state of mind at the time where I was
20 really, I think, focusing on the competence of the
21 medical staff and the nursing staff in the management of
22 this case, so a review around competence would have
23 seemed to me at that time as being a logical step
24 forward.
25 THE CHAIRMAN: And it would be particularly important for

1 you, wouldn't it, because you're a director of the body
2 which commissions services from this Trust? So if it is
3 the case that a consultant in the Trust is not competent
4 to provide those services, that is something that the
5 Western Board would be very, very interested in?
6 A. Yes.
7 THE CHAIRMAN: And in fact, you would want, at the
8 Western Board, to be reassured that the outcome of the
9 competency review is that the consultant is actually
10 competent or, if he isn't, if he's got weaknesses or
11 gaps in his knowledge, that some training or support is
12 going to be put in place to make sure that his
13 imperfections do not put local children at risk?
14 A. Yes, I agree.
15 THE CHAIRMAN: Right.
16 MR WOLFE: That's the competence issue and we have your
17 evidence on that. But should the board have been
18 seeking assurances from the Trust that with regard to
19 the clinical outcome for this child that further work
20 would be done by it in order to get, if you like, to the
21 bottom of what had happened?
22 A. Yes -- I mean, that, of course, is a reasonable approach
23 to take. From my own personal point of view, I think
24 I became distracted by what I would have perceived to be
25 the competency issues, regretfully, but I did become

1 distracted by that. If I may say so, there is a logic
2 that if you can get to the bottom of the competency
3 issues, you might also get to the bottom of what exactly
4 happened here in relation to the death of Lucy.
5 THE CHAIRMAN: Did you ever get the reassurance about
6 competence?
7 A. I personally don't think I did, really.
8 THE CHAIRMAN: Okay. Do you know of anybody in the
9 Western Board who got reassurance about competence?
10 A. I'm assuming that Dr McConnell did.
11 THE CHAIRMAN: Do you know if he saw Dr Stewart's reports?
12 A. I don't know.
13 THE CHAIRMAN: Did you see Dr Stewart's reports?
14 A. No.
15 MR WOLFE: I promised to go back to the steps that you did
16 take and if we could just have up on the screen, as an
17 aide memoire for you, what you said in your witness
18 statement. It's WS307/1 at page 11. We asked you at
19 23:
20 "Did you give any consideration to whether any of
21 the issues arising out of Lucy Crawford's case warranted
22 dissemination to a wider audience in the NHS in
23 Northern Ireland? If so, explain the consideration you
24 gave to this matter, the conclusions which you reached
25 and any action that you took."

1 Just before we get into the steps that you took,
2 question 22, I think, it's helpful perhaps to start
3 there. You are asked to:
4 "Outline the criteria or factors which you would
5 have taken into account when determining whether issues
6 identified as a result of a critical incident needed to
7 be disseminated to others in the NHS in
8 Northern Ireland."
9 And really, it's a professional judgment call and
10 what you've explained is you would need to work out:
11 "... whether the incident was unique or likely to
12 occur again, particularly if there were conditions
13 within the clinical environment which might lead to
14 a recurrence."
15 So if you like, that's the test. And you say that
16 among local directors of nursing, you brought up
17 a number of points. Is that, professor, because, if you
18 like, the test had been met? There were issues emerging
19 from your understanding of what had happened in the case
20 of Lucy Crawford, which were of sufficient either
21 uniqueness or held the characteristic that they could
22 recur again that caused you to bring them forward to
23 a wider audience?
24 A. Initially, I was bringing those forward to the local
25 directors of nursing. Those would be the directors of

1 nursing within the Western Trust. And then I did raise
2 the issues with my other colleagues in the other three
3 area boards as a matter of information. These issues,
4 however, are not unique in the sense that if you look at
5 things that go wrong in healthcare, I'm afraid -- with
6 the exception maybe of the final indent -- maintaining
7 accurate clinical records, fluid balance and ensuring
8 accuracy in administration of intravenous fluids and
9 making sure that prescriptions are not ambiguous, all of
10 those are recurring themes right up to today. Even as
11 we speak, the National Clinical Standards Authority in
12 England are consulting on the same administration of
13 intravenous fluids because it still remains an ongoing
14 issue for us.
15 Q. Yes.
16 A. In relation to the need for maintaining good
17 observations of a sick child and being aware of the
18 early signs of deterioration, the first part of that
19 in relation to good observations is obviously again
20 something that we continue to struggle with and make
21 sure that that happens as and when it is required.
22 I think the issue with Lucy Crawford was the
23 apparent suddenness of her deterioration, and I think
24 just being aware of the need to be really, really aware
25 of such deterioration in a young child, which can

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

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

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

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

1 (4.07 pm)

2 (The hearing adjourned until 10.00 am the following day)

I N D E X

DR MOIRA STEWART (called) 1

Questions from MR WOLFE 1

PROFESSOR MARTIN BRADLEY (called) 91

Questions from MR WOLFE 91