1 Tuesday, 25 June 2013
2 (10.30 am)
3 THE CHAIRMAN: Good morning. Ms Anyadike-Danes?
4 MS ANYADIKE-DANES: Good morning. Could I call Dr Curtis,
5 please.
6 DR MICHAEL CURTIS (called)
7 Questions from MS ANYADIKE-DANES
8 MS ANYADIKE-DANES: Good morning, doctor. Can I ask you if
9 you have your curriculum vitae there, please?
10 A. Yes, I do.
11 Q. And do you have a copy of your statement?
12 A. Yes.
13 Q. Doctor, I'm going to ask you whether you adopt as your
14 evidence what is in your statement, subject to anything
15 that you may say now in evidence.
16 A. Yes.
17 Q. So that we're clear on the statements to which I refer,
18 you have made two statements, both for the inquiry: one
19 dated 13 November 2012 and the other dated
20 11 January 2013. The series is 275, so that's 275/1 and
21 275/2. Do you adopt those as your evidence?
22 A. I do. 13 November and 11 January.
23 Q. That's correct.
24 A. Yes.
25 Q. Thank you very much indeed. Then if we go to your

1 curriculum vitae, and if we can pull up, please,
2 alongside each other, 315-024-001 and 002. From that,
3 we see that you qualified first as a doctor in 1977;
4 is that correct?
5 A. That's correct.
6 Q. And you did your horsemanship -- you had a period in
7 general medicine, it would appear, in Sunderland, and
8 then a period in surgery in Middlesbrough.
9 A. Yes.
10 Q. Then you also identify that, whilst you were at
11 Newcastle -- so that's a period from 1979 to 1986 -- you
12 would give frequent presentations in clinicopathological
13 presentations and you did similarly when you were in
14 north Manchester, 1986 to 1988.
15 A. That's correct.
16 Q. Can I ask you in what circumstances you would be
17 engaging or providing those clinicopathological
18 presentations?
19 A. Well, I was functioning as a consultant histopathologist
20 at the time in Manchester and as a senior registrar in
21 Newcastle, and these would have been conferences where
22 clinicians would come along to discuss clinical
23 presentation and treatment of patients and then the
24 pathologist would show the pathology, show the
25 photographs of the gross specimen and then would show

1 the microscopy of the specimen.
2 Q. Is that a death that would have happened in that
3 particular hospital?
4 A. Yes. In fact, very often it wasn't a death; it was
5 surgical pathology, it was on resected specimens from
6 living patients.
7 Q. What was the purpose of those clinicopathological
8 correlations or presentations?
9 A. Basically, if you like, a global understanding of all
10 aspects of the case to assist in further treatment of
11 the patient.
12 Q. So for example, you would have seen the slides and you
13 would be presenting from your perspective as
14 a pathologist --
15 A. Yes.
16 Q. -- what you saw? You'd be presenting that in a forum
17 when there were the clinicians who would have treated
18 the patient and the two of you -- not necessarily just
19 two, but the two disciplines -- would try and identify
20 what the problems might be, what might be the cause or
21 the condition, as a way forward in treatment?
22 A. Yes. If it were to be a tumour, for instance, the
23 nature of the tumour, the staging -- that's how far it
24 spread -- and then, on the basis of that information,
25 the clinicians would decide the future treatment plan of

1 the patient.
2 Q. Yes, and did you do that in circumstances where there
3 had been a fatality as well?
4 A. Yes.
5 Q. Is that something that routinely happened in those
6 hospitals?
7 A. Yes.
8 Q. You came to Northern Ireland in 1999.
9 A. Yes.
10 Q. And when you did that, you came as an assistant State
11 Pathologist?
12 A. Yes.
13 Q. And you have said in your first witness statement -- we
14 don't need to pull it up, but the reference for it is
15 witness statement 275/1, page 3 -- that from time to
16 time you were consulted for assistance by other
17 pathologists who may have had concerns about autopsy
18 findings.
19 A. Yes.
20 Q. Were you aware, when you were working as the assistant
21 State Pathologist, of those other pathologists
22 themselves engaging in clinicopathological correlations
23 or presentations?
24 A. Yes. I knew such conferences happened in the hospitals.
25 I mean, they are commonplace, routine in fact.

1 Q. Good practice, would you say?
2 A. Good practice and, I would say, universal practice.
3 Q. Thank you very much. You had worked in the
4 State Pathologist's office for seven months or
5 thereabouts prior to the events surrounding Lucy's
6 death, or thereabouts. She died in April 2000.
7 A. Yes. I think I started there on 1 September 1999.
8 Q. By that time, that is by the time of her death
9 in April 2000, how familiar were you with the
10 arrangements between the State Pathologist's office, for
11 example, and the coroner's office?
12 A. Oh, very familiar.
13 Q. Very familiar. And when you say that, does that mean
14 that you had a lot of communication with the coroner's
15 office?
16 A. Yes.
17 Q. When you were providing us with your statement -- this
18 is 275/1, page 3 -- you say when you worked at the
19 State Pathologist's office, you fulfilled the role as
20 a consultant forensic pathologist for the
21 Northern Ireland Office.
22 A. That's correct.
23 Q. In that capacity you attended scenes of crime, you
24 performed autopsy examinations, prepared reports and
25 attended court and so forth as an expert.

1 A. Yes.
2 Q. And you said you would also receive informal requests
3 for advice from medical colleagues -- that would
4 normally be in the form of telephone calls -- and that
5 would include advice regarding the cause of death in
6 particular cases. In the course of all of that, did you
7 receive calls from the coroner's office asking you to
8 provide advice?
9 A. Yes, infrequently.
10 Q. When you did that, who would those calls come from,
11 typically?
12 A. It would be either staff within the coroner's office,
13 and I think on rare occasion, possibly the coroner
14 himself.
15 Q. And this is seeking your guidance in relation to what
16 sort of issues?
17 A. General advice regarding matters medical.
18 THE CHAIRMAN: Can I just check with you: was it only the
19 Belfast coroner who you had contact with, or with the
20 coroner for Tyrone or Antrim?
21 A. Yes, with coroners throughout Northern Ireland.
22 THE CHAIRMAN: Thank you.
23 MS ANYADIKE-DANES: And when you say "matters medical",
24 might that be to assist in understanding or identifying
25 the cause of death in certain circumstances?

1 A. Yes, offering --
2 Q. Offering them advice?
3 A. Offering advice and maybe explanation and clarification.
4 Q. Yes. And when you were doing that, did you ever do that
5 speaking to a clinician directly who had been referred
6 to you from the coroner's office that you can recall?
7 A. I can't recall. I can't recall specific examples.
8 I have a feeling it might have happened very
9 infrequently.
10 Q. Very infrequently?
11 A. Yes.
12 Q. But in the main, it was your advice being provided
13 either to the coroner or coroners or personnel in their
14 office?
15 A. Yes.
16 Q. And the personnel in their office, are these the
17 personnel who, so far as you'd be aware, are those
18 taking the reports of death and therefore needing to get
19 some guidance on what the next steps ought to be?
20 A. Yes.
21 Q. Then can I just ask you very briefly about your
22 knowledge of hyponatraemia and fluid management to the
23 extent that that's relevant in this case? How familiar
24 were you generally with paediatric cases?
25 A. Not very familiar.

1 Q. Well, if your advice was being sought in relation to
2 a paediatric case, is that the sort of thing that you
3 might wish to have other input before you expressed
4 a view or ...
5 A. It would depend on what I was being asked. To go back
6 to your original question regarding fluid balance,
7 I would profess no expertise there.
8 Q. Yes, I was going to come to that. So that was something
9 that you wouldn't be able to help with if you were being
10 asked about that?
11 A. No.
12 Q. If you were being asked about a case of gastroenteritis,
13 a fatality involving gastroenteritis, would you be able
14 to express a view as to how common the incidence of
15 gastroenteritis was likely to be in terms of a cause of
16 death?
17 A. No.
18 Q. Would you even know?
19 A. It's not terribly common, but still occurs in the UK.
20 Q. Would you be surprised to hear of a paediatric death due
21 to gastroenteritis in Northern Ireland?
22 A. No. I mean, people can get fulminant infections and
23 succumb to them.
24 Q. If you were being asked about it, would you want to know
25 a little bit more about it if it's not something that's

1 particularly common? I mean more about the
2 circumstances of it.
3 A. Yes.
4 Q. Would you have been sufficiently familiar with
5 paediatric -- well, not even just paediatric cases, but
6 if you had been asked about a case involving both
7 dehydration and cerebral oedema, for example, would you
8 have been sufficiently familiar with that to even ask
9 questions about the likelihood of those two things being
10 present?
11 A. Oh, I'd understand the theory of that.
12 Q. And when you say that, does that mean that you might
13 have been surprised to hear that a person had both
14 dehydration and cerebral oedema?
15 A. No.
16 Q. Why wouldn't you be surprised?
17 A. Because cerebral oedema can occur due to a variety of
18 mechanisms. In an ill person, a lack of oxygen getting
19 to the brain can cause brain swelling. In severe
20 dehydration, the amount of circulating blood volume can
21 be reduced so therefore there is not enough blood flow
22 to the brain and, in response to both of those insults,
23 the brain can swell. Furthermore, in dehydration, the
24 blood can sludge and clot in the cerebral veins, the
25 veins inside the skull, bringing about cerebral oedema.

1 So there are several mechanisms by which cerebral oedema
2 could occur with dehydration resulting from
3 gastroenteritis.
4 Q. Yes. It's also possible, is it not, for the
5 inappropriate treatment of dehydration to produce
6 cerebral oedema?
7 A. That is possible, yes.
8 Q. So if you were just given those two things,
9 a combination of those two things, to express any kind
10 of view, would it be fair to say you'd need to know
11 a little bit more about whether you're dealing with an
12 unfortunate but natural consequence of a condition or
13 the intervention of some iatrogenic act?
14 A. I would not really have suspected a problem with any
15 kind of iatrogenic act unless my attention had been
16 drawn to it.
17 Q. Not so much suspected, but because there are a number of
18 routes from which you could get from dehydration to
19 cerebral oedema, not all of them necessarily entirely
20 natural, some of them might be the product of
21 inappropriate treatment in whatever respect, what I was
22 asking you about is: if you're given those two things
23 before you would express a view as to whether that was
24 safe to say that that was a natural death, would you not
25 want to know a little more?

1 A. I don't think I have the expertise to really take that
2 on board.
3 Q. So if you were given those two things, you wouldn't want
4 to express a view because you wouldn't consider that to
5 be within your area of expertise?
6 A. Certainly the fluid management bit wouldn't be within my
7 area of expertise. Certainly I would not have suspected
8 fluid mismanagement unless that had been drawn to my
9 attention.
10 Q. I was putting it to you in a slightly different way,
11 which is because there could be a number of different
12 routes to get from one to the other, if I can put it
13 that way, if you're given just those bald facts before
14 you expressed a view, would you wish to know a little
15 more?
16 A. Speaking today, the answer is yes.
17 Q. Even in 2000, would you want to know a little more?
18 A. I don't think alarm bells would have rung in my head
19 regarding that. I would have not -- if I had -- on what
20 is alleged here, if I had been given three entities,
21 gastroenteritis, dehydration, cerebral oedema, I would
22 not have had alarm bells ringing in my head to think
23 there was clinical mismanagement here.
24 Q. No, I'm putting it to you slightly differently here;
25 I haven't gone to the clinical mismanagement or even the

1 alarm bells. Would you simply want to know a little bit
2 more before you gave anybody any guidance as to whether
3 you thought that was a natural death?
4 A. Only in the sense -- would be to ask if there was any
5 problem with management or are there any other factors
6 that I should be aware of.
7 Q. Yes. If I put it to you in this way: if a clinician had
8 phoned you up and said, "Look, I have just had a child
9 die here. From what I can see, it's certainly cerebral
10 oedema because I've looked at the CT scan. Started off
11 with gastroenteritis and became dehydrated; what do you
12 think?", the conversation wouldn't end there, would it?
13 You would ask that clinician a little bit more about the
14 circumstances.
15 A. Yes, and ask more about the circumstances.
16 Q. And the reason you would be asking more is so that you
17 can form, so far as you can, an informed judgment as to
18 whether you think this is a natural death or not?
19 A. Yes.
20 Q. Thank you. If I can now tease out a bit the
21 relationship between the coroner's office and the
22 State Pathologist's office. The coroner has described
23 it in this way -- have you seen the coroner's two
24 witness statements?
25 A. Yes.

1 Q. Thank you. In his second witness statement, so it's
2 277/2, page 4, it's described like this:
3 "From my own knowledge, I can state that in
4 Greater Belfast --
5 THE CHAIRMAN: It's at paragraph 1(a) on the screen, doctor,
6 in front of you.
7 MS ANYADIKE-DANES: It starts at the third sentence:
8 "From my own knowledge, I can state that in
9 Greater Belfast, the practice had evolved as seeking
10 from time to time advice and guidance from the
11 State Pathologist's Department. Such advice would be
12 sought only if it was unclear to either the coroner or
13 the staff if it was appropriate for a death certificate
14 to be issued by the reporting doctor or if there should
15 be a post-mortem examination. This arrangement was
16 informal."
17 You were asked about your knowledge at that
18 time, April 2000, of the relationship between
19 the coroner's office and the State Pathologist's office,
20 and you provided in your second witness statement, at
21 275/2, page 3, you say:
22 "I am not aware of any formal arrangement between
23 the State Pathologist's office and the coroner's office.
24 Certainly, I was never briefed regarding any such
25 guidelines nor provided with any written guidelines from

1 the Northern Ireland Office or its staff. I cannot say
2 that there was an informal arrangement either."
3 Can you help us further: are we to take it from your
4 witness statement that you don't entirely accept the way
5 the relationship is characterised?
6 A. No, I would accept that. I would accept that we would,
7 on an informal basis, try and be helpful and give advice
8 when it was sought.
9 Q. Yes. And when you joined, did you have that explained
10 to you --
11 A. No.
12 Q. -- that that was one of the sorts of things that might
13 happen from time to time?
14 A. No, it was just taken as read.
15 Q. It just happened and you responded as best as you could?
16 A. Yes.
17 Q. When you did have those sorts of contacts, leaving aside
18 the ones that you might have with the coroner, I think
19 you also recognise that some of them would come from the
20 personnel in the office who were charged with recording
21 the report from a clinician, we're dealing with in this
22 instance, of a death and seeking to provide some
23 guidance to that clinician as to what the next step
24 should be. So this would be a call coming to you from
25 a non-medical person, a person in the coroner's office.

1 Did you understand when a call like that came, whether
2 it was coming to you as part of seeking general
3 information or coming to you because a person was unable
4 to make contact with the coroner?
5 A. General information.
6 Q. Were you ever aware that a call was coming because the
7 person contacting you couldn't reach the coroner,
8 a decision had to be made that the clinician was waiting
9 to know what they should do and really you were being
10 asked to give the sort of guidance that a coroner might
11 give to the person calling you? Did you ever appreciate
12 that?
13 A. No. And that's not a role I would see it appropriate
14 for me to adopt.
15 Q. If you'd known that's what was happening, what would
16 have been your response?
17 A. My response would be that's not my place to assume that
18 role.
19 Q. And why would that have been your response?
20 A. Well, because that is properly a coroner's role, which
21 is the specific function of the coroner.
22 Q. Yes. It's not difficult to see how it might happen.
23 The coroners do have to be available 24/7, but that's
24 simply not always possible; they're engaged doing other
25 things.

1 A. Mm-hm.
2 Q. Then you've got, if I can call it this way, laypeople
3 in the office.
4 A. Yes.
5 Q. They're taking a report, there's a doctor who needs to
6 know, "Can I issue a death certificate in these
7 circumstances?", or, "Is the coroner going to take it
8 into his own jurisdiction, request a post-mortem or
9 whatever?", or, "Am I going to be told you can issue
10 a form 14?", if you're aware of the terminology, but
11 whatever it is, there's a doctor there wanting to know,
12 "What can I do?". So it's not difficult to see that the
13 person receiving that call, trying to find the coroner,
14 can't find the coroner, looks to the office with whom
15 they have a relationship, which is the
16 State Pathologist's office, and really is asking for
17 guidance as to: is it all right to tell this doctor that
18 a death certificate can be issued? It's not difficult
19 to see how that might arise.
20 A. Right.
21 Q. Were you ever aware of that circumstance?
22 A. I don't think so. Not specifically, no. Not knowingly.
23 It's not a role I would assume. It's not a role I could
24 assume. I would be able to give general advice, I'd be
25 able to quote the kinds of cases that should be referred

1 to the coroner --
2 Q. Yes.
3 A. -- and really, not above and beyond that. If you're
4 asking me, "Would I, in those circumstances, make the
5 decision whether or not a case needs to go to
6 a post-mortem or not?", no. I could say a case like
7 that should be reported to the coroner or must be
8 reported to the coroner, I could say that's natural, and
9 if there are no other circumstances to cause concern
10 then it would be appropriate to offer a certificate.
11 Q. Yes. But to a layperson on the other end of that, if
12 that was their problem, they wanted to know what they
13 could tell the clinician, having spoken to a trained
14 person who says, "That sounds to me like a natural cause
15 of death", or, "I think that's a matter that the coroner
16 ought to pursue further by way of an autopsy", you can
17 see, can't you, that to a person like that, that might
18 seem like the answer and they might then go back to
19 a clinician and say, "I think you can issue your death
20 certificate"?
21 A. They might, but any discussion I had would be in terms
22 of general advice; it would not be to assume the role of
23 the coroner. That could not happen.
24 THE CHAIRMAN: So if there was an exchange along the lines
25 of case X is referred to you and you say, "That sounds

1 as if it should go to the coroner", or, "That sounds
2 natural, so it's appropriate to issue a death
3 certificate", you're giving that as advice? You never
4 understood yourself to be giving that as the final
5 decision?
6 A. That's exactly correct, sir.
7 THE CHAIRMAN: Thank you.
8 MS ANYADIKE-DANES: Thank you. Just so that we clear it
9 up -- well, make sure it is clear -- although you were
10 giving that advice, you weren't intending it to be
11 a final decision, you were trying to be helpful, nor
12 were you ever alerted to the fact that it was being used
13 in that way?
14 A. Both of those statements are correct.
15 Q. Thank you. Have you since ever understood that advice
16 from any of the pathologists in the State Pathologist's
17 office was being used like that by the personnel in the
18 coroner's office?
19 A. Could you just explain that? Are you saying that do
20 I understand that I was de facto acting as the coroner?
21 Q. No, not quite. That was the position up
22 until April 2000, that in your view you didn't
23 appreciate, if it was being used like that, you didn't
24 appreciate that it was.
25 A. Yes.

1 Q. That's the first point that you've made very clear.
2 What I'm asking you now is: thereafter, have you ever
3 learnt or appreciated that the advice that the
4 pathologists were giving to the personnel in the
5 coroner's office was actually being used like that?
6 A. No.
7 Q. You've never appreciated that?
8 A. No.
9 Q. And that's never been discussed with you? All the time
10 up until 2004 -- I think November 2004 you left --
11 that's not been discussed with you all the time you were
12 there?
13 A. It has not.
14 Q. And if others were doing that, you certainly weren't
15 aware of that?
16 A. That is perfectly true.
17 Q. Did you know that your name at least is recorded in the
18 main register of deaths in relation to the report made
19 about Lucy?
20 A. Yes.
21 Q. When did you first know that?
22 A. When the inquiry contacted me.
23 Q. You didn't know that at the time?
24 A. No.
25 Q. If that was going to happen, would you have wanted to

1 know that?
2 A. Um ...
3 Q. Let's pull it up --
4 A. Not necessarily. I would have assumed that if someone
5 was asking my advice, they would have made a note of it.
6 Q. Yes. Let's pull it up. 013-053a-290. Here we are.
7 Mrs Dennison, who is the author of this record, says
8 this is her record of the report of Lucy's death that
9 was made to her, that she took on the 14th. And she
10 says she would have taken down the details of the phone
11 call in her own notebook and there was one central main
12 register of deaths and that they would all then
13 transcribe what was in their notebooks into that main
14 register of deaths and there was only one. And
15 thereafter, the details in that main register would be
16 put into the coroner's database.
17 A. Right.
18 Q. So this then is a formal document, if I can put it that
19 way.
20 A. But internal to the coroner's office.
21 Q. Oh yes, yes. And you can see that it says there:
22 "Spoken to Dr Curtis."
23 If you knew you were going to be recorded in any
24 way, would you want to be clear on the basis on which
25 you were being recorded?

1 A. I would have accepted or assumed that whatever had been
2 recorded would be an accurate record of what I'd said --
3 Q. Yes.
4 A. -- bearing in mind that what I would have said would
5 have been restricted to general advice.
6 Q. But in any event, you weren't aware that a record might
7 be being made to indicate that you had given any kind of
8 information which was forming the basis of a decision by
9 that person other than a decision being made by
10 the coroner? You weren't aware of that?
11 A. No.
12 Q. So I --
13 A. Could I just clarify that?
14 Q. Of course.
15 A. I'd be aware that whoever was speaking to me would have
16 been taking notes over the telephone. I have no doubt
17 about that. Those notes would have been put to some
18 use.
19 THE CHAIRMAN: And you would expect that if somebody asked
20 for your advice, they'd consider it when they reached
21 a decision?
22 A. Yes.
23 THE CHAIRMAN: But you don't regard that as making
24 the decision yourself?
25 A. No.

1 THE CHAIRMAN: So if you ring somebody for advice, whether
2 it's a lawyer, a doctor or whoever, and they give
3 advice, it's not surprising to you to see a note which
4 says, "Spoken to Dr Curtis", that's fine?
5 A. That does not surprise me.
6 THE CHAIRMAN: In fact, that's better --
7 A. Yes.
8 THE CHAIRMAN: -- that there's some sort of record that
9 there was some conversation with you. The distinction
10 is whether you were understood or somehow interpreted as
11 making the decision as opposed to giving some general
12 advice?
13 A. That's correct.
14 THE CHAIRMAN: Thank you.
15 MS ANYADIKE-DANES: Mrs Dennison, who is, as I say, the
16 person who made that record, gave evidence yesterday.
17 I'm going to pull up a bit of the transcript so you have
18 what she says.
19 I should preface all of this that nobody has a very
20 clear recollection of these telephone calls,
21 unfortunately. There are only actually two notes that
22 were made. This is one, the entry in the main register
23 of deaths. Another is an entry that was actually made
24 in Lucy's medical notes and records by the neurological
25 registrar. But anyway, if we pull up and have them next

1 to each other, the transcript for 24 June 2013, pages 67
2 and 68. I take it you haven't seen this transcript?
3 A. No.
4 Q. That's why I'm pulling it up so you can see the context
5 of it.
6 What Mrs Dennison was describing is the circumstance
7 where the clinician phones in, so she's got the
8 clinician making a report on the phone, and what she
9 says is -- you can pick it up where I'm reciting
10 something that she said earlier in evidence. Starting
11 at line 12 of page 67:
12 "If the report is made to you and you say, 'Hang on,
13 I will just get hold of the coroner', and then you can't
14 get hold of the coroner, how do you get a decision on
15 what to do then?"
16 And she goes on at line 20:
17 "-- I knew I wasn't going to be able to get in touch
18 with him and at the same time I have a doctor on the
19 line, then we contacted the State Pathology Department,
20 who we worked very closely with, and who always took our
21 calls, and I would have explained that I had a doctor on
22 the line and had a medical death and would somebody be
23 willing to talk to me."
24 And then we see how that's put and the question
25 comes again:

1 "Question: You can't reach the coroner, who would
2 otherwise be able to give the direction as to happens.
3 So you get hold of somebody in the State Pathology
4 Department and once you have discussed it with that
5 person, then do you have a way forward for the
6 clinician?
7 "Answer: Yes, usually the pathologist has guided me
8 in a direction that I can speak to the doctor and I have
9 a decision then, yes."
10 And if we go to line 21:
11 "Question: But one way or another, the result of
12 all of that is to give the clinician the direction as to
13 what's going to happen; is that correct?
14 "Answer: That's correct."
15 And I ask her later on if that's what happened when
16 she took the call in relation to the report about Lucy's
17 death and she acknowledged that that is what happened.
18 So the result of all of this is that it comes in as
19 a query because Mrs Dennison can't reach the coroner,
20 having tried to do that, and it comes out, if I can put
21 it that way, with Dr Hanrahan understanding that this is
22 not going to be taken within the jurisdiction of
23 the coroner and he can go and issue his death
24 certificate. In fact, the death certificate he can
25 issue is one that indicates gastroenteritis.

1 Somewhere in there, a decision has been made and
2 what we're trying to explore here is how that decision
3 got to be made. What I'm understanding you to say is,
4 "If a decision was made, it wasn't made by me and
5 I didn't understand that I was actually making one"?
6 A. I'm not making a formal decision. I would offer advice
7 as to say -- it'd really be a very simple algorithm. If
8 it is a natural cause of death and there are no other
9 concerns, then it would be appropriate to go ahead and
10 offer a death certificate. In any other circumstances,
11 the matter would have to be referred to the coroner, and
12 it is a very simple algorithm.
13 THE CHAIRMAN: So when Dr Hanrahan, who gave evidence
14 already to the inquiry, said he didn't know why Lucy
15 died, that's clearly a case for the coroner?
16 A. If you don't know why somebody has died, that is clearly
17 a case for the coroner, unequivocally.
18 THE CHAIRMAN: And that's strengthened by the fact that this
19 is the first time he can recall reporting a case to
20 the coroner, he wasn't sure what his obligations were
21 under the Coroner's Act to report a case, and he agrees
22 that the account is noted on Mrs Dennison's note, which
23 you saw a few moments ago, it doesn't make sense and is
24 a hopelessly incomplete report of the death. So none of
25 that adds up to it being safe to go ahead with the

1 hospital post-mortem; is that right?
2 A. I'm really sorry, could I ask you to say that again?
3 THE CHAIRMAN: Dr Hanrahan, who contacted the coroner's
4 office, said to this inquiry that he didn't know why
5 Lucy had died, something very unusual had happened.
6 He wasn't sure of his precise statutory obligations to
7 report to the coroner, he was reporting out of instinct
8 rather than that he understood the Coroner's Act and the
9 note, as made by Mrs Dennison, he said that the
10 important omission was hyponatraemia, what's in the note
11 doesn't make sense as a cause of death and the report
12 was incomplete. In fact, he said "hopelessly
13 incomplete". None of that would reassure you about the
14 wisdom of deciding to proceed with a hospital
15 post-mortem as opposed to a coroner's post-mortem?
16 A. No. If you don't know the cause of death, it has to go
17 to the coroner.
18 THE CHAIRMAN: Yes.
19 MS ANYADIKE-DANES: Dr Hanrahan has conceded that there were
20 deficiencies and omissions in what he relayed to
21 Mrs Dennison, and she, if she's seeking any guidance
22 from you, is only going to be as good as the information
23 that she herself receives. But from the way that
24 you have answered the chairman, I take it that if
25 Dr Hanrahan had said any of that to Mrs Dennison, which

1 had then been passed on to you, I think what you're
2 saying is your way is clear and you'd have said, "That's
3 for the coroner".
4 A. That's for the coroner, absolutely.
5 Q. Yes. So insofar as we can deduce what was being told to
6 you, whatever it was was being told to you that you were
7 then discussing with Mrs Dennison, that was something
8 that gave you no indication whatsoever that it wasn't
9 a perfectly straightforward and natural death?
10 A. That's correct.
11 Q. Leaving aside the fact of whether you thought you were
12 making a decision or not, which would lead to the
13 clinician doing one thing or another, leaving that aside
14 because you've already very clearly said, "I don't think
15 I was doing that", but if nonetheless you were being
16 asked to give more than just general advice, "I actually
17 really need to know whether you think this is a natural
18 cause of death or not", then would you have wanted to
19 have more information yourself, would you have been
20 directing Mrs Dennison to go and get you more
21 information?
22 A. Yes, if there were any misgivings along the lines --
23 I keep using this phrase, the simple algorithm, but
24 really that is what is at the forefront of the mind.
25 The simple algorithm: is it a natural cause of death

1 without other concerns or is it not? And it's as simple
2 as that.
3 Q. The problem, of course, is that if you're dealing with
4 somebody who is a layperson, not perhaps used all the
5 medical terminology, by that stage she would have been
6 in office from some time in 1999 to April 2000, and she
7 was learning on the job, as it were, so she may not be
8 a master of all of those permutations, and if you know
9 you're speaking to an untrained person in that way,
10 without any disrespect to Mrs Dennison, an officer from
11 the coroner's office, if you know that, she may not be
12 in a position to tell you whether there are any
13 misgivings because she may not know enough to recognise
14 that there should be misgivings. So if she's simply
15 having that conversation with you, would you think
16 it would be appropriate for you to say something like,
17 "If you really want me to advise as to whether I think
18 this is a natural death or not, get me some more
19 information and this is the sort of thing I think you
20 should be asking"?
21 A. It depends what I was told and I have no recollection of
22 this.
23 Q. I appreciate that. I'm even moving away from what would
24 be told you. Once you know this is going to feature in
25 somebody's decision-making process, admittedly you're

1 not thinking you're making the decision, but it's going
2 to feature in somebody's decision-making process, do you
3 still not require more information?
4 A. It depends on the context of the case. If we're talking
5 about those entries on there, that (indicating), she has
6 been contacted by a clinician --
7 Q. Yes.
8 A. -- who is offering gastroenteritis as a principal cause
9 of death, which is a natural condition --
10 Q. Yes.
11 A. -- with dehydration, which is a well-recognised
12 complication of gastroenteritis, and cerebral oedema,
13 which can occur as a complication of the dehydration or
14 as a complication of the child being ill with hypoxia or
15 with hypovolaemia, then I would not have seen a need to
16 interrogate anybody further on that, bearing in mind
17 that I'm not making the decision.
18 Q. Yes, exactly. But if you recognise that you might be
19 providing information to somebody else to do that,
20 clearly a clinician who's reporting a death thinks that
21 there is an issue, otherwise they don't report it. If
22 they thought it was a natural death, they wouldn't be
23 reporting it. So if a clinician has phoned up about
24 a paediatric death in those circumstances for some
25 reason which you wouldn't know necessarily, that

1 clinician believes that there is an issue. So if you
2 just receive that, do you not at least say, "Well,
3 what's the clinician's problem? What's the issue here?"
4 A. I don't know. I don't remember the --
5 Q. I know you don't --
6 A. -- conversation.
7 Q. -- I'm trying to work out a thought process. Is that
8 not at least an appropriate question to ask before you
9 go any further, "Why is the clinician reporting it?"
10 A. It would be, but it appears in this case that the
11 approach was made by a clinician who says he has no
12 experience of dealing with coroners and reporting
13 deaths.
14 Q. But you wouldn't have known that at the time. You would
15 have simply have had Mrs Dennison phoning you and
16 saying, "This is what I've been told, the clinician has
17 phoned up", and all I'm asking you is: is it not
18 appropriate for you to say, "Why is that clinician
19 reporting that death? Some of those things are actually
20 natural. Why is he reporting it?"
21 A. I may have asked that --
22 Q. That would be appropriate to do?
23 A. Yes.
24 Q. And of course, if the answer to all that is, when I get
25 back on the phone, actually because he doesn't know why

1 she's died, then that's your trigger?
2 A. If he doesn't know why she's died, it has to go to
3 the coroner, unequivocally.
4 Q. Thank you. Mrs Dennison has also, to a degree, called
5 into question as to whether you spoke or -- not you
6 personally -- whether you and Dr Hanrahan spoke to each
7 other in relation to this. The notation is not
8 particularly clear on it and where she's asked about
9 that ... If we advance in the transcript a little bit
10 to page 73 and then put 74 alongside it, we can see the
11 chairman starts the questioning at line 10:
12 "Question: Can I just check with you, when it says,
13 'Spoken to Dr Curtis', does that mean you have spoken to
14 Dr Curtis or that Dr Hanrahan has spoken to Dr Curtis or
15 can't you remember?
16 "Answer: I can't remember."
17 Then I ask if I can assist her with that. I put to
18 her the scenario that she has just painted, which is
19 having the clinician on hold, trying to reach the
20 coroner, and failing the coroner, a pathologist. And
21 I say at line 20:
22 "Question: How often would you put the clinician in
23 direct contact with somebody from the
24 State Pathologist's office?
25 "Answer: I don't know that I would. I don't know."

1 Then I ask:
2 "Question: Let me help you in this way: can you
3 ever remember doing that?
4 "Answer: No."
5 Then I ask her:
6 "Question: Does that mean -- and I know that you
7 can't directly remember it -- that reference to 'Spoken
8 to Dr Curtis' is more likely to be reference to you
9 having spoken to Dr Curtis?
10 "Answer: Yes, probably, yes."
11 In the evidence that we've asked you, you have
12 absolutely no recollection at all of her call or
13 anything in relation to this?
14 A. I do not.
15 Q. If you were speaking to the clinician directly, who
16 you'd been put on to because, for whatever reason,
17 there's a problem that the clinician wants to discuss
18 aspects surrounding the child's death, do you think
19 that is likely to be a more detailed discussion than of
20 the sort that you would have if Mrs Dennison phones you
21 up and says, "What do you think about gastroenteritis,
22 dehydration and cerebral oedema?"
23 A. Probably, yes.
24 Q. And if you'd had a discussion, colleague to colleague,
25 in that way, do you think you might be more likely to

1 remember that?
2 A. Not after a period of --
3 Q. That's fine.
4 A. It's 12 years between the inquiry contacting me and
5 these events.
6 Q. I understand that.
7 THE CHAIRMAN: And there are two other reasons. One is at
8 that time you couldn't possibly have foreseen the --
9 A. No, it wouldn't have seemed remarkable.
10 THE CHAIRMAN: And secondly, at that time, it would have
11 depended what information you were receiving.
12 A. Yes.
13 THE CHAIRMAN: Because if it was straightforward information
14 which pointed very clearly one way or the other,
15 you have no reason to remember it at all. You have far
16 more reason to remember something troubling than
17 something apparently straightforward.
18 A. Yes.
19 MS ANYADIKE-DANES: If I follow that up with you, if you had
20 been speaking directly to the clinician, that would have
21 been the opportunity for the clinician to explain to you
22 that he just didn't understand why this child had died.
23 In fact, we have asked him in evidence as to why he was
24 reporting the case in the first place, and in a series
25 of places throughout his evidence in his witness

1 statements, the reason he gives is because he doesn't
2 understand why the child had died. In his view, she
3 shouldn't have died, it's quite a rare thing and he just
4 doesn't understand it. So if that had come out, I think
5 you've already explained to the chairman what you would
6 have done if that had come out. So if you were speaking
7 directly to the clinician, is that an opportunity to
8 probe a little further in a way that you couldn't with
9 somebody who was a non-medical person?
10 A. Of course.
11 Q. Can I ask you something else that you might help us
12 with? The coroner has expressed the view that you were
13 perhaps in some way acting on his behalf. I think you
14 must have seen that reference because we have put it to
15 you. Are there any circumstances in which you would
16 describe yourself as acting on his behalf?
17 A. Yes.
18 Q. What would they be?
19 A. When specifically instructed to do so in terms of
20 carrying out a post-mortem examination and, indeed, if
21 one were to pull out any of our reports, post-mortem
22 reports, they begin with a preamble, "Acting on
23 instructions of the coroner".
24 Q. Yes. Let me pull up, so you have the context of it,
25 it's the coroner's first witness statement for the

1 inquiry, 277/1, page 4. It's in the answer to (g).
2 There's a series of questions, these are all predicated
3 on the basis that you've had a direct conversation with
4 Dr Hanrahan, which nobody knows whether you did or not,
5 but that's the run of these questions. Also, at that
6 stage, the coroner's evidence was he believed that that
7 had happened, and so these are questions to the coroner,
8 this is his witness statement. So you see at (g):
9 "On whose behalf was the pathologist acting when he
10 engaged with Dr Hanrahan in a consultation?"
11 This is the discussion. The coroner answers:
12 "The pathologist would have been acting on my behalf
13 as HM Coroner for Greater Belfast."
14 Can you help us with that?
15 A. I would not have been acting formally on behalf of
16 the coroner; I would have been fulfilling the role of
17 giving general advice.
18 Q. When you say "formally", just so that we understand what
19 that means, were you acting at all on behalf of
20 the coroner?
21 A. No.
22 Q. Formally or informally?
23 A. I was acting in the role of offering general advice if
24 this conversation occurred.
25 Q. Yes. But that would be you as a pathologist in the

1 State Pathologist's office?
2 A. Exactly.
3 Q. Not in any way on behalf of or for the coroner?
4 A. Correct.
5 Q. Thank you. Dr Hanrahan has been asked: if there was
6 a discussion between you and he, then what did he think
7 your role might be in it, if I can put it in those
8 terms? We don't need to pull it up, but the reference
9 for it is 5 June 2013, page 107, line 5. He says:
10 "I may well have been under the impression that
11 he was linked in with the coroner's office."
12 A. That's a misconception.
13 Q. If -- and it's an "if" -- the coroner's office in those
14 circumstances puts a clinician through directly to
15 a pathologist at the State Pathologist's office, can you
16 see how a clinician who wasn't particularly versed in
17 reporting deaths might feel that that pathologist had
18 some sort of role in the decision-making process?
19 A. I suppose so, but I ... You know, I would have thought
20 that most educated professional people would know there
21 was a difference between a forensic pathologist and
22 a coroner. We work in a coronial system, not a US-style
23 medical examiner's system.
24 THE CHAIRMAN: You'd need to be pretty ignorant of the
25 system to think that.

1 A. I would have thought so, yes.
2 MS ANYADIKE-DANES: But in any event, you are quite clear
3 that you weren't taking on any role on behalf of
4 the coroner?
5 A. No.
6 Q. Just a few questions about the hospital post-mortem.
7 I don't know if you know subsequently what happened; are
8 you aware of what happened subsequently?
9 A. I am, yes.
10 Q. So then just in brief, after those conversations or the
11 conversation, whichever way it fell, there is then by
12 consent, as it must be, a hospital post-mortem --
13 A. Yes.
14 Q. -- performed on Lucy.
15 A. By Dr O'Hara.
16 Q. Exactly so. And thereafter, a death certificate is
17 issued --
18 A. Yes.
19 Q. -- which I'm sure you have seen.
20 A. I don't think I've seen the death certificate. I know
21 of the death certificate, but I don't think I've
22 actually seen it.
23 Q. It doesn't change materially from what's recorded.
24 Do you have experience with a consent post-mortem
25 starting like that, ending up with a referral by the

1 pathologist to the coroner's office?
2 A. I haven't done a hospital post-mortem examination in
3 decades. Okay? I've been a forensic pathologist since
4 1988, I think it is, so it's a long time since I did
5 a hospital post-mortem.
6 Q. I understand that. But whilst you were working at the
7 State Pathologist's office, you might be asked to carry
8 out a post-mortem for the coroner, it having come
9 through that route and the pathologists formed the view
10 that "Not sure this is actually a matter that we should
11 deal with, I think this really is a coroner's matter".
12 A. Yes.
13 Q. So what I'm asking you is: were you aware of
14 circumstances when pathologists find themselves in
15 a position that they're going to have to report back to
16 the coroner?
17 A. Yes, or inform the coroner and say, "I am not happy with
18 this, therefore I'm not proceeding with it", or another
19 scenario would be where they start a post-mortem and
20 then they stop it because they're not happy with
21 something they've found. Usually after a hospital
22 post-mortem, the results would be communicated to the
23 clinician.
24 Q. Yes.
25 THE CHAIRMAN: Can you give me an example of that, doctor,

1 from experience about something which might start as
2 a hospital post-mortem but ends up with a referral
3 to the coroner?
4 A. Yes. Somebody starts a post-mortem and finds
5 a laryngeal fracture, or something like that, or finds a
6 or a head injury, a subdural haematoma or something like
7 that.
8 THE CHAIRMAN: Which suggests a blow to the head rather than
9 a natural death?
10 A. Or neck compression or something like that. Those are
11 the sorts of things where cases are stopped and then
12 referred to a forensic pathologist. And then, at
13 a slightly more trivial level, I have known people start
14 post-mortems and find, for instance, a pleural plaque
15 and wonder about the legal implications of
16 asbestos-related disease and stop.
17 MS ANYADIKE-DANES: You might not be able to help with this,
18 but let's see if you can: assuming a circumstance where
19 the hospital post-mortem is really being carried out
20 because the clinicians are unsure of the precise
21 mechanism of death --
22 A. Yes, that's a key word: mechanism of death, not the
23 cause of death, but mechanism of death. Either
24 mechanism of death or extent of disease or effective
25 treatment on disease.

1 Q. So that's a learning process?
2 A. Yes.
3 Q. "We think the person died from this cause, but I'm not
4 quite sure how they got to that." That's the mechanism?
5 A. Yes.
6 Q. So you might carry out a hospital post-mortem for
7 learning purposes in those circumstances?
8 A. Yes.
9 Q. It seems this hospital post-mortem was being carried out
10 perhaps because of that, perhaps because Dr Hanrahan
11 didn't feel at that point in time he could actually
12 write a death certificate, so he needed the results of
13 a post-mortem to assist him in being able to do that.
14 So let's just assume that's the case.
15 A. But still assuming a natural cause of death? Otherwise
16 it would have to have been reported to the coroner.
17 Q. That I understand. If you have a willing suspension of
18 disbelief for the moment and let's assume --
19 A. I'm sorry, I don't mean to be rude.
20 Q. Let's just assume a circumstance where the clinician
21 doesn't feel they can issue a death certificate and
22 believe that that would be assisted by having a hospital
23 post-mortem.
24 A. Right, okay.
25 Q. There's consent for that and that starts. The report

1 that comes back doesn't actually clarify the position at
2 all because the pathologist is unable, actually, to
3 clearly establish in this case why it is that the child
4 suffered the fatal cerebral oedema. Nobody's under any
5 doubt that the cerebral oedema caused the death, what
6 nobody quite understands is how the child got to the
7 cerebral oedema. Let's assume that.
8 A. Could I just interrupt you there? Because I thought the
9 cause of death was bronchopneumonia.
10 Q. Well, there we are. There may be an issue about that.
11 But let's assume that when the pathologist in that
12 situation completes a report and is unable to provide
13 a clear explanation for the child's death, if I can put
14 it that way, or at least why the child developed the
15 cerebral oedema, is that a circumstance in your view
16 that leads the pathologist to go to the coroner and say,
17 "I was being asked to produce this to assist, but
18 I actually can't help, so we've still got an
19 inconclusive basis for why this child died"?
20 A. That would seem to be a reasonable course of action.
21 Q. That pathologist would go back to the coroner, as far as
22 you're concerned, in those circumstances?
23 A. Yes, if those circumstances are as you have portrayed
24 them, but if it is a case we have a natural cause of
25 death such as pneumonia, then I wouldn't see why he

1 should.
2 THE CHAIRMAN: I think the difficulty is about the
3 pneumonia -- there's a view that that's far more likely
4 to be as a result of Lucy being in intensive care and
5 developing bronchopneumonia. It's a well-recognised
6 consequence of being intubated --
7 A. And comatose.
8 THE CHAIRMAN: Yes. So that develops, but it's not the
9 cause of death. That develops after she's coned.
10 A. Okay.
11 MS ANYADIKE-DANES: Although I know that, as you have said,
12 for many years you've been a forensic pathologist and
13 unlikely to find yourself in that situation because the
14 autopsies you would be doing are autopsies invariably
15 under the auspices of the coroner, but in your view,
16 though, is the pathologist's way clear in those
17 circumstances?
18 A. If the pathologist feels that he has not established
19 a cause of death, then that really should be referred to
20 the coroner. Again, it's that simple algorithm: if you
21 don't have a cause of death, you don't have a natural
22 cause of death.
23 Q. One of the issues that may come up is whose
24 responsibility is it to do it? You may not be able to
25 help with this. You've referred to the fact that the

1 pathologist would be sending the report to the clinician
2 --
3 A. Yes.
4 Q. -- so potentially, there are two who could do it?
5 A. Yes.
6 Q. The pathologist could do it as soon as he finalises his
7 report, realises the situation we're in and, in the way
8 you've described, he could just contact the coroner.
9 Alternatively, when he sends that report and has his
10 discussion -- perhaps, as part of
11 a quasi-clinicopathological correlation with the
12 clinician -- the clinician could do it having been the
13 original, in this case, report-requesting clinician.
14 A. Yes.
15 Q. Either way, somebody should do it in your view?
16 A. If the cause of death has not been established, then
17 yes, someone should do it.
18 Q. If I can ask you a little bit about the aftermath. You
19 leave the State Pathologist's office in November 2004.
20 A. Yes, to take up my current appointment.
21 Q. Exactly. At any time between when the communication was
22 made with you in April 2000 and November 2004 was there
23 any contact with you about anything relating to Lucy's
24 death?
25 A. No. There was no contact with me until this inquiry

1 contacted me in 2012.
2 Q. If I can put up two letters very briefly. The first is
3 a letter -- in fact, this is how the matter first came
4 to the coroner's attention. It's a letter from
5 Stanley Millar. You'll see the details as I pull it up,
6 013-056-320. If we pull up the next page to that, then
7 you'll see how it arises.
8 A. This is 2003.
9 Q. This is 2003, exactly. Lucy dies in April 2000, fast
10 forward to 2003. This is the chief officer of the
11 Western Health and Social Services Council, Mr Millar.
12 He is assisting the parents of Lucy, so he knows about
13 Lucy's case. He also learns about another case, a child
14 called Raychel, who died in Altnagelvin. He
15 effectively, when he hears about this, puts the
16 information that he has in relation to Raychel with that
17 which he had with Lucy and comes to the conclusion that
18 there may be similarities in those two children's
19 deaths.
20 A. Right.
21 Q. That's what leads to the questions on the next page. So
22 really, one of the things he wants to know is -- because
23 of course he knows there wasn't an inquest in Lucy's
24 case. The question for him is:
25 "If there had been, might there have been lessons

1 learnt arising out of that which could have had
2 a beneficial impact on Raychel's treatment about
3 14 months thereafter?"
4 So that's what this is about.
5 A. Right.
6 Q. Then comes the reply from the coroner, which is at
7 013-056a-322. If we perhaps pull up the next page. You
8 can see that the coroner responds very quickly,
9 3 March 2003. He is seized of it, he's going to engage
10 a consultant paediatric anaesthetist to look at it, and
11 then he comes to the circumstances, which you see at the
12 final paragraph on that first page:
13 "At the time the death was reported to my office,
14 a note was made to the effect that Dr Michael Curtis of
15 the State Pathologist's department spoke to Dr Hanrahan
16 of the Children's Hospital. He concluded that
17 a post-mortem was not necessary. That explains the
18 office note which indicates that a death certificate was
19 to be issued and that the cause of death was
20 gastroenteritis."
21 And then he goes on about what happened thereafter.
22 So the coroner has reached a view, based on that
23 note, as to what he thinks happened surrounding the
24 report of Lucy's death. We asked Mrs Dennison about it
25 and her evidence was that she doesn't recall being asked

1 at all about the circumstances surrounding her recording
2 of that until she was asked by the PSNI to make
3 a statement, which happened on 7 December 2004,
4 I believe.
5 So can I be clear that nobody had asked you to
6 confirm or not whether this was an accurate portrayal of
7 what had happened?
8 A. No. Again, I never knew about this until I was
9 approached by this inquiry in the year 2012.
10 Q. Thank you. Then I wonder, just one final thing, subject
11 to anybody else in the chamber with a question, one
12 final thing from me though is: the coroner wrote to
13 Dr Jack Crane at the State Pathologist's office
14 in relation to this, and we can pull that up.
15 013-060-373. This is also very quickly after that, it's
16 dated 11 March 2003. Can we pull up the next page too,
17 please?
18 He's reciting the facts as he believes them to be
19 in the second paragraph on that first page. Again,
20 there's that reference:
21 "This shows that enquiries were made by
22 Dr Mike Curtis and subsequently my office was advised
23 that a death certificate would be issued giving the
24 cause of death as gastroenteritis."
25 And it goes on as to the post-mortem and that the

1 hyponatraemia is suggested, but wasn't picked up. And
2 then he goes on to deal with Dr Sumner. Dr Sumner is an
3 expert that the coroner had previously used in a much
4 earlier case of hyponatraemia, a case in 1995. He
5 states that all the evidence he has to state points to
6 classic hyponatraemia. That's in Lucy's case. Over the
7 page is a point I want to ask you about:
8 "My concern is that when deaths, of children in
9 particular, are reported to my office, the proper
10 questions may not be asked. There is now a concern that
11 other hyponatraemia-related deaths may not have been
12 picked up. I would find it most helpful if we could
13 meet to discuss this issue."
14 So what the coroner there is expressing to the
15 State Pathologist is that deaths are being reported to
16 his office and the proper questions are not being asked.
17 In other words, the information that would lead people
18 to understand that what they would be dealing with in
19 this case might be a hyponatraemia-related death is just
20 not being extracted.
21 A. Mm-hm.
22 Q. So that's his issue and he's asking if there could be
23 an discussion between the two of them, the heads of
24 their respective bodies, if I can put it that way.
25 A. Yes.

1 Q. Were you aware of that at all?
2 A. No.
3 Q. Were you aware of any kind of discussion as to how the
4 State Pathologist's office may be able to facilitate
5 that deficit in information or that problem that
6 the coroner is identifying there?
7 A. No.
8 Q. Thereafter, did you become aware of that?
9 A. No.
10 Q. Just so that I'm clear, when I was asking you about
11 whether anybody had asked you about the circumstances of
12 Lucy's death, I don't necessarily mean the coroner, just
13 to check and confirm that his view accorded with yours,
14 but did the State Pathologist ask you that?
15 A. No.
16 Q. This is the source of a point that I was putting to you
17 about gastroenteritis and whether that should be
18 regarded as a natural cause of death. I should have put
19 to you the source of that. The inquiry has instructed
20 Professor Lucas as an expert paediatric pathologist to
21 give guidance on it. His view is that that formulation
22 simply doesn't actually make any sense.
23 A. Yes, I think I've already addressed that.
24 Q. Yes, exactly. I'm going to give the reference now so
25 that those who see it can note it. It's 252-003-009.

1 Just while we're there, it's under his comment and it's
2 in the middle of that paragraph:
3 "This reflects the general ignorance of the
4 potential seriousness of the condition among clinicians
5 and pathologists at that time. Gastroenteritis per se
6 would not normally be of interest to HM Coroner, being
7 a natural clinical pathology, although that statement
8 should be qualified according to circumstance, egg death
9 in children, which usually activates more attention than
10 death in adults."
11 And then he goes on in relation to the particular
12 formulation of "gastroenteritis, dehydration and brain
13 oedema". That's just so that you have the reference,
14 but you have given your view. You have explained what
15 you would have taken from that.
16 A. Yes, and these are not my own esoteric views; these are
17 views taken from textbooks.
18 MS ANYADIKE-DANES: I understand. I have no further
19 questions, Mr Chairman.
20 THE CHAIRMAN: Any more esoteric views?
21 A. I hope note!
22 THE CHAIRMAN: Thank you.
23 Any questions from the floor? Everyone satisfied?
24 Doctor, thank you very much. Thank you for your
25 help and thank you for coming north to help us today.

1 You're now free to leave.
2 (The witness withdrew)
3 It's 11.45. We usually break for the stenographer
4 at some point during the morning, so let's take a break
5 for 10 minutes and start with Mr Leckey at about 11.55.
6 Thank you.
7 (11.45 am)
8 (A short break)
9 (12.00 pm)
10 MS ANYADIKE-DANES: If I may call the coroner, Mr Leckey,
11 please.
12 MR JOHN LECKEY (called)
13 Questions from MS ANYADIKE-DANES
14 MS ANYADIKE-DANES: Good afternoon, sir. You were here,
15 I think, when Dr Curtis was giving his evidence, or at
16 least some part of it.
17 A. I was.
18 Q. The form is that I'm going to ask you if you adopt the
19 various statements that you have made in relation to
20 a number of these cases, subject to anything that you
21 may say here today.
22 A. I do adopt them.
23 Q. Then for the record, if I might give them, there is
24 a witness statement for the inquiry in Adam's case,
25 dated 15 July 2005. The reference to that is 091/1.

1 There was a second witness statement in that case, dated
2 25 March 2011. The reference for that is 091/2.
3 Then, sir, you made two inquiry statements in Lucy's
4 case. The first is dated 26 October 2012, the second is
5 21 January 2013, and the reference for those are 277/1
6 and 277/2, respectively. Then you also made
7 a preliminary statement as an opening, I believe, to
8 Lucy's inquest, and the reference for that is
9 013-004-006. Then finally, you provided a statement to
10 the PSNI, also in Lucy's case, dated 25 January 2005,
11 and the reference for that is 115-034-001.
12 A. That's correct.
13 Q. Thank you very much indeed. There are a number of
14 areas, sir, where I hope you can help us. The issue
15 that I hope you will have appreciated by now that the
16 inquiry is really dealing with is the apparent failure
17 to either correctly identify and/or learn from lessons
18 in all of these cases. Broadly, what we have been
19 seeking to do is to unpick whatever happened to try and
20 see if we can expose where the scope for any improvement
21 in systems or practices may lie. So to that end, there
22 are some aspects of the cases of Adam, Claire, Lucy and
23 Raychel on which we would really welcome your input.
24 If I might start first with a point that arises --
25 and I ask you about this generally, although it might

1 have arisen in any number of these cases and I think it
2 certainly did in Adam, and that's to do with rule 23.
3 I'm not sure if you have seen it, but the inquiry had an
4 expert, Dr Bridget Dolan, who's also a part-time
5 coroner, as well as being a lawyer, and she provided
6 some guidance on rule 23. The reference I have -- and
7 we'll see if it's the correct one -- is 308-013-242.
8 We'll see if that's the correct reference. It's not
9 coming up so it might not be. The correct reference may
10 be 303-052-741.
11 THE CHAIRMAN: 303 or 308?
12 MS ANYADIKE-DANES: There are two references for it,
13 unfortunately, Mr Chairman. It may be that it is
14 recorded in two places. Let's try this one. There
15 we are.
16 In this, what Dr Dolan is talking about is really
17 the way that rule 23 statements might work. She says:
18 "A coroner who believes that action should be taken
19 to prevent the occurrence of fatalities similar to that
20 in respect of which the inquest is being held may
21 announce at the inquest that he is reporting the matter
22 to the person or authority who may have power to take
23 such action and report the matter accordingly."
24 And that's how you would understand how rule 23
25 operates?

1 A. That's correct.
2 Q. Can I ask you, though, from your experience, the sort of
3 circumstances in which you have felt it appropriate to
4 issue a rule 23 report?
5 A. I can think of one example where a drowning took place
6 along a section of water that was not fenced and a child
7 drowned. I made a report -- I can't remember to whom,
8 probably the Local Authority -- drawing this to their
9 attention and asking them to consider taking appropriate
10 action.
11 Q. Yes. This is something that arose in Adam's case. I'm
12 not going to ask you why you did or did not make one in
13 Adam's case. In fact, you did provide an explanation
14 at the time. We have a manuscript note of it.
15 A. Yes.
16 Q. If I can pull up 122-044-050. It's a bit difficult to
17 make out, but you can see -- partly because the
18 left-hand side is a bit chopped off. Your view starts,
19 the tail end of "coroner", that you are expressing the
20 view that you don't think this is an appropriate case
21 for a recommendation. Do I take it that you use that
22 expression "a recommendation" interchangeably with
23 rule 23?
24 A. I don't think I would have used the term
25 "recommendation" because my understanding of the law

1 is that coroners are not able to make recommendations.
2 Q. So this is perhaps an incorrect notation?
3 A. I think it's an incorrect note.
4 Q. But in any event, where you go on to explain your
5 thinking about it is -- if we can pull the next page up
6 alongside of this, you can see it starts at the bottom.
7 You say:
8 "Thinking a lot about the evidence given made me
9 feel this is not an appropriate case. The medical
10 opinion is not clear, management is not clear.
11 I will not make a recommendation if it is not crystal
12 clear to me."
13 And that then would be a reason why you wouldn't
14 make one?
15 A. Can I just say I have no recollection of anything along
16 those lines being said.
17 Q. I understand.
18 A. What I do remember is that, after Adam's inquest, there
19 was a discussion about how the message should be
20 disseminated about best practice. In the statements
21 I made to the inquiry, I took the view to go along with
22 Dr Sumner's suggestion that the best way would be an
23 article or an editorial in the journal of which he was
24 editor, the Journal of Paediatric Anaesthesia.
25 Q. That's exactly so, sir, and I'm going to take you to

1 those parts. But in terms of rule 23 reports generally,
2 is it your view that their use has increased at all?
3 This period is really 1996.
4 A. Yes, it's a different era and the use of rule 23 at that
5 time would have been uncommon. Now, the use of that
6 rule would be much more common.
7 Q. Why is that, sir? If you can help us.
8 A. I think, in part, bereaved families are much more
9 inclined to say that they want action taken to prevent a
10 recurrence of the fatality and coroners, I believe now,
11 because of that development, are more likely to use the
12 rule as a vehicle to achieve that end.
13 THE CHAIRMAN: So it's a response to families wanting
14 something more than they might have done 15 or 20 years
15 ago?
16 A. Yes.
17 MS ANYADIKE-DANES: Thank you. I have just found in
18 Dr Dolan's report the very point that you mentioned.
19 If we pull up 303-052-738. She starts it at 5.5, at the
20 top about the incidence of the use of those reports, and
21 then at 5.6, which is your point:
22 "Despite such reports often being construed as
23 coroner's recommendations, the relevant rules actually
24 provide no power to make any recommendation or propose
25 remedies for any danger; they only give a power to

1 report facts. Notwithstanding, the coroners frequently
2 use the report to suggest necessary action to relevant
3 bodies."
4 And then it goes on to say at 5.9:
5 "The coroner has no power to enforce action under
6 the rules and the view of many is that the only weight
7 the reports had was the adverse media publicity, either
8 when the report was made or when the media later asked
9 questions about what had been done in response."
10 I'm wondering, sir, if there is any, so far as
11 you're aware, way in which the incidences of report
12 making under rule 23 are recorded, collated, so that if
13 anyone wanted to analyse them and produce an annual
14 report, for example, that would be possible? Are you
15 aware of that?
16 A. In Northern Ireland, the answer is no, but my
17 understanding is that in England and Wales, these are
18 collated by the Ministry of Justice and my belief
19 is that they are published annually. That is the
20 referral and the response to that.
21 Q. Yes. I think, almost in the latter part of her report,
22 Dr Dolan does comment on that. If we look at
23 303-052-741. It's at 5.21. She says:
24 "I have not been able to identify any formal or even
25 informal mechanisms in place in Northern Ireland for

1 consideration of rule 23 reports."
2 Her previous section is dealing with what happens
3 in the rest of the United Kingdom. The she says:
4 "I am informed that the coroner's service does not
5 currently hold central figures for rule 23 reports, each
6 coroner being aware of their own rule 23 reports."
7 And then right at the end at paragraph 5.23, she
8 says:
9 "I am informed by Mr Sherrard that there is a plan
10 in place for the Northern Ireland Coroner's Service to
11 record rule 23 reports in the future."
12 Are you aware of any such plan?
13 A. It has been discussed, but nothing has happened, and
14 I know there was some discussion about whether the
15 coroner's service, after Northern Ireland became
16 a single coroner's district, should produce an annual
17 report, and that would be a document that would allow
18 for rule 23 referrals and responses to be published.
19 But also, I think I should advise you that there is some
20 suggestion of rule 23 in our legislation being amended,
21 and that is under consideration at the present time.
22 I know that within the Northern Ireland Court Service,
23 overtures are being made to the newly appointed
24 Chief Coroner of England and Wales, Mr Peter Thornton,
25 to see how that process is working out in England and

1 Wales with a view to us taking similar action here.
2 Q. And sir, do you know what the purpose of the change
3 would be to do, what it is that, in this jurisdiction,
4 one believes would be helpful to move towards?
5 A. Well, the problem is that in the past, whenever reports
6 pursuant to rule 23 were made, sometimes you heard
7 nothing other than an acknowledgement. But if this was
8 taken forward along the lines on which it has in England
9 and Wales, that would be formalised and there would be
10 not only a record that a rule 23 report had been made,
11 but a response to it. And if no response had been
12 forthcoming, that would be very apparent, and I would
13 have thought would be a source of concern.
14 Q. And it would permit, presumably, research to be
15 undertaken --
16 A. Absolutely.
17 Q. -- on the incidence of certain sorts of things happening
18 in certain sorts of institutions?
19 A. That is correct.
20 Q. From your experience, because you have been the coroner
21 in all these inquests, is that something from your
22 experience you feel would be a helpful development?
23 A. Rule 23, as presently drafted, was drafted for
24 a different era. We are now in the second decade of the
25 21st century and what was fit for purpose 60 years ago

1 needs to be looked at again.
2 Q. Thank you very much. Staying loosely with Adam's case
3 if I may, if I can turn now to the issue of
4 dissemination of learning within the
5 Children's Hospital.
6 If I can pull up this statement, which was provided
7 to you and appended to Dr Taylor's deposition.
8 Dr Taylor was the consultant paediatric anaesthetist in
9 Adam's case. The statement is at 011-014-107a.
10 That was provided to you as part of the evidence
11 being tendered in relation to Adam's inquest; do you
12 recall that?
13 A. I do.
14 Q. Thank you. Then you have referred to two parts of the
15 evidence that you provided to us in relation to the
16 aftermath, if I may call it that. The first is in your
17 first witness statement for the inquiry, and that's to
18 be found at 091/1, page 2. It's there at the bottom,
19 and the question you are being asked is the details of
20 the mechanism that you believe was in place at that time
21 for the dissemination of expert opinions obtained by you
22 for your assistance at inquests to the medical
23 profession. The issue was you had got a very
24 experienced consultant paediatric anaesthetist in
25 Ted Sumner to come over from Great Ormond Street.

1 He had provided not only an opinion, but the evidence
2 that he had given, and what we were asking about is what
3 was the best way of getting that message out, if I can
4 use it in those colloquial terms. You say:
5 "There was a discussion at the inquest as to how the
6 views of Dr Sumner could be disseminated amongst the
7 medical profession in Northern Ireland and the consensus
8 was there was no effective means of doing so other than
9 through the medical literature. At that time he
10 mentioned that he was the editor of the Journal of
11 Paediatric Anaesthesia and he undertook to arrange for
12 Professor Arieff [who provided the 1992 article that is
13 referred to in that statement] to write an editorial."
14 Then you go on to say:
15 "I cannot recall anyone, myself included, querying
16 whether the chief medical officer had any educational
17 role."
18 Then you go on to say that there was, then and now,
19 no formal interface between the coroners and the chief
20 medical officers. The "now" that you're talking about
21 relates to July 2005.
22 A. Yes.
23 Q. And then if we go over the page to page 3 of this
24 statement, you can see that we invite you to make any
25 other comments that you might wish to make:

1 "I had assumed that the Children's Hospital would
2 have circulated other hospitals in Northern Ireland with
3 details of the evidence given at the inquest and,
4 possibly, some best practice guidelines. Children are
5 not always treated in a paediatric unit and, in the
6 event of surgery, the anaesthetist may not be
7 a paediatric anaesthetist."
8 How important did you regard that latter observation
9 that this is something that might have broader
10 applicability than the specialist Children's Hospital in
11 Belfast?
12 A. I attached great importance to it, bearing in mind that
13 the Royal Victoria Hospital was pre-eminently a teaching
14 hospital, and I also bore in mind what Dr Sumner told
15 me, that hyponatraemia is really something for
16 a paediatric anaesthetist, but having said that, it is
17 not new science. Dr Sumner did not give any evidence to
18 the inquest that was new science; he was really relaying
19 the current situation.
20 Q. And in fact, he did refer and attach the article from
21 Professor Arieff and others titled "Hyponatraemia and
22 death or permanent brain damage in healthy children".
23 A. Yes.
24 Q. And the reference we have for that, just for people to
25 be assisted, is 220-002-201. So is that part of what

1 led you to believe that the question of hyponatraemia,
2 quite apart from the fact that Dr Sumner was really not
3 seeking to say anything in any way innovative, but the
4 article that he had provided to you, which was published
5 in 1992, was really addressing hyponatraemia as
6 something that can be a problem for previously healthy
7 children and therefore that might be its applicability
8 to clinicians outside the Children's Hospital?
9 A. That was my understanding.
10 Q. In having that understanding, did you form any view as
11 to whether the clinicians from the Children's Hospital
12 saw it in those terms also?
13 A. I would like to think that they did, yes.
14 Q. Let me pull this statement back to you, 011-014-107a.
15 I'm sure it's some time since you have seen it. The
16 first part refers to the Arieff article. Then it also
17 refers to nine other cases in the United Kingdom
18 involving hyponatraemia, but this is in the context of
19 renal transplant. Then you have the middle paragraph,
20 which would appear to be a commitment being made or
21 a statement to you as to how things are going to be done
22 in the future:
23 "In future, all patients undergoing major paediatric
24 surgery who have a potential for electrolyte imbalance
25 will be carefully monitored."

1 And so forth. Then it says:
2 "Furthermore, the now known complications of
3 hyponatraemia in some of these cases will continue to be
4 assessed in each patient, and all anaesthetic staff will
5 be made aware of these particular phenomena and advised
6 to act appropriately."
7 And then there's another statement about what
8 they're going to do about laboratory facilities for
9 operating theatres.
10 If that statement is being provided to you to give
11 you some assurance as to how things are going to be
12 done, by whom would you have wanted such a statement to
13 be authorised?
14 A. Well, the statement was given to me in the context that
15 I was presiding over judicial proceedings and on that
16 basis I would have thought that the person who gave it,
17 the person or persons who gave it were duty-bound to see
18 it through.
19 Q. Yes. And duly authorised to make that statement as to
20 how things were going to be done in the
21 Children's Hospital thereafter?
22 A. That is my view.
23 Q. That statement could have been made -- and was made --
24 as a press release as well --
25 A. Yes.

1 Q. -- but it's also being tendered to you as evidence in an
2 inquest. Did you regard that as being particularly
3 significant in terms of how the public should regard
4 that statement?
5 A. Yes. I had real concerns in relation to the
6 circumstances of Adam's death -- and indeed all the
7 children -- and I was very, very concerned that the
8 message, albeit it did not relate to new science, was
9 disseminated as widely as possible -- not only within
10 Northern Ireland, but further afield -- because one of
11 the points that I made in one of my statements was that
12 Dr Sumner described fluid management, hyponatraemia, as
13 a Cinderella area of medicine and that the position in
14 Northern Ireland was no better or no worse than in other
15 parts of the United Kingdom. So I had to look beyond
16 the dissemination of the message in Northern Ireland to
17 throughout the United Kingdom and that is why
18 Dr Sumner's journal, the Journal of Paediatric
19 Anaesthesia, which was published throughout the
20 United Kingdom, seemed to me to be a good vehicle for
21 getting the message out.
22 Q. Yes. And coupled with this commitment that was being
23 made as to what was going to happen, particularly in
24 terms of the advice being given to the anaesthetic
25 staff, that was a significant factor for you, I take it?

1 A. It was.
2 Q. Well, that's, as I understand it, what you thought the
3 position was. You were being given a statement by
4 somebody who was able to make that statement, behind it
5 would be a commitment, and presumably an ability, to
6 deliver on that statement.
7 A. Yes.
8 Q. The actual position, as it has turned out in the
9 evidence that the inquiry has heard, was that the
10 paediatric lead, who was Dr Elaine Hicks, knew nothing
11 about the statement at the time, nor did the medical
12 director or the CEO.
13 A. Sorry, was the last thing you said "the CMO"?
14 Q. The CEO.
15 A. Yes, I beg your pardon.
16 Q. So none of the people who you might have thought would
17 be involved in giving the authority for a statement to
18 be made as to a change in practice in the
19 Children's Hospital, in their evidence to the inquiry,
20 none of them actually knew about it. The paediatric
21 lead wasn't routinely told about coroner's cases at all
22 in order to at least keep that kind of perspective. The
23 medical director, Dr Carson, when he gave evidence, says
24 he would have expected a statement like that, that was
25 being made, to have been approved, authorised and

1 discharged by him or the chief executive, that that
2 would be high-level action. The reference to that is in
3 his transcript for 11 June 2013 at page 146. That is
4 what he thought would have to happen for you to be able
5 to have the impression that you got -- or at least the
6 reliance you placed on a statement like that.
7 And then the broader issues were to be taken forward
8 through initially a seminar, but that didn't happen
9 because the person in charge of organising that,
10 Dr Murnaghan, initially was off on holiday, then he was
11 off sick, and then he just simply forgot about it.
12 There seemed to be no governance structure by which that
13 kind of commitment to you could be developed,
14 implemented, monitored or evaluated.
15 Dr Peter Crean says he didn't actually know about
16 this statement which referred to:
17 "All anaesthetic staff will be made aware of these
18 particular phenomena."
19 There was another statement that the three
20 consultant paediatric anaesthetists signed off on, but
21 didn't have this commitment in it. And in fact, his
22 evidence was nothing really happened about this area at
23 all.
24 A. I read that in some of the material from the inquiry
25 that I have seen and I was extremely disappointed and

1 also very upset to learn that.
2 Q. We'll come to it in a moment about what lies behind the
3 production of a statement like that, but from your point
4 of view what you thought you were receiving and what was
5 going to happen didn't?
6 A. That's correct.
7 Q. And those are the circumstances. So if you are going to
8 receive a commitment -- and one might easily see how
9 a Trust would want to indicate that they had learnt
10 lessons and that they were changing practices, which
11 they hoped would reduce the chances of something like
12 that happening again, and that they would want to
13 produce that at an inquest, that's the place where the
14 families' concerns are rawest and that would get the
15 message not only to them but to the public. So one can
16 see why a Trust would want to do that. But in future
17 though, what would be your expectations as to how
18 a statement that was to have that effect should actually
19 be produced? What would you want?
20 A. Well, I think that 12 years on, if the inquest was being
21 held now, I would want the medical or the clinical
22 director to come along to the inquest and to give
23 evidence, and then I would have a commitment from the
24 most senior appropriate person within the Trust that
25 action would be taken.

1 Q. Yes. And if I take you back to your broader point,
2 which is, yes, Adam's death, which arose out of
3 a transplant operation, might tell you some things about
4 major paediatric surgery, but this hyponatraemia issue,
5 you saw as being of much broader application than just
6 that circumstance.
7 If I take you to that, the evidence that the inquiry
8 heard from the clinicians involved is that they actually
9 saw this solely in terms of major paediatric surgery.
10 They were the only institution that carried out major
11 paediatric surgery in the region and therefore there was
12 absolutely no need to take this message any further
13 effectively than themselves, and by themselves they
14 meant the three or four consultant paediatric
15 anaesthetists.
16 A. Well, I really am quite shocked to hear that because my
17 clear understanding at the inquest was the views of
18 Dr Sumner had been expressed, he expressed no doubt
19 about what was required, and my expectation was that
20 there would be dissemination throughout at least
21 Northern Ireland, with the journal articles being
22 disseminated much more widely.
23 Q. And I wonder if I can ask you about that. Dr Sumner
24 said that he could get an editorial out, which he did,
25 and a editorial was published in 1998.

1 A. And he sent me a copy of it.
2 Q. And you very kindly provided the inquiry with one. Did
3 it occur to you that the local clinicians who had been
4 there -- some of them have provided expert evidence,
5 like Dr Jenkins, for example -- that they might also
6 locally try and publish material relating to this
7 phenomenon? Well, it's not really a phenomenon, it's
8 relating to the condition of hyponatraemia and the
9 apparent lack of understanding of it. Did that occur to
10 you?
11 A. I'm not sure it did. Everyone seemed content with the
12 approach as suggested by Dr Sumner, but as I have
13 indicated previously, I thought in addition to that the
14 best practice guidelines might be drafted and circulated
15 within Northern Ireland.
16 Q. Yes. The best practice guidelines, is that because,
17 from your perspective, the Children's Hospital being
18 a regional centre, they were in a position with some
19 authority to produce something of that sort to the
20 district hospitals?
21 A. I would have thought that if anything emanated from the
22 Children's Hospital, that any hospital in
23 Northern Ireland would pay great attention to it.
24 Q. Thank you. In fact, some other things did happen.
25 Dr Chisakuta, he was a consultant paediatric

1 anaesthetist, he was involved in Lucy's case --
2 A. Yes.
3 Q. -- and he came to the Children's Hospital
4 in August 1997. He took it upon himself to give a talk
5 in 1998 to the inaugural meeting of the Western
6 Anaesthetic Society, and part of his talk was on the
7 problems of post-operative hyponatraemic encephalopathy,
8 and he based it on Arieff's 1998 editorial. But that
9 effort of his was not done recognising that the
10 Children's Hospital had had any prior exposure to the
11 failings of clinicians in respect of hyponatraemia
12 because he knew nothing about that. By the time he
13 came, that message was not travelling even within the
14 hospital. So he did that as a one-off, but seeing that
15 he might do that, is that not something that you might
16 have hoped, in the general spirit of what you have just
17 been saying, that that could have been done in a more
18 systematic way by the Children's Hospital?
19 A. I do not disagree with you.
20 Q. And then when I was taking you to your witness
21 statement, 091/1, page 2, you said that:
22 "No one queried whether the chief medical officer,
23 including [yourself], had any educational role."
24 Would you have been aware that the chief medical
25 officer had special advisory committees at that time?

1 A. No, I wasn't aware of that.
2 Q. Ah. The chief medical officer had special advisory
3 committees in paediatrics, for example, anaesthetics and
4 surgery. Let me pull that up. 320-110-001. We have
5 a problem with that. I'll see if I can find it just to
6 read out the relevant part to you.
7 There you can see its terms of reference:
8 "To advise the department, through the CMO, on
9 strategic policy [leaving aside the planning issues].
10 To comment on the quality of service provision with
11 specific reference to agreed quality standards. To
12 advise on the implications for the Health Service of
13 impending medical, technological and scientific
14 advances."
15 Not they alone, but the clinicians at the
16 Children's Hospital, some of them, sit on these
17 committees. For example Dr Taylor has, Dr Savage, who
18 you know, Dr Crean, they've all sat on them, and
19 ultimately the issue of hyponatraemia was actually
20 raised at one of them. It didn't happen until the
21 special advisory committee in paediatrics on
22 30 October 2001, but it was raised then. And both
23 Dr Hicks, who you know or have heard of, she was the
24 paediatric lead at the time, and Dr Carson, who was the
25 medical director at the time, both gave evidence to say

1 that if there was a clinical issue of concern, it could
2 have been brought to one of these special advisory
3 committees.
4 Given that, would you have wished somebody to say
5 that this was a possibility and therefore a means of
6 getting the debate out in terms of hyponatraemia?
7 A. Well, looking back, I think it is unfortunate that
8 no one told me that our chief medical officer did have
9 such an advisory committee. And if that had been the
10 case, I have no doubt that I would have suggested that
11 hyponatraemia and what happened in Adam's case should be
12 placed before it.
13 Q. In fact --
14 THE CHAIRMAN: Sorry. Did it actually go beyond that,
15 Mr Leckey? If you had known that she had a number of
16 specialty advisory committees, then that might have
17 helped you or encouraged you to suggest -- whether you
18 did it yourself or whether you encouraged others to do
19 it -- that these issues would be taken up through them.
20 A. Yes, you're quite correct. And can I just say that,
21 speaking now, I wasn't aware of the advisory committees
22 that you've referred to?
23 THE CHAIRMAN: Thank you.
24 MS ANYADIKE-DANES: In fact, sir, in that admittedly
25 handwritten transcript of what you said at Adam's

1 inquest, you did offer to write a letter if that would
2 help to broadcast the issues more, and that was being
3 made to the solicitor on behalf of the Trust. Were you
4 ever taken up on that? Did anyone ever come back to you
5 and say, "That would be very helpful"?
6 A. To the best of my recollection, the answer is no, but
7 I think the reason that wasn't taken forward is because
8 everyone seemed content with Dr Sumner's suggestion.
9 Q. Thank you.
10 A. And also, I suppose I would have had reservations about
11 drafting a letter about a medical sub-specialty such as
12 hyponatraemia just in case I didn't get things quite
13 right.
14 Q. I understand.
15 THE CHAIRMAN: But you also had the statement in front of
16 you, provided by Dr Taylor, about the training that was
17 going to be done from then on?
18 A. Yes, that's correct.
19 MS ANYADIKE-DANES: But of course, if you appreciated that
20 there was an avenue to involve the chief medical
21 officer, that is something that you might have
22 considered taking up?
23 A. Yes. Can I just say that until the hyponatraemia
24 inquests, to the best of my knowledge there was never
25 any coronial contact on any occasion with the chief

1 medical officer? And the hyponatraemia-related deaths
2 was the catalyst for the first coronial contact with the
3 chief medical officer.
4 Q. Thank you very much. Can I ask you what can happen now
5 if you conduct, or one of your colleagues conducts, an
6 inquest and you see that there is an issue of more
7 general applicability in terms of a medical point? What
8 happens now in terms of possible communication between
9 your office and the chief medical officer?
10 A. Well, since Northern Ireland became a single district in
11 2006, we now have a medical adviser to the coroner's
12 service, Dr Gillian Clarke, and contact with the chief
13 medical officer about medical matters that emerge are
14 now the subject of fairly regular contact between the
15 coroner's service and the chief medical officer. So if
16 the hyponatraemia-related deaths happened now, things
17 would happen differently.
18 Q. There's a forum where --
19 A. There's now a forum.
20 Q. And could that also involve the State Pathologist's
21 office, who of course were involved in Adam's inquest?
22 A. Yes. The problem at the time Adam died was that state
23 pathology was really the sole source of medical advice
24 for coroners in Northern Ireland. Back then -- not so
25 now -- the pathologists attached to the

1 State Pathologist's department were really viewed as
2 a jack of all trades: they were asked for advice on
3 every conceivable medical sub-specialty where a death
4 was reported. I wouldn't say they were happy to give
5 advice back then, but they were willing to do so. That
6 would not be the case now.
7 Q. So now, if you had a matter which you were thinking had
8 broader application than the instant case before you,
9 you have a forum where you could involve the chief
10 medical officer?
11 A. Yes.
12 Q. And what I was trying to ascertain is: if it were
13 appropriate to do so, could that also involve the
14 State Pathologist's office?
15 A. Yes, it could, and it could also involve hospital
16 pathology because some hospital pathologists are on the
17 Secretary of State's list of pathologists authorised to
18 carry out coroner's post-mortems.
19 Q. So the upshot of it is that there are better places for
20 that kind of debate to happen from the point of view of
21 trying to disseminate learning than existed then?
22 A. That is correct.
23 Q. If I move now to, in terms of time, to the next case,
24 which is Claire's case. Her death was the subject of
25 a brain-only hospital post-mortem, and she only came to

1 you as an inquest, really after the UTV programme and
2 some considerable time. I think it was 2006 when her
3 inquest was carried out. But what I would like to ask
4 you is this: the post-mortem report that was received in
5 Claire's case wasn't entirely conclusive. We have the
6 inquiry's expert, Professor Lucas, who has provided
7 a report saying that what really should have happened,
8 because it was inconclusive -- and just to give you some
9 context to that, it really couldn't rule out a metabolic
10 cause and it really couldn't pinpoint exactly why or how
11 Claire had died, if I put it loosely in those terms.
12 So the conclusion from that that Professor Lucas
13 came up with was that what really should have happened
14 is that there should have been a mortality conference
15 after the autopsy, one of the type of
16 clinicopathological correlations or presentations that
17 Dr Curtis had talked about this morning.
18 A. I wonder, could you remind me who did the post-mortem
19 in that case and the cause of death given, please?
20 Q. Yes, I can. Although that turned out to be an issue in
21 itself. The consultant in charge was Dr Mirakhur.
22 A. Yes.
23 Q. Her registrar, who did some of the work, was Dr Herron.
24 A. Yes.
25 Q. The final report, I think, if you wanted to see that,

1 was 090-003-004 and going into 005. But the conclusion
2 from it was that -- and going to 005. There we are. If
3 you see under the comment, so after they've described
4 the description of the brain, the histology and so
5 forth, you get to the comment:
6 "In summary, the features here are those of
7 a cerebral oedema with neuronal migrational defect and
8 a low-grade sub-acute meningoencephalitis. No other
9 discrete lesion. The reaction in the meninges and
10 cortex is suggestive of a viral aetiology, although some
11 viral studies were negative. The clinical history of
12 diarrhoea and vomiting, this is a possibility though
13 a metabolic cause cannot be entirely excluded. As this
14 was a brain-only autopsy, it is not possible to comment
15 on other systemic pathology in the general organs. No
16 other structural lesion ... was found."
17 When we submitted that to the two experts that the
18 inquiry engaged, their view on it is: you don't have
19 a definitive view in that summary, and what was required
20 is some sort of correlation between the clinicians on
21 the one side and the pathologists on the other, and what
22 Professor Lucas concluded with was -- the reference in
23 his report is 239-002-012:
24 "Perhaps, had there been a mortality conference
25 after the autopsy, a bright clinician might have asked,

1 'But is that enough information, encephalitis, to
2 account for what has happened?', then the initial story
3 would have unravelled and a focus on other causes such
4 as hyponatraemia may have emerged."
5 And in fact, when the clinicians went back and
6 looked at it, it became clear in the evidence that there
7 really wasn't enough pathological evidence of a virus at
8 all.
9 So the question that I have for you is: when
10 clinicians -- and this is something that also arises in
11 Lucy's case -- are faced with inconclusive reports when
12 a hospital post-mortem is carried out, from a coroner's
13 point of view, what, if any, expectation do you have?
14 What is your view that they should be doing?
15 A. Can I just ask you to confirm, because I can't remember
16 each individual post-mortem report: was this a consent
17 post-mortem?
18 Q. Yes, it was.
19 A. And what cause of death was given? You've shown me the
20 comments section, but I'm just wondering, how was death
21 formulated?
22 Q. I'll have to pull up the death certificate. If you'll
23 bear with me, I'll get that brought up. That was
24 a death certificate that changed as a result of the
25 inquest that you carried out into it. The death

1 certificate and the reference for it is 091-002-002.
2 No, this is what it changed to, I'm sorry. We'll pull
3 up the original one. This is what it changed to:
4 "Cerebral oedema due to meningoencephalitis,
5 hyponatraemia due to ADH production and status
6 epilepticus."
7 A. Can I just say that not all post-mortem examinations, as
8 I'm sure you know, are able to achieve a definitive
9 cause of death?
10 Q. Yes.
11 A. There's a subjective element. Some pathologists are
12 more robust at giving a cause of death than others, but
13 there is a percentage of post-mortem examinations where
14 a cause of death cannot be achieved.
15 Q. Yes.
16 A. And so the cause of death, for example, may be recorded
17 as unascertained or undetermined.
18 Q. Yes. So the fact that you can't find a cause of death
19 does not necessarily mean it's a case that needs to be
20 reported to the coroner?
21 A. That is correct. And I have experience over the years
22 of post-mortem examinations where all the pathologist is
23 able to say is that there's no evidence that the cause
24 of death was other than a natural cause, albeit an
25 unknown natural cause.

1 Q. Yes. So the sort of inconclusive, if I can put it that
2 way, post-mortem report that becomes of interest to you
3 as a coroner is when there are features in there,
4 I assume, which are suggestive of some iatrogenic act?
5 A. Yes.
6 Q. So if there is a suggestion, for example, that the
7 hyponatraemia may have been the result of poor fluid
8 management, that becomes an issue that comes to you?
9 A. Oh, absolutely, yes.
10 Q. I understand. So what you're wanting the clinicians to
11 do is to look very carefully at the mechanism of death
12 and to understand whether there is anything in there
13 that falls out of the, if I can put it this way, the
14 natural cause or chain of cause of events?
15 A. That is correct.
16 Q. And if it moves into an iatrogenic act, that is
17 something that you believe is a matter to be reported to
18 you?
19 A. Definitely.
20 Q. And something that you want to know about?
21 A. That's correct.
22 Q. So if they had formed that view, and thought even it was
23 possible, because I think the bar is "reason to
24 believe", if they'd formed that view, then that's
25 something that should have been reported to you?

1 A. My expectation with consent post-mortems is that if at
2 any stage the pathologist feels that the cause of death
3 is not a natural one or has any misgivings at all, the
4 phone should be picked up and myself or my office
5 contacted. And that does happen: in the course of
6 a consent post-mortem, the pathologist will phone and
7 say, "I think this should be made into a coroner's
8 post-mortem".
9 Q. Thank you. I'd like to deal with an issue that did
10 arise in Claire's case, which is to do with the
11 gathering of statements, and moving on to an issue to do
12 with candour, which is something that you've referred to
13 in a number of your witness statements for us.
14 If we take the first point about the statements that
15 are being provided to you apart from the medical notes
16 and records and the X-rays and so on, your primary
17 evidence as to the narrative of what happened is coming
18 presumably from those statements, from the clinicians
19 and the nurses involved.
20 A. That's correct. Can I also say that in addition to
21 that, and before that stage happens, a clinician would
22 be asked, for the benefit of the pathologist, to prepare
23 a clinical summary --
24 Q. Yes.
25 A. -- which, I would like to think, would give key

1 information that the pathologist could focus on?
2 Q. I see. When you say "the pathologist", are you meaning
3 when you have decided that this is an issue over which
4 you want to exercise jurisdiction, so this is going to
5 be a coroner's autopsy, if I can put it that way, what
6 you're requiring is the relevant clinician to provide
7 a clinical summary to go to that pathologist?
8 A. That is correct. As soon as a decision is made that
9 it's a coroner's case and that there will be
10 a post-mortem examination, the clinician is always asked
11 to prepare a clinical summary, setting out the key
12 milestones on the road that culminated in the death of
13 the patient.
14 Q. Yes. I suppose that's part of where your candour might
15 start.
16 A. Absolutely.
17 Q. Because that clinician, whether the clinician themselves
18 or colleagues in their department, may be part of the
19 story as to the child's demise in this case, so what
20 you're expecting is an accurate account of, as you put
21 it, the key milestones, which may expose that?
22 A. It should be not only factually accurate, but also flag
23 up any concerns that the clinician had about any aspect
24 of the care and treatment of the patient. This does
25 happen. I can think of many instances where

1 a consultant has telephoned me and has said, for
2 example, "I think something went wrong in the course of
3 surgery". So they are being upfront from the word go.
4 Q. And at that stage, you are relying on them to be
5 entirely frank about errors that maybe they've made or
6 maybe their junior colleagues might have made?
7 A. That's correct.
8 Q. And built around that frankness, is it their duty to the
9 GMC and is there any other place other than this is the
10 correct thing to do where you find the source of that
11 transparency, if I can put it that way?
12 A. I think it has to come from the medical staff. All the
13 staff involved have to be totally transparent, can
14 I just say, not only for me as exercising a judicial
15 function, but for the bereaved family.
16 Q. Yes. Yes of course.
17 THE CHAIRMAN: Sorry, just to get it clear: you started off
18 this segment by saying that you expect to have that
19 candour in the clinical summary which you want to be
20 factually accurate and also to flag up concerns.
21 A. Yes.
22 THE CHAIRMAN: When that then leads on to you seeking
23 witness statements from the doctors and nurses who were
24 involved, do you expect that those will only be factual
25 statements or do you also expect that, if they have

1 concerns, that they will be flagged up in those
2 statements?
3 A. Both, and this does happen.
4 THE CHAIRMAN: I have to tell you, Mr Leckey, it hasn't
5 happened in this inquiry, and on a number of
6 occasions -- and Ms Anyadike-Danes will come on to it --
7 what you might call the underplaying of information or
8 the withholding of information is a recurring theme in
9 this inquiry.
10 A. Can I just say, chairman, that I can think of some very
11 eminent consultants in Northern Ireland -- I will not
12 mention any names -- who have telephoned me and have
13 been completely candid.
14 THE CHAIRMAN: Right.
15 MS ANYADIKE-DANES: Thank you. Because you asked me -- and
16 I will apologise, I wasn't able to pull it up when you
17 did -- about the original formulation of cause of death
18 on Claire's original death certificate. That is to be
19 found at 091-012-077. That has simply, "Cerebral
20 oedema, status epilepticus".
21 A. Yes.
22 Q. And then to be compared with 091-002-002. There
23 you have it. So so far as everybody was concerned, the
24 child died of cerebral oedema, that had been brought
25 about by status epilepticus. As a result of your

1 inquest, the child dies of cerebral oedema, but that is
2 brought about by meningoencephalitis, hyponatraemia,
3 which in turn has been brought about by an excess
4 production of ADH and also the status epilepticus.
5 A. Yes.
6 Q. And the hyponatraemia point, of course, is the one that
7 was of interest because that was, it is believed, in
8 part due to an inappropriate fluid regime that was
9 administered to Claire. Then if I just move on --
10 THE CHAIRMAN: Let me pause for one second. The point you
11 made, Mr Leckey, a few moments ago about you do have the
12 experience of leading consultants in Northern Ireland
13 being candid with you --
14 A. Yes.
15 THE CHAIRMAN: Can I ask you: do you find people to be more
16 candid in recent years or would you say this is
17 a continuum of experience over two decades?
18 A. It's difficult to remember back.
19 THE CHAIRMAN: The reason I'm asking is this: I'm being told
20 repeatedly in this inquiry that the evidence and
21 information I'm being given reflects practices which
22 weren't what they should be, but things are much, much
23 better now. I'm being told that there are far more
24 cases referred to your service, I'm told that there are
25 far more reports to the GMC, and I'm being told that the

1 way in which some of the families in this inquiry were
2 treated would be far less likely to happen now. And in
3 this context, in essence, I'm being reassured that there
4 is more openness, that doctors are more candid than the
5 evidence in this inquiry would suggest they have been.
6 Maybe this is too general a question for you to be able
7 to answer, but can you say whether the openness that you
8 are experiencing in some cases is more typically
9 a recent event or whether it would have been prevalent
10 in the mid-1990s, to take one example?
11 A. I cannot quote you statistics, but I have a sense that
12 there is more openness in recent years. I think in part
13 at least that is explained by the medical professionals
14 being encouraged to admit mistakes if they believe
15 mistakes may have occurred.
16 MS ANYADIKE-DANES: One of the ways in which it was
17 explained to us, or at least the inquiry, is that there
18 was a certain culture and that culture was a defensive,
19 protective culture.
20 A. Yes.
21 Q. And as the wagons circled, within there, one tried to
22 redress matters and improve matters, but it wasn't
23 something that you necessarily broadcast because you,
24 I think -- I think one consultant referred to you
25 trumpet your successes and you keep rather quieter about

1 your failures. So that was presented as a cultural way
2 of doing things, and the issue about that is it's
3 completely opposite what you want, if you're talking
4 about lessons learnt, disseminating those lessons so
5 that we don't have to keep falling into the same sort of
6 traps, people learn from other people's mistakes. So
7 I think where we were going with that, and where I was
8 going to take you on to, is whether you can have, even
9 if it's only anecdotal, a sense of the culture shifting.
10 A. Well, I would agree with you. My sense is the culture
11 has shifted. There's one thing I would wish to add.
12 I said that one of the reasons I think is that medical
13 professionals are being encouraged to admit if something
14 has gone wrong. But also, what is a very significant
15 development is bereaved families are much more likely to
16 question information they have been given, and the
17 experience in my office is that we receive, on a regular
18 basis, both letters and telephone calls from bereaved
19 families, expressing concerns about treatment. And that
20 wouldn't have happened 20 years ago, but it is happening
21 now.
22 Q. Yes, so it may not be a natural evolution from the
23 medical community thinking this is a very good idea, it
24 may be something that there is a degree of pressure to
25 change --

1 A. Yes.
2 Q. -- also being brought about by families arming
3 themselves with more information and requiring a better
4 standard?
5 A. Yes; and the Internet of course is a marvellous source
6 of medical information and I think you're quite right
7 in the point that you've made.
8 MS ANYADIKE-DANES: Thank you.
9 Mr Chairman, I was going to go on to this issue of
10 statements, which is a slightly different point. I'm
11 looking at the time.
12 THE CHAIRMAN: I want to make sure we finish Mr Leckey this
13 afternoon and a time that is not too late. Could we
14 take 45 minutes for lunch and resume at a quarter to?
15 Thank you.
16 (1.00 pm)
17 (The Short Adjournment)
18 (1.45 pm)
19 (Delay in proceedings)
20 (1.55 pm)
21 MS ANYADIKE-DANES: Good afternoon, sir. Can we please pull
22 up a letter that you wrote to the medical director,
23 Michael McBride, on 30 January 2004, the reference is
24 129-007-001. And can we pull up alongside it the second
25 page of that?

1 This was a letter, sir, that you're writing to the
2 medical director at the Royal. You're raising an issue
3 that has been, in turn, raised with you, as you describe
4 it, by a senior police officer. What you say is:
5 "In particular, concern was expressed that the
6 system that has been in operation for a number of years,
7 whereby the medical director or clinical director of the
8 hospital will arrange to obtain statements from staff
9 involved and forward them to me without the statement
10 makers having been interviewed by a police officer. In
11 many instances, the individual concerned had consulted
12 their legal adviser prior to making a statement and the
13 legal adviser had input into how it was drafted. It was
14 put to me that this approach did not constitute best
15 practice as the police should interview those concerned
16 as soon after the event as possible and, where
17 necessary, seize medical notes and any relevant
18 equipment ... and treat, if appropriate, the area of the
19 hospital as a potential crime scene."
20 And then you say:
21 "I agree that in future I would agree to a police
22 officer interviewing those concerned and the present
23 system would be discontinued. I would anticipate that
24 the police officer concerned would call upon you to
25 provide assistance in identifying those involved and

1 seeking their co-operation for interview."
2 Then you say:
3 "Subsequently, I wrote to the chief constable
4 suggesting the need for some form of protocol and
5 consultation with the medical directors of the various
6 hospitals."
7 And then you recite that:
8 "The possible way forward that has been suggested
9 is that all hospital deaths reported to me should then
10 be reported to Mr Kinkaid, who would designate an
11 investigating officer."
12 You suggest, having written on 20 January 2004,
13 that:
14 "Consideration be given as to the merits of a round
15 table meeting involving medical directors, Mr Kinkaid,
16 or DCI Steele and [yourself]."
17 So that's the issue. The issue is that when you've
18 got a death in hospital which is going to be the subject
19 of an inquest, there was concern about the hospital
20 personnel themselves assisting in the drafting of the
21 statements which are then going to form an important
22 part of the evidence that's submitted to you as to what
23 happened.
24 When you sent that letter on 30 January 2004, sir,
25 what did you expect would be the immediate result of it?

1 A. Well, I suppose I expected that some planning would take
2 place into the formation of a protocol, but what I know
3 happened was that it had been tried -- that is a police
4 officer taking statements -- but it didn't seem to work.
5 There are some reasons for that, which I could tell you,
6 if you wish me to.
7 Q. Yes.
8 A. First of all, a police officer is not familiar with
9 medical terminology, let alone the minutiae of medical
10 procedures. Secondly, a hospital is a big place, and
11 a police officer is likely to encounter major difficulty
12 finding the individuals concerned. And thirdly, with
13 the present shift systems in hospital, the person the
14 police officer wants to interview may not be on duty at
15 that particular time. And there were difficulties about
16 the hospital providing outside hospital contact details
17 for the members of the medical staff. There's a further
18 difficulty -- a further difficulty was that in the
19 increasingly litigious age we live in, members of
20 medical staff were, how shall I say, cautious about
21 putting pen to paper at the request of a police officer
22 without the benefit -- in some cases, but not in all
23 cases -- of legal advice.
24 Q. I understand that, and thank you for that, but what was
25 the concern that you were trying to get at in terms of

1 the way the old system worked?
2 A. The concern then -- and to some extent a concern that
3 still exists now -- is that we had been experiencing
4 long gaps between the death occurring, which then was
5 reported to me, and statements coming into my office.
6 Many, many months often passed, and the view was that
7 if we nipped this in the bud and had a police officer
8 take statements as soon as possible after the death,
9 that would speed the process up and sometimes it was not
10 until the statements came in that there was
11 a realisation that perhaps mistakes had been made or
12 that things should be done or that things weren't done
13 that needed to be done. And we were concerned the trail
14 was going cold.
15 Also, if I just might add this: 20 years ago, the
16 medical profession by and large were stationary, they
17 had careers within Northern Ireland. That is no longer
18 the case. Doctors in particular move in and out of
19 Northern Ireland for short-term contracts, it's a very
20 mobile population. And when they leave
21 Northern Ireland, you may not be able to get in touch,
22 and there were instances where that happened.
23 Q. So that would suggest that it would be helpful to have
24 a speedier system of getting --
25 A. Absolutely.

1 Q. -- the evidence from the doctors and nurses concerned as
2 to what happened?
3 A. Yes.
4 Q. Did you think also that a benefit might be a more
5 independent narrative?
6 A. Oh yes, I have no doubt that independence is a very
7 desirable aim. Can I just say that in England and
8 Wales, where perhaps not all coroners but most coroners,
9 particularly the bigger districts, have coroner's
10 officers. Coroner's officers in England and Wales can
11 and do take statements in such circumstances and then,
12 of course, independence would be guaranteed --
13 Q. Exactly.
14 A. -- because they're not employed by a hospital trust,
15 but -- well, in England and Wales, by the Local
16 Authority on behalf of the coroner.
17 THE CHAIRMAN: In that scenario, do the doctors still want
18 to be accompanied or assisted by their own lawyers?
19 They must do, mustn't they?
20 A. I think it depends, but from speaking to coroners in
21 England and Wales, it doesn't seem to be the problem
22 there that it is here.
23 THE CHAIRMAN: Okay, thank you.
24 MS ANYADIKE-DANES: Can you recall when you first became
25 aware that, notwithstanding the letter that you had

1 written, the old system was still continuing to be used?
2 A. When did I?
3 Q. Let me help you. The letter you wrote is
4 30 January 2004.
5 A. Yes.
6 THE CHAIRMAN: Sorry, had that idea been run past the police
7 before you wrote to Dr McBride?
8 A. This suggestion had surfaced on a number of occasions
9 since my appointment as a deputy back in 1985. It had
10 been tried without success. I remember in one instance,
11 the police officers -- a police officer threatened to
12 arrest a surgeon who was operating unless he made
13 himself immediately available, so there were problems
14 with using police officers for this purpose.
15 THE CHAIRMAN: Thank you.
16 MS ANYADIKE-DANES: What I had asked you is if you can
17 recall when you became aware that the old system that
18 you were seeking to have changed was still in use.
19 A. Well, I always knew that it was in use because whenever
20 a hospital death occurs, we immediately liaise with
21 a contact in each of the hospitals to arrange for
22 statements to be taken.
23 Q. Yes. Were you aware of the fact that, notwithstanding
24 that at that stage the inquest that we're moving towards
25 is the inquest of Claire, which took place in 2006, so

1 that post-dates this letter of yours by some
2 considerable time. But were you aware that what the
3 Trust was doing was it was taking down the statements of
4 the clinicians or nurses, as the case may be, on what
5 appeared to be pro forma PSNI witness statement sheets,
6 even though the PSNI were not actually involved?
7 A. Well, I can't recall that, but I'm sure you're correct
8 in saying that.
9 Q. If that was happening and it wasn't something that you
10 particularly authorised, is that something that would be
11 of concern to you?
12 A. Well, I would wonder how a hospital trust would secure
13 PSNI statement forms.
14 Q. A stationery issue. If I pull up witness statement
15 176/1, page 9. This is a witness statement -- I'm
16 trying to see whose witness statement it is. If we go
17 back to the first page, we can see whose it is. I think
18 it might be Mr Walby's, but I don't want to say that
19 unless I'm accurate. There we are, it is Mr Walby. So
20 if we go back to the original page.
21 Mr Walby, at that stage, was in the office of risk
22 management.
23 A. That's correct, yes.
24 Q. What he says there, as you can see:
25 "... if these statements [it is our question] were

1 prepared on police witness paper and if they were,
2 please explain why."
3 Well, they were prepared on police witness paper,
4 and the answer is:
5 "This was the historical format preferred by
6 HM Coroner."
7 A. Well, I'm sure that that is correct, but I think
8 coroners would not have -- would perhaps have wanted the
9 format of a police statement to be used without
10 requiring it to be on the actual police forms.
11 Q. Yes. I mean, for example, if those statements then
12 become evident to the families and so forth, do you see
13 that it creates an impression that those statements have
14 been statements taken by the PSNI and therefore have the
15 degree of independence that you were perhaps referring
16 to?
17 A. I can see that, yes.
18 Q. And if that's not the case, but actually they're being
19 taken by the trust risk manager, that perhaps puts
20 a different colour on things, or might do?
21 A. That is correct.
22 Q. Then apart from the actual format, one of the areas that
23 I would like to take you to is the extent to which the
24 Trust's management team were actually involved in
25 drafting or amending the witness statements.

1 The 2002 system, which was the old system, permitted
2 that to happen so long as the clinician, if that were
3 the case, had agreed to that. And so they were
4 accepting whatever helpful suggestions were made in
5 terms of changing it. The issue that arose in Claire's
6 case is that you had Dr Webb, who was a consultant
7 paediatric neurologist and, in fact, was the consultant
8 who actually saw Claire for the purpose of her
9 treatment. For various reasons the consultant
10 paediatrician who was her consultant didn't see her all
11 the time the treatment was being provided. So Dr Webb
12 prepared and signed his own very detailed statement in
13 Claire. At that stage he was no longer at the
14 Children's Hospital.
15 A. Mm-hm.
16 Q. We don't need to pull it up, but the reference is
17 139-098-002. When he signed that, it included this
18 particular statement, and he sent the entire statement
19 to Mr Walby. I think this is worth pulling
20 up: 139-098-021.
21 In there, it refers to the fact that:
22 "I made the mistake of not seeking an intensive care
23 placement for Claire before I left the hospital."
24 If you ignore, sir, the manuscript change and just
25 look at it in its original typewritten form because

1 that's the form in which it went to Mr Walby, it's the
2 final paragraph:
3 "I made the mistake of not seeking an intensive care
4 placement for Claire before I left the hospital on the
5 evening of October 22nd."
6 Dr Webb gave evidence about that and his evidence
7 was that was, in his view, an error; he should have done
8 that. As it turned out in the evidence, it may have
9 been that that was significant. The inquiry's experts
10 thought that she would have benefited from the
11 one-to-one nursing that she would have received if she
12 had been admitted to paediatric intensive care. That
13 was the paediatric nursing expert. The neurological
14 expert thought that that --
15 THE CHAIRMAN: It's okay, you don't need to go through what
16 the experts said. The evidence was that by the time
17 Dr Webb left the Children's Hospital at around 5 or
18 6 o'clock on that evening, Claire was very seriously
19 ill. That's why he put in his statement he says:
20 "I made the mistake of not seeking a transfer to
21 intensive care before I left."
22 He put that into his statement and then the
23 handwritten changes that you see there were proposed by
24 others and he adopted them. So the statement as it
25 reached you was not as he had drafted it. On the basis

1 of what you were saying this morning, you would want
2 a factual statement, but you would also want people to
3 be candid and open with you?
4 A. Absolutely, yes.
5 THE CHAIRMAN: So if Dr Webb thought he had made a mistake,
6 that's exactly the sort of thing that you would want to
7 see in a statement?
8 A. That is correct.
9 MS ANYADIKE-DANES: Yes. And the reason why, when the
10 evidence came out, that he was given -- this is
11 Dr Webb -- for changing that is because he was being
12 told that it was inappropriate for him to offer an
13 opinion like that and that is the sort of thing that
14 should emerge in the course of the inquest. So
15 notwithstanding the fact that he actually believed that
16 to be the case, that he had made that error, he was
17 being told that's inappropriate for you to say that, and
18 you give your factual evidence and the coroner will
19 reach his conclusion.
20 A. Well, I think the answer to that is if medical
21 practitioners believe they have made a mistake, I would
22 encourage an admission of that, and it seems that
23 Dr Webb is doing exactly that in the original version of
24 this statement. And in my view, if that was Dr Webb's
25 belief, sincerely held, that's the way it should remain.

1 THE CHAIRMAN: It might turn out that he's right or wrong
2 about that, whether it's a mistake or not, or what the
3 seriousness or the extent of the mistake is.
4 A. Yes.
5 THE CHAIRMAN: That's what you want to hear, so what's
6 inappropriate is that he's persuaded to change his
7 statement when in fact he's prepared it in the proper
8 format?
9 A. And of course, chairman, at the inquest the statement
10 would be read over, in this case to Dr Webb, and he
11 would be asked to confirm that it was accurate and would
12 also have an opportunity to qualify any part of it if --
13 is Dr Webb male or female?
14 THE CHAIRMAN: Male.
15 A. If he felt it was appropriate.
16 THE CHAIRMAN: Yes. But what he's been encouraged to
17 believe is that his statement should be factual, not
18 expressing an opinion.
19 A. Yes.
20 THE CHAIRMAN: And that's why he's in effect been told "it
21 may be your opinion that you made a mistake, but it's
22 not a fact that you made a mistake, therefore change the
23 presentation of the statement". That wouldn't prevent
24 him adopting the statement or confirming it that he
25 stands over it when it reaches you. It gives him an

1 impression which you don't want him to have about what
2 the ambit of the inquest is.
3 A. That is correct.
4 THE CHAIRMAN: Just to complete that: this isn't the only
5 example in this inquiry of a statement being changed
6 at the instigation of managers within the hospitals in
7 order to control the information which reached you.
8 I presume you find that disappointing.
9 A. I do.
10 MS ANYADIKE-DANES: And if we go back to Adam's case, during
11 the course of the inquiry's work in Adam's case a note
12 of a consultation was made available to us, and that
13 consultation was on 14 June 1996, and therefore
14 pre-dated the start of the inquest into Adam's case,
15 which was just slightly later in June of that year. The
16 whole tenor of that consultation was to see how best
17 arguments might be formulated to meet the points that
18 Dr Sumner had made and therefore, if you like, challenge
19 the notion that there had been a fluid overload. It's
20 quite a lengthy document and the chairman has had the
21 benefit of going through it and hearing what all the
22 clinicians have said about it, but just on the point
23 that you were exchanging with the chairman, there was
24 one very telling one. 122-001-004.
25 Just before I take you to the point, sir, there was

1 quite a bit of evidence as to whether all the events
2 happened in exactly the order that they're recorded in
3 this note, who took the note and so forth. It was the
4 matter of quite a bit of evidence from the participating
5 clinicians. But in any event, if you go just halfway
6 down, sir, you can see that Dr Savage there, who was, as
7 you may recall, Adam's nephrologist, was saying:
8 "Dr Savage commented that one could not argue
9 against the point that there was hypernatraemic fluid
10 overload although there was correct logic in how the
11 fluid calculations were done. Dr Taylor was very
12 strongly of the view that there had not been a fluid
13 overload."
14 Then if you go down almost to the bottom:
15 "Again Dr Taylor was concerned to say that one could
16 not conclude that there had been fluid overload and it
17 was confirmed that this phrase would not be used."
18 Quite apart from that, there were a number of other
19 instances of trying to see what other possible arguments
20 might be mounted to meet, if you like, Dr Sumner's
21 report, and what I'm asking -- because of course, you
22 don't know this sort of thing, you're only meeting the
23 evidence as it's presented to you in the inquest. What
24 I'm asking you to reflect on is that at this stage
25 you have Dr Murnaghan, who is the director of risk

1 management, and that therefore when the evidence, if
2 it's being formulated by those who may have a dual
3 allegiance -- one to assist you, the other to protect
4 the interests of their employer -- I'm just wondering if
5 you were ever concerned about the quality of those
6 statements that you might be receiving.
7 A. Well, the way this aspect has been put to me would make
8 me concerned, but perhaps I would have some reassurance
9 by the fact that each of the individuals would be giving
10 evidence under oath and I attach very great weight to
11 someone who gives evidence under oath that in fact they
12 are telling the truth.
13 Q. Yes. The difficulty about that, sir, is that at that
14 time the evidence that we heard in the inquiry is that
15 all those clinicians were being told that they stick
16 very narrowly to the factual things that they were
17 engaged in, so even if they had formed views that were,
18 if you like, adverse to perhaps their employer's
19 position, that's not something that they were
20 particularly going to volunteer or even being told it
21 was appropriate to volunteer, and that's the area that
22 we are in and one sees the same thing happening with
23 Dr Webb much later on in relation to Claire's case.
24 That's why I'm really asking, without an independent
25 person being involved in the gathering of the

1 statements, whether you don't see a possible tension
2 between those who are managing the interests of the
3 employer -- for all they know, on the back of this is
4 coming litigation -- and also those who are trying to
5 give you an account of what actually happened so that
6 you can do your duty in terms of the inquest, whether
7 you don't see that tension and whether it doesn't
8 concern you when you hear these sorts of things or read
9 these sorts of things.
10 A. Can I just say, I agree from what you're telling me that
11 indeed there is a tension and it is concerning.
12 Q. Thank you.
13 THE CHAIRMAN: The concern that I have, sir, is that we have
14 had doctors who eventually have expressed very clear
15 views here about what went wrong and those are views
16 which were not expressed to you at the inquest. If
17 I take Adam as an example, both Dr Keane and Dr Savage
18 had a clear view, almost immediately upon Adam's death,
19 that the cause of Adam's death was the excess of fluid
20 which he had been administered due to a terrible mistake
21 made on the day by Dr Taylor. But I'm quite sure that
22 that is not a view that was conveyed to you in anything
23 like those terms.
24 A. Nor was it a view that was conveyed to the pathologist
25 in Adam's case, who, from my recollection, that was

1 Dr Alison Armour, because I had a series of telephone
2 conversations, which I still remember very, very well,
3 and Dr Armour was really at a loss to explain the
4 cerebral oedema that she found, and it was only after
5 a series of discussions and speculations that I went
6 down the route of securing the assistance of Dr Sumner
7 from Great Ormond Street Hospital. So I'm sure if
8 Dr Armour had been aware of that, it would have, if you
9 like, shortened her investigation.
10 THE CHAIRMAN: Thank you. It's not to suggest that
11 witnesses have lied on oath, but when the witnesses
12 confine their evidence within a narrow remit, they are
13 in effect trying to avoid issues which are less
14 comfortable for them because it may involve pointing the
15 finger at a colleague.
16 A. Yes.
17 MS ANYADIKE-DANES: Because I know it is of concern to some
18 of the families, if one stays with Claire's case, for
19 example, as you know her inquest took place in 2006, but
20 the evidence that the inquiry has received is that by
21 2004 the Trust had formed the view that fluid
22 mismanagement was a contributory factor. We have that
23 from the transcript evidence of her consultant
24 paediatrician, Dr Steen. We don't need to go into it,
25 but the reference for it is 17 October 2012 at page 143,

1 and that the failure to carry out repeat electrolyte
2 tests which, if you remember, goes all the way back to
3 that statement that was provided to you in Adam's
4 inquest, which is the importance of carrying out
5 electrolyte tests for those who were vulnerable to
6 hyponatraemia, that the failure to carry out a repeat
7 electrolyte test was an error in her care, and Mr Walby
8 acknowledged that in his evidence to the inquiry. Also,
9 that there were substantial overdoses of midazolam and
10 phenytoin, which, even of themselves, Dr Herron -- who
11 you know in the department of pathology -- had said, had
12 he appreciated that, that would have led him to suggest
13 that your office should have been involved much earlier.
14 A. Yes.
15 Q. And then finally, that the histological evidence of
16 meningoencephalitis, which formed an important part of
17 the conclusion as to her cause of death, that that
18 actual histological evidence was so minimal as to be
19 capable of being discounted. The concern that the
20 family have is that this is something that the
21 clinicians should have known and appreciated in 2004 and
22 yet, when it comes to 2006, they're concerned that
23 you are not being provided either with that information
24 then or certainly not being provided as soon as the
25 clinicians formed that view, which on the way that

1 we have been discussing their duty to report to you, one
2 would have thought would have generated a requirement to
3 notify you much sooner of their own volition.
4 A. I agree.
5 Q. Then one other issue on this same theme and then we will
6 move on.
7 If we bring it into Raychel's case. In Raychel's
8 case, you may recall that there was an issue which in
9 fact you were specifically addressed about in
10 correspondence from the Trust. There was an issue as to
11 whether Raychel had suffered prolonged and extensive
12 vomiting. You may recall that. And as a result of
13 that, you were asked if you would permit the nurses to
14 give evidence because the way it was being put to you
15 is that they were the people dealing with Raychel and
16 therefore they would be able to give you evidence of
17 prolonged and extensive vomiting, which was being denied
18 by the Trust at that stage, in contrast to the expert
19 that you had received who had formed the view that she
20 had suffered prolonged and extensive vomiting and that
21 and the response to it had contributed to her condition.
22 As part of the Trust's investigation to pursue that
23 argument that they were wishing to put forward, they
24 engaged a consultant paediatric anaesthetist, an
25 independent expert from Dublin, Dr Warde. The

1 difficulty is that when he produced his report to the
2 Trust, he actually did implicate severe and protracted
3 post-operative vomiting, so far from supporting that
4 hypothesis, his view actually was that there was that.
5 We don't need to pull it up, but the reference is
6 022-006-023. That was a report that wasn't provided to
7 you at all.
8 In addition to that, the trust had obtained a report
9 from a consultant paediatrician, Dr Jenkins, and his
10 initial view of it is that he would want to see
11 confirmation that the extent and severity of the
12 vomiting is something that fell within the normal
13 parameters, if I can put it that way. He never got that
14 confirmation. The report that he produced, that
15 ultimately was tendered to you, makes no reference to
16 any of that at all.
17 So the evidence that you have coming is a report
18 which suggests "I'd like to be satisfied about this",
19 but it doesn't include it, and no report to the contrary
20 suggesting that there might actually have been severe
21 and protracted post-operative vomiting. You can see,
22 when the families learn about that, that's a concern.
23 A. Can I just clarify that there was an expert report from
24 a Dr Warde from Dublin --
25 Q. Yes.

1 A. -- which I didn't -- I wasn't provided with a copy?
2 Q. Exactly, exactly. You weren't provided with it and the
3 explanation of why you weren't provided with it was
4 because that's subject to privilege. They've got the
5 report and they didn't have to show it to you.
6 A. Anyone who appears in any inquest I conduct will be
7 aware of my practice, and that is that any expert report
8 that I get will be disseminated to all involved and my
9 expectation is -- and I've said this on a number of
10 occasions -- that I would expect in exchange to be
11 provided with a copy of any expert report they obtain.
12 There may be an issue raised of privilege, but what
13 I would say is: are we not investigating in this case
14 the death of a child and let's not dwell on legal
15 niceties? We want to get to the truth.
16 Q. Yes. Particularly, presumably, if what's included
17 in that report is something that appears to run counter
18 to the argument that has been presented to you
19 previously.
20 A. Yes.
21 Q. Well, that's what happened. So in your view, you would
22 want the Trust to find a way of communicating that
23 information to you?
24 A. Certainly I would.
25 THE CHAIRMAN: It's not a question of the Trust finding

1 a way to communicate the information; it's the Trust
2 handing over their report. This is one judicial officer
3 investigating the causes of a child's death and a public
4 body obtaining an expert's report and then deciding
5 that, because it's inconvenient to them, they will
6 withhold it from the coroner.
7 MS ANYADIKE-DANES: Exactly.
8 A. Can I just add this: that I usually get expert reports
9 from hospital trusts and I do so on the basis -- that
10 I hope isn't mistaken -- that there has been complete
11 disclosure because I, in turn, provide complete
12 disclosure of anything that I've obtained.
13 THE CHAIRMAN: So you'd like to think that the reports and
14 the statements which you receive are in fact the
15 original reports and statements?
16 A. That is correct.
17 THE CHAIRMAN: Thank you.
18 MS ANYADIKE-DANES: And so therefore you don't want to have
19 version three, which removes some of the caveats that
20 may have been present in version one?
21 A. Not at all.
22 Q. Thank you. If we move to the actual reporting of deaths
23 to your office. I wonder if you might cast yourself
24 back to April 2000 and explain what the organisation in
25 your office was for the receipt of reports of deaths and

1 how they were dealt with.
2 A. At that particular time, I was coroner for the district
3 of Greater Belfast, and so far as I can ascertain I was
4 based then at Newtownabbey courthouse where the office
5 was located. Then there was no full-time deputy, so
6 essentially it was really just me and, I think, three
7 office staff.
8 Q. And in terms of the way it worked -- I don't know if
9 you've had the opportunity to read Mrs Dennison's
10 transcript of her evidence yesterday.
11 A. No.
12 Q. What she essentially describes is that she and the
13 others in that office, all of them, irrespective of
14 whether one was your secretary and one was a clerk, they
15 would all respond to telephone reports of deaths.
16 A. Yes.
17 Q. The impression was, because of the pressure of work,
18 they really had to do that. So they would all do that
19 and she said they would make a note of whatever was on
20 the telephone, the subject of the telephone
21 conversation, and then subsequently they would
22 transcribe that into the main register for deaths.
23 Would you accept that that was what was happening?
24 A. That is correct.
25 Q. That in due course, that main register for deaths, the

1 information on it was put on to the coroner's database.
2 She also said that, in essence, her role was one of
3 information gathering. So once she had got the report
4 of the death, she would try and get in what she
5 considered to be the relevant information for you to
6 convey that to you so that you could make a decision as
7 to what was to happen thereafter. Would that seem about
8 right?
9 A. Not necessarily in all cases because a death -- it might
10 be absolutely clear that a death reported fell within
11 the coroner's jurisdiction and required a post-mortem
12 examination. The best example perhaps being the victim
13 of homicide.
14 Q. Yes. Well, I was actually more dealing with the
15 hospital -- I beg your pardon, I should have prefaced it
16 by that; I was really dealing with hospital deaths.
17 When they got a report from a doctor, that is what they
18 were seeking to do?
19 A. Yes.
20 Q. They've logged the report, as it were, got such
21 circumstances as seemed to them to be appropriate and
22 then they're contacting you to see whether this is
23 an issue that you're going to take within your
24 jurisdiction in whichever form, or it's a matter that
25 you're not and therefore the clinician is going to issue

1 a medical cause of death certificate in the usual way.
2 A. Yes.
3 Q. Would that summarise matters?
4 A. Yes.
5 Q. The other part of the evidence that she gave was that,
6 normally speaking, when that happens, she's got the
7 clinician on hold on the phone here, and then she's
8 trying to reach you to give the information so that she
9 can get a direction as to what she should tell the
10 clinician. I asked her what she did if she couldn't
11 reach you for any reason, there's only one of you, you
12 could be involved in any number of things, and she said
13 in those circumstances -- she said they didn't happen
14 very often, but in those circumstances, she would, as
15 would her colleagues, contact the State Pathology office
16 to get some guidance. Were you aware that happened?
17 A. Yes. The position then, and it remains the position,
18 is that many deaths are reported to the office where
19 there really is no need for that to be done, and
20 it would be appropriate for a death certificate to be
21 issued. I think I said in one of my statements that the
22 reason for that is that often the doctor either is
23 uncertain how to draft the causal chain of death or
24 wants reassurance that a death certificate is
25 appropriate. And bearing in mind that neither myself

1 nor any of my staff then had any medical training, the
2 circumstances of the death might well point to the need
3 for some guidance being given and the only source of
4 guidance then was the State Pathologist's department.
5 Q. Yes. The direction I'm coming at it from is this: my
6 understanding of the text that you wrote together with
7 Greer, "Coroner's Law and Practice in Northern Ireland",
8 which was published by SLS, 1998, is that once the
9 report has been made, that seems to be a defining
10 moment. When you've actually got a report of death,
11 then it seems from the text that the coroner has to make
12 a decision as to whether he's going to assume
13 jurisdiction. And where I take that from is -- if I can
14 help you with that, it's paragraph 5-02, but I'm trying
15 to give you a page that will come up. I think it's
16 170-006-001.
17 THE CHAIRMAN: What's the page reference then?
18 MS ANYADIKE-DANES: That's it there. You can see it at
19 paragraph 5-02:
20 "Before assuming jurisdiction, however, the coroner
21 must be satisfied that there is good reason for him to
22 do so."
23 So a report has been made, where a coroner has been
24 informed, a report has been made to your office,
25 Mrs Dennison confirmed that she had received a report of

1 a death, so the report has happened. Then it would seem
2 from the way this text is drafted that the coroner has
3 to decide whether he's going to assume jurisdiction. As
4 you said, just because a report is made doesn't mean
5 that you consider it's a death that you ought to
6 investigate in whichever way.
7 A. No.
8 Q. And so the coroner has to be satisfied that there is
9 good reason to assume jurisdiction. What that seems to
10 point to is, once the report is made, there's a coronial
11 decision, and what I'm trying to elicit is how that gets
12 made in the circumstances that Mrs Dennison describes,
13 which is she receives the report, she's got the
14 clinician on hold, if you like. She's then
15 communicating with the State Pathologist's office to get
16 some guidance and direction on where to go. The upshot
17 of that, whatever it is, is to go back to the clinician
18 and the clinician goes off and in due course issues
19 a medical cause of death certificate, which means that
20 it is not being pursued as one in which the coroner is
21 assuming jurisdiction. So what I'm asking you is: how,
22 in those circumstances, has the coroner made a decision
23 about the assumption or not of jurisdiction?
24 A. I cannot remember that particular day and being told
25 about Dr Hanrahan making my report. But my

1 understanding, based on the information which has been
2 provided to me, is that Dr Hanrahan was unsure whether
3 he could issue a death certificate. He spoke to the
4 office and that was followed by a conversation between
5 him and Dr Curtis, leading to the issue of a death
6 certificate. And if Dr Hanrahan, following that
7 conversation, either didn't agree with any advice given
8 by Dr Curtis or felt that this really was a death that
9 should be investigated by the coroner, what I would have
10 expected to have happened would be for him to ask to
11 speak to me on my return to the office.
12 Q. Yes. I understand that's the view that you formed or at
13 least the information that you thought you were getting.
14 The difficulty is that when Mrs Dennison was giving her
15 evidence, her evidence seemed to suggest that there
16 might not actually have been a discussion between
17 Dr Curtis and Dr Hanrahan; rather what might have
18 happened is what happened in those isolated occasions,
19 which is that she received the report from Dr Hanrahan,
20 put him on hold, she spoke to Dr Curtis, received some
21 information from Dr Curtis that allowed her to tell
22 Dr Hanrahan, "This is a matter which could proceed by
23 way of you issuing a death certificate". So if that
24 happened, then clearly you are not taking jurisdiction
25 over that case, even though it has been reported, so

1 somewhere in there a decision has been made, but it
2 doesn't seem to have been made by you.
3 A. No. Well, as I said, I knew nothing --
4 Q. I understand that.
5 A. -- and knowing Mrs Dennison over many years, I would be
6 surprised that, bearing in mind two things -- this was
7 the death of a child --
8 Q. Yes.
9 A. -- and bearing in mind the background -- she would not
10 have suggested that Dr Hanrahan speak directly to
11 Dr Curtis.
12 Q. No.
13 A. And this isn't uncommon that clinicians will speak
14 directly to a pathologist because they speak the same
15 language and perhaps matters can be teased out that
16 I would not have the medical knowledge to.
17 Q. Oh, yes, I understand that, sir, and I put that to her
18 directly. In her view, she had never done that. In
19 those circumstances --
20 THE CHAIRMAN: Sorry, she couldn't remember doing that,
21 which is slightly different.
22 MS ANYADIKE-DANES: Sorry, I'm just trying to find the
23 relevant thing to take you to. I will take you to what
24 she actually says. That's obviously important. What
25 I'm trying to explore with you at the moment -- she did

1 say, though, that practice, which she acknowledged
2 didn't happen very often, but that practice of getting
3 guidance when you could not be reached from the
4 State Pathologist's office so that the clinician could
5 be told, "This is either a matter that's going to be the
6 subject of a post-mortem by the coroner", or, "It's
7 a matter that you can take forward by way of a medical
8 cause of death certificate", that sort of thing she said
9 did happen. Not only did she do it from time to time,
10 so did others in the office.
11 And what I'm putting to you is: in those
12 circumstances, it would appear that a decision that the
13 coroner ought to make, which is, "Am I or am I not going
14 to take jurisdiction of this death?", has effectively
15 been made without you, the coroner, being involved.
16 A. I think that proposition would be subject to this: that
17 at the end of the day Dr Hanrahan issued a death
18 certificate, and Dr Hanrahan would have been aware of
19 the statutory basis which would permit him to issue
20 a death certificate.
21 THE CHAIRMAN: I'm afraid, Mr Leckey, that while that seems
22 absolutely clear to you, Dr Hanrahan didn't understand
23 the Coroner's Act. He said he had received no training
24 in it since he'd come over and he was only contacting
25 your office as a gut instinct because he qualified

1 in the south and then moved to England and then came
2 here and said that he had not, at that time, received
3 any training about his responsibilities under
4 the Coroner's Act. I'm just saying that to you because
5 I entirely understand why you were about to say that
6 Dr Hanrahan, as a properly informed consultant, should
7 have been absolutely clear of the circumstances in which
8 he could and could not issue a death certificate. I'm
9 afraid that, on the evidence that he gave, he just
10 didn't understand his responsibilities.
11 A. Can I just say that, of course, the pad of death
12 certificates --
13 THE CHAIRMAN: Has the information?
14 A. -- does contain guidance and gives details -- quite
15 interesting -- of causes that should not be put in the
16 death certificate. But interestingly enough, two causes
17 that are not mentioned in that list are hyponatraemia
18 and cerebral oedema.
19 THE CHAIRMAN: Yes. Well, what he actually said to the
20 inquiry was that he, like Dr Curtis and Mrs Dennison,
21 really doesn't remember these exchanges at all or how
22 many exchanges there were and so on. But he said if the
23 information which is contained in Mrs Dennison's note is
24 all that he said, then he gave incomplete information
25 and the important omission from what is recorded on

1 Mrs Dennison's note is hyponatraemia.
2 A. Yes.
3 THE CHAIRMAN: And he said, in fact, the note which
4 Mrs Dennison made, which might be of the information
5 that he gave him, just doesn't make sense --
6 A. Yes.
7 THE CHAIRMAN: -- and he then went on to accept that the
8 death certificate which he issued did not make sense.
9 A. Yes. I was interested to hear this morning the exchange
10 with Dr Curtis and Dr Curtis felt it was a logical
11 causal chain, whereas Professor Lucas, I know, strongly
12 felt it was not.
13 THE CHAIRMAN: Yes.
14 A. But perhaps that's a matter that could be left to
15 others.
16 MS ANYADIKE-DANES: It may well be. If I can take you to
17 the transcript of yesterday, 24 June, and if we can pull
18 up pages 67 and 68 side by side. About halfway down
19 page 67, sir, this is how it arises. I say:
20 "If the report is made to you and I say, 'Hang on,
21 I'll just get hold of the coroner', and you can't get
22 hold of the coroner, how do you get a decision on what
23 to do then?"
24 And this is all prefaced, sir, with how she is
25 looking for a decision that she can then give to the

1 reporting clinician as to what to do. The answer to
2 that is:
3 "So if I'm thinking of this case, but if the coroner
4 was in a meeting or out in court or out of reach for
5 some other reason and I knew I wasn't going to get in
6 such with him and at the same time I have a doctor on
7 the line, then we contacted the State Pathology
8 Department, who we worked very closely with, and who
9 always took our calls, and I would have explained that
10 I had a doctor on the line, had a medical death, and
11 would somebody be willing to talk to me."
12 I say:
13 "Question: You're looking for assistance at that
14 stage?
15 "Answer: I definitely am, yes.
16 "Question: You can't reach the coroner, who would
17 otherwise be able to give the direction as to what
18 happens, so you get hold of somebody in the
19 State Pathology department and, once you have discussed
20 it with that person, then do you have a way forward for
21 the clinician? Let me put it this way: what's the
22 result of that discussion, typically?
23 "Answer: Yes, usually the pathologist has guided me
24 in a direction that I can speak to the doctor and I have
25 a decision then, yes.

1 "Question: And so when that happens, you then go
2 back to the clinician and tell the clinician whatever
3 it is that you've received some guidance on, either this
4 is going to be a post-mortem or you can issue your
5 form 14 --
6 "Answer: Yes.
7 "Question: -- or go and issue your death
8 certificate?
9 "Answer: Yes.
10 "Question: But one way or another, the result of
11 all of that is to give the clinician the direction as to
12 what's going on happen; is that correct?
13 "Answer: That's correct."
14 And then when I asked her whether she had learnt
15 that -- if I can pull up 69, so just shuffle them along:
16 "Question: Did everybody do that so far as you were
17 aware?
18 "Answer: Yes. It didn't happen very often."
19 So the point I'm putting to you is that Mrs Dennison
20 is quite clearly describing a practice where you start
21 off with a report of a death from a clinician and you
22 end up with a direction as to what the clinician may do,
23 and he's being told, because we translated it back into
24 Lucy's case, that there isn't going to be a coroner's
25 post-mortem, you can go and issue a death certificate

1 and the note, according to her, is to be interpreted
2 as: you can issue a death certificate with
3 gastroenteritis. So the point that I'm putting to you
4 is: it would seem that a decision has been made, which
5 is a decision that really you ought to make, sir, but
6 without your benefit.
7 A. If there had been any uncertainty or doubt, Dr Hanrahan
8 could have been told that I would call him back when
9 I returned to the office.
10 Q. Yes.
11 A. And that does happen, because, for instance, deaths are
12 reported when I'm in court --
13 Q. Yes.
14 A. -- and if I'm not available to deal with it, I will
15 telephone back once the court is over. So it wouldn't
16 be unusual.
17 Q. I understand that.
18 A. And the staff know that a decision is not that urgent
19 because, to put it bluntly, the person is dead --
20 Q. I understand that.
21 A. -- and that sad state of affairs isn't going to be
22 changed by having to delay for a short period until
23 I get back to the office.
24 Q. I understand that, but for whatever reason it is,
25 Mrs Dennison seems to have described a practice,

1 admittedly only engaged in infrequently, which would
2 appear a decision being made that really ought to be
3 your decision. That's what I'm putting to you. For
4 example, if we pull up another part of your text,
5 170-004-004, if we look at paragraph 3-07:
6 "Where a medical practitioner believes a death is
7 reportable to the coroner ..."
8 Dr Hanrahan did believe this death was reportable to
9 the coroner and, in a number of different witness
10 statements, he explained why he thought it was
11 reportable: it was reportable because he actually didn't
12 know why the child had died and it was recorded as
13 having been reported to the coroner. This text says:
14 "A death certificate should not be issued unless,
15 having reported the death [which appears to have
16 happened] and discussed the circumstances, the coroner
17 directs that a death certificate may be issued."
18 In those circumstances, the death is reported, there
19 may have been a discussion, whether through the
20 intermediary or not of Mrs Dennison, but the coroner has
21 not directed a death certificate may be issued, but one
22 subsequently is.
23 A. Yes.
24 Q. The question I wanted to ask you is: did you appreciate
25 that that happened in your office?

1 A. All I can remember is that in such circumstances,
2 I would have spoken to the reporting doctor or the
3 member of staff would have spoken to me and said, "This
4 is what we've been told. Is it okay if the doctor
5 issues a death certificate or do you feel there should
6 be a post-mortem examination?". That was the practice
7 then, that remains the practice.
8 Q. I asked Mrs Dennison that. I asked her if that had
9 happened, would she then go back and tell you while you
10 were away, got the call, this is what I've done, in
11 other words to sort of bring you up-to-date, and her
12 answer to that was, "Well, not necessarily". So it's
13 possible that you wouldn't know that a situation like
14 that had actually occurred. So I was asking in a more
15 general way: did you know, isolated practice or not,
16 that that sort of thing happened in your office?
17 A. My understanding was that it did not. I know that the
18 practice of the staff was to make a note if they'd
19 spoken to me about the report of a death and the action
20 I specified.
21 Q. Yes. If that were happening in your office, would you
22 be concerned about it?
23 A. Well, yes, I would, because coroners want to make sure
24 that all questionable deaths are properly investigated.
25 Q. Yes. Because in this case, the consequence of that is,

1 however the arrangement worked, the consequence is that
2 a death which subsequently was considered -- and perhaps
3 even by some at the time -- something that ought to be
4 reported to the coroner, ended up with a death
5 certificate being issued, which some of the clinicians
6 have said simply didn't make sense, and yet had the
7 effect of meaning that there was no inquest into Lucy's
8 death until some considerable time afterwards.
9 A. But what I now know from this morning is that if that
10 causal chain had been put forward by Dr Curtis,
11 Dr Curtis will have said, "That does make sense ".
12 THE CHAIRMAN: I think what's unfortunate is that what
13 wasn't reported to Dr Curtis -- and a lot of this
14 evidence is highly speculative because no one really
15 does remember what happened, but there's no suggestion
16 by anybody that what was mentioned to Dr Curtis was that
17 there were concerns among a series of doctors that there
18 had been fluid mismanagement. And even if Dr Curtis had
19 thought that the sequence made sense, if he had been
20 told that there was a concern about fluid mismanagement,
21 he would inevitably then have given advice in different
22 terms to whatever advice he gave and was understood.
23 A. I have no doubt about that, and can I just say that if
24 I had been there and had spoken to Dr Hanrahan, I'm not
25 saying that I would have immediately spotted the

1 problems and said, "This is definitely a coroner's
2 case". I would have been looking for key words or
3 phrases to assist me, such as hyponatraemia, fluid
4 management. Those would have been the words and phrases
5 that would have rung alarm bells with me because I was
6 still very, very conscious of all that had been involved
7 in the Adam Strain inquest.
8 MS ANYADIKE-DANES: Yes, and I'm wondering if this goes back
9 to something when I read out to Dr Curtis, the letter
10 that you had written to Professor Jack Crane, saying
11 that you were -- and this was a letter that you wrote
12 in --
13 A. I remember the letter well, yes.
14 Q. -- concerned about being able to extract the appropriate
15 information. And if the people -- and this was in
16 advance of you having the medical adviser. So if the
17 people who were tasked with obtaining the information
18 are not medically trained themselves, then it may well
19 be that they don't appreciate, particularly if the
20 doctor is not terribly clear, the questions that they
21 should be asking so as to disclose some of those
22 difficulties. And Dr Curtis quite fairly said --
23 of course, he can't remember whether he spoke to
24 Dr Hanrahan or not, but his view was, had he spoken to
25 Dr Hanrahan, the likelihood is that they would have had

1 a deeper conversation than he would have had with
2 Mrs Dennison and that might itself have flushed out
3 Dr Hanrahan's difficulties and his view was, if he had
4 been told that Dr Hanrahan was not entirely certain
5 about the cause of death, then the guidance then would
6 have been, "You had better speak to the coroner".
7 A. Dr Curtis, of course, said that his knowledge of
8 hyponatraemia was scant --
9 Q. Yes.
10 A. -- and I remember what Dr Sumner expressed very firmly,
11 and that was hyponatraemia is outwith the competence of
12 really anyone bar a paediatric anaesthetist.
13 Q. Yes, although I think Dr Curtis in his evidence to us
14 said if he had heard the expression "hyponatraemia",
15 that would have been enough.
16 A. I have no doubt about that. But I think what Dr Curtis
17 really was saying was that he would not have had the
18 expertise to analyse fluid charts and draw conclusions
19 from that, but you quite rightly state that if that word
20 had been used, as it would have been the same for
21 myself, it would have rang alarm bells.
22 Q. And this sort of situation that we're talking about when
23 it may be that part of the reason that a fuller probing
24 doesn't happen because, for whatever reason, the person
25 who is doing the probing or charged with doing the

1 probing hasn't the sufficient experience or expertise to
2 do it, is that the sort of thing that lay behind your
3 letter to Professor Jack Crane?
4 A. That is correct.
5 Q. We will come on to that shortly. In fact, we're just
6 going to come on to it right now. If we pull up your
7 witness statement, 277/2, page 5. This is the witness
8 statement that you made in Lucy's case. I can tell you
9 what you said. You say, echoing the correspondence that
10 you had previously sent to Professor Jack Crane:
11 "It remains my concern that when the death of
12 a child is reported to my office, the proper questions
13 may still not be asked."
14 That isn't necessarily a criticism of the person
15 charged to ask; it may just be a reflection of their
16 lack of knowledge about the issue. And then you go on
17 to say:
18 "Needless to say, it is vital that there is complete
19 candour on the part of the medical practitioner
20 reporting the death and that as much information as
21 possible is given."
22 And then you go on to say:
23 "That points to the need for the medical
24 practitioner not be a junior."
25 We asked a number of the clinicians their view as to

1 the level of information that they thought ought to be
2 provided to the coroner when you're reporting a death
3 and Dr Chisakuta, whose name I have mentioned before,
4 the consultant paediatric anaesthetist, he said that, in
5 his view, the clinician would have to have the relevant
6 medical notes to hand and to provide a fairly full
7 account of them and of the circumstances when making
8 a report.
9 I take it from what you have said in your witness
10 statement, you'd accept that?
11 A. Oh yes, I think the doctor should be familiar with the
12 medical records and be able to give a synopsis of that
13 when making the report.
14 Q. And I think the chairman has taken you to Dr Hanrahan's
15 own evidence, the reference for it is 5 June of this
16 year, page 106, where he concedes that he gave
17 a hopelessly incomplete report on Lucy's death. So
18 whatever happened, Mrs Dennison was only going to be as
19 good as the information she was given. That was in
20 2000 --
21 A. Mm-hm.
22 Q. -- can you help us with what the position is now?
23 A. Well, the position is that we have a permanent
24 appointment, a full-time appointment, a medical adviser
25 to the coroner's service, and she will look each day at

1 all the death reports that have come into the office.
2 She obviously, because of her medical qualifications, is
3 better placed than myself or my colleagues to identify
4 a death which could be described as questionable.
5 Q. And how long has this new system been in place?
6 A. Northern Ireland became a single district in 2006.
7 Dr Clarke has been in post, I think, two years.
8 Q. If I just pull it up, because I said I would to give you
9 an opportunity to comment on it, it's the letter that
10 you did write to the State Pathologist. It's
11 013-060-373 and if we have alongside it 374. So it's
12 the part that I read to Dr Curtis -- I think you were
13 in the chamber when I did that. It's right up at the
14 top. I don't want to have prejudged what you meant by
15 that. What did you actually mean by:
16 "When deaths of children in particular are reported
17 to my office the proper questions may not be asked."
18 What did you mean by that? It's at the top of the
19 second page, sir. I beg your pardon.
20 A. Well, as I've said before, key words or phrases need to
21 be included in the report, the obvious phrase being
22 "fluid management may be an issue". I can tell you,
23 because my office was very, very aware of the series of
24 inquests held into hyponatraemia-related deaths, that
25 that phrase by itself would have rung an alarm bell.

1 THE CHAIRMAN: Can I just check that with you? Because
2 unfortunately, there was a gap between Adam's inquest --
3 Adam died in 1995, the inquest was spring of 1996.
4 A. Yes.
5 THE CHAIRMAN: The next hyponatraemia death actually
6 reported to you was Raychel's, which took place
7 in June 2001.
8 A. Adam's inquest was still very fresh, both in my mind and
9 the minds of the staff, because, looking back, it was
10 one of the most important inquests I've ever held.
11 THE CHAIRMAN: Because?
12 A. Just because of how the diagnosis of hyponatraemia was
13 arrived at and the investigations that ensued following
14 the report of the death. It was a very significant
15 inquest in, I would say, the history of the Coroner's
16 Service since 1990.
17 THE CHAIRMAN: Do I take it from that, Mr Leckey, that makes
18 you even more disappointed that, while you learned so
19 much from it and you regarded it as so important, that
20 the learning spread out so thinly after the inquest?
21 A. Very disappointing.
22 MS ANYADIKE-DANES: And if we leave that there for the
23 moment, is what you are meaning to suggest here that
24 although the proper questions may not be being asked
25 from the point of view of your office, the appropriate

1 information is not being proffered by the reporting
2 clinician? I'm just trying to see what you meant by --
3 A. I suppose a bit of both because, for whatever reason the
4 doctor might not say the things that will cause concern
5 to be raised.
6 Q. The trigger words?
7 A. Whereas deaths of children, unlike deaths of elderly
8 people, do not happen with the same regularity. And if
9 there was a standard set of questions in relation to the
10 death of a child -- and by the way, I'd be willing to
11 accept medical advice on what questions would be
12 appropriate -- that would assist not only myself, my
13 colleagues, but also the staff who man the telephones
14 seven days a week and take reports of deaths.
15 Q. So up until your office gained a medical adviser, you
16 were very largely dependent on the clinicians
17 themselves, the information they gave you --
18 A. Yes.
19 Q. -- and for you to be able to understand -- not just you,
20 your staff -- in the way that information was being
21 given that this is an issue that really fell within your
22 remit or, alternatively, the assistance that you were
23 able to gain from the State Pathologist's office?
24 A. Yes.
25 Q. Is that what the system was?

1 A. That is correct.
2 Q. If we go to the reporting end, if I put it that way,
3 from the clinician's point of view, we asked about the
4 guidance and training being provided to doctors to do
5 this because it may surprise you to know that the
6 doctors, some of them, considered that they had
7 inadequate training and guidance on their statutory
8 duties in making a report to the coroner's office. So
9 the information deficit may have been all round, if
10 I can use that expression, in particular, Dr O'Donohoe
11 and Dr Hanrahan.
12 Dr O'Donohoe was Lucy's consultant paediatrician,
13 you may recall. His evidence and Dr Hanrahan's evidence
14 was that they hadn't received any real training on
15 reporting to the coroner. So not just a matter of
16 getting together the appropriate clinical information,
17 but how to provide that in its most helpful form to the
18 coroner's office. They felt they hadn't really received
19 any information or guidance on that. Can you express
20 a view as to whether that surprises you that they hadn't
21 been trained or got the guidance?
22 A. As I indicated earlier, and as you are aware, the pad of
23 death certificates forms does contain --
24 Q. You're quite right.
25 A. -- guidance.

1 Q. Let's pull it up now. You're quite right, sir. I can
2 pull up 315-019-002. This is the second page. The
3 first page says:
4 "Medical certificate of cause of death."
5 And that's the front of the pad, if you like. This
6 is the part I think you're referring to because these
7 are the notes.
8 A. That's correct.
9 Q. "Notes and suggestions to certifying medical
10 practitioners."
11 In fact, I took Dr Hanrahan through this, and some
12 of the other clinicians, and you can see at the top:
13 "The certifying practitioner must notify the death
14 to the coroner if there is reason to believe ..."
15 And there is a series of circumstances in which that
16 needs to be done. And further help and guidance is
17 provided under these notes.
18 That having been said, his view still was that it
19 wasn't something that they received training on. He
20 believed the report he made in Lucy was the first report
21 to a coroner he had made. So he felt that he was not
22 knowledgable about the process. What I'm really asking
23 you is: quite apart from this, were you aware of
24 training being provided, perhaps from your office, as to
25 what the coroners wanted from the clinicians?

1 A. Well, I would ask the question, was there not training
2 provided at undergraduate level in a medical degree or
3 postgraduate level en route to qualifying as a general
4 practitioner? What about induction training days at
5 hospitals? I would have thought that every hospital in
6 Northern Ireland, throughout the United Kingdom, would
7 provide induction training for new appointees to the
8 staff. For myself, before Dr Clarke was in post,
9 I often spoke at induction training in some hospitals in
10 Northern Ireland, particularly the Belfast ones, but
11 I wouldn't pretend that that ensured that every doctor
12 practising in Northern Ireland was conversant with the
13 requirements of when deaths needed to be reported to the
14 coroner. And really, the coroners do not have the
15 resources to achieve that gold standard of seeing that
16 all doctors in practice in Northern Ireland are
17 conversant with the reporting requirements.
18 Q. And from the way you've described it, that's something
19 that you would expect, at least together with you, the
20 universities and the hospitals themselves to --
21 A. Very much so, yes.
22 Q. Well, that's whether they had the information or the
23 knowledge about what was expected of them.
24 Another issue arose in the course of the evidence,
25 which really goes to their inclination to -- and I think

1 this is something that the chairman referred you to
2 earlier today when you were giving evidence -- identify
3 deaths where there might be some form of mismanagement.
4 The evidence that we received from Dr Crean -- and
5 it's the transcript of 4 June 2013 at page 150 -- the
6 line that the chairman referred you too can be found at
7 10 to 13. This is really quite a striking line:
8 "I think the worry for a lot of people was, 'If
9 I put my head above the parapet and say about this,
10 they'll shoot me for it', and it was trying to get
11 people to think in a different way."
12 In a sense what Dr Crean really was dealing with
13 there is whether, if you perceive, as the
14 Children's Hospital did, that there errors have been
15 made in the referring hospital, to what extent really it
16 was your duty or it would have been prudent to identify
17 that with the referring hospital.
18 But the reason I've pulled it up to you is this was
19 part of, it seems, a general shrinking from wanting to
20 address with other clinicians or other authorities
21 in relation to other clinicians occasions when there
22 might be some below standard care, if I can put it that
23 way.
24 A. If you go back to the previous exhibit, the explanatory
25 notes on the pad of death certificates.

1 Q. Yes, 315-019-002.
2 A. In bold print at the top, there's a requirement to:
3 "Notify the coroner if the death was a result of
4 negligence or misconduct or malpractice on the part of
5 others."
6 Q. So irrespective of the shrinkage, it was your statutory
7 duty to do it?
8 A. Your duty is clear. And forget about legal niceties,
9 what we're talking about is the death of children.
10 THE CHAIRMAN: That's absolutely right, Mr Leckey, but in
11 a sense, to be fair to our doctors, the current
12 controversy in England reflects a similar pattern over
13 there, doesn't it?
14 A. It does, that's right.
15 THE CHAIRMAN: I'm told -- and to a degree you've confirmed
16 this -- that there's now some more openness and more
17 willingness to face up to what actually happened than
18 there was some years ago.
19 A. Mm.
20 THE CHAIRMAN: My concern is that the bar was set so low
21 some years ago that actually you couldn't fail but to
22 make progress on it, and the remaining question is how
23 prevalent this culture remains. Dr Crean was cited to
24 you, the quote from his evidence a few weeks ago about
25 how you'd be shot. Dr Crean was sufficiently concerned

1 in Lucy's case that he rang Dr Jarlath O'Donohoe in the
2 Erne to talk to him about the fluid management and I've
3 had a series of witnesses who have said, both in the
4 Royal and one particular witness in the Erne, that fluid
5 mismanagement was clearly identified as a significant
6 problem in Lucy's case. But whatever else was
7 communicated to your office and whatever else was
8 discussed between whoever discussed it, it seems to me
9 to be absolutely certain that that wasn't.
10 A. No, it wasn't.
11 THE CHAIRMAN: And we're not talking about ancient history
12 here; we're talking about 2000. It was Mrs Ferguson who
13 made the point before Easter that what happened in
14 Raychel's case was not ancient history, it was this
15 millennium, it was June 2001 in Raychel's case. The
16 concern, if we're looking forward -- and there is
17 a point at which the inquiry absorbs all this evidence
18 and then looks forward, which is why Ms Anyadike-Danes
19 was asking you about Dr Clarke and general questions
20 about your perception of things now. The concern today,
21 moving forward, is accepting that some things have
22 changed, it's how much they've changed and what more can
23 be done.
24 A. Well, can I just say, chairman, that might be difficult
25 to establish unless we adopted a system akin to that

1 suggested by Dame Janet Smith arising out of the Shipman
2 inquiry, and I forwarded to the inquiry chapter 19 of
3 her third report, which made certain far-reaching
4 suggestions that all death certificates would be
5 scrutinised and some chosen at random for particularly
6 detailed scrutiny.
7 MS ANYADIKE-DANES: You mean audit, really?
8 A. An audit. I think unless we have some akin to that,
9 it'd be very difficult to answer the chairman's point
10 accurately.
11 THE CHAIRMAN: And the inquiry is particularly focused on
12 four or five children, but the truth is that nobody
13 knows if there are more hyponatraemia deaths which
14 haven't been disclosed. Because in a sense, two of the
15 ones that we are looking at came about by accident: they
16 came about because Stanley Millar was following Lucy's
17 inquest and then Mr and Mrs Roberts happened to be
18 watching Ulster Television that night. So only two came
19 to inquest and disclosure in the regular way.
20 A. Yes.
21 THE CHAIRMAN: Thank you.
22 MS ANYADIKE-DANES: I'm sorry to keep dipping in and out of
23 the specifics, but some of these things, as you might
24 imagine, the families do want to understand your
25 position about. If we're on the specifics of Lucy,

1 I had mentioned to you that Dr Hanrahan, on a number of
2 occasions in his evidence to the inquiry, had indicated
3 his reason for reporting Lucy's death. If I just go
4 very quickly through some of them so that you understand
5 the context:
6 "The cause of death was unclear to me. Lucy also
7 had died within a short time of admission to the
8 hospital."
9 That's in his first inquiry witness statement,
10 289/1, page 10:
11 "The reason for her death was not entirely clear."
12 That's a little further on in page 17:
13 "I felt a post-mortem was desirable as I was not
14 confident as to the cause of death."
15 And in fairness to him, he goes on to say:
16 "My uncertainty did not extend to believing that the
17 patient had died an unnatural death, but simply that
18 a child presenting with gastroenteritis should not then
19 have brain oedema without the matter being further
20 investigated."
21 That's to the police at 116-026-004:
22 "I was sufficiently concerned that the cause of
23 death be properly examined and I assumed that I did say
24 that the patient died of gastroenteritis, dehydration
25 and brain oedema."

1 That's later on in that witness statement at 007:
2 "I voluntarily contacted the coroner's office
3 because I felt that the death in the context of an
4 usually trivial illness was unusual."
5 Same statement, but at 011:
6 "And certainly I felt the coroner needed to be
7 informed about this and so I suppose I had spontaneously
8 written that in the notes."
9 That goes back to a point -- just so that you
10 understand what that means, sir -- even before the
11 brainstem death tests have come back negative,
12 Dr Hanrahan had written in Lucy's notes that if she was
13 to succumb, they would need to have a post-mortem and,
14 more to the point, the coroner would need to be
15 informed. So that was always his thought process if I
16 can put it that way. So when you hear all that, would
17 you accept that that is something that he was correct in
18 reporting to you if he was of that view?
19 A. He was correct, yes.
20 Q. Where things go a little bit astray is that when he gave
21 his evidence he said he never really was sure of the
22 cause. I don't mean sure in the way that you said there
23 are some cases which you just can't be sure about; he
24 never really felt confident that he could issue a death
25 certificate or that one should be issued, if I can put

1 it that way, and that was so even when he received the
2 post-mortem report from Dr O'Hara. And his evidence to
3 the inquiry was, at that stage, he really felt he should
4 have come back to you at that stage. So the difficulty
5 for everybody following this and seeing the missed
6 opportunity of an early inquest is that you have the
7 principal clinician there really feeling that this is
8 a matter that he's not certain about, he has reported it
9 and somehow he comes out of the process with ultimately
10 directing his registrar to issue a death certificate.
11 Is that not something of some concern to you?
12 A. It is concerning, I agree with you, and it should have
13 been the subject of a report that was actioned on. But
14 one wonders why Dr Hanrahan, for example, would not have
15 spoken to his colleagues and told of his dissatisfaction
16 about what happened when he contacted the coroner's
17 office. And of course, it was open to him or his
18 colleagues, singly or in combination, to say they would
19 like to speak to me.
20 Q. I'm glad you said that because that's something I wanted
21 to ask you about. If Dr Hanrahan had had a conversation
22 with his colleagues and said, "I reported that matter
23 and the coroner thinks it's not within his
24 jurisdiction" -- the inquiry also heard evidence that
25 there were at least some of the clinicians who felt that

1 Lucy's condition, if you like, was at least brought
2 about in part by an inappropriate fluid regime --
3 A. Yes.
4 Q. -- established at the Erne --
5 A. Yes.
6 Q. -- and that Dr Chisakuta was of that view, Dr Stewart
7 was of that view, and their evidence to the inquiry was
8 that they were not alone in that. So that would suggest
9 that that is a case that ought to be reported to
10 the coroner because that's an iatrogenic event --
11 A. Mm-hm.
12 Q. -- or an involvement of the treatment. If then
13 a coroner's inquest or post-mortem is not to be
14 conducted, in your view, if they had not been persuaded
15 out of their concerns about the fluid regime, what
16 do you understand their duty to be?
17 A. Their duty was to report.
18 THE CHAIRMAN: We really can't take this any further,
19 Ms Anyadike-Danes, because we don't know the terms in
20 which Dr Hanrahan did report. There's a big gap in this
21 aspect of the hearing. It doesn't appear that he
22 reported in any way which is coherent or sensible, which
23 may be why things turned out as they did. And he's
24 pretty much accepted that already.
25 MS ANYADIKE-DANES: I beg your pardon, sir. I was actually

1 seeking what the coroner's view was of the duty of the
2 others because, elsewhere in your evidence to the
3 inquiry, as I understood your evidence to be, that is
4 a duty that falls on all clinicians, so in the same way
5 as the principal treating clinician had a duty to do so,
6 so too did the pathologist if he'd had any concerns
7 after carrying out his post-mortem, so too did any of
8 the other clinicians if they had concerns, including
9 those in the Erne, which is where I'm going to go to
10 shortly. Is that your view?
11 A. That is correct.
12 Q. So if those other clinicians had not been given some
13 explanation that overcame their concern about the role
14 of her fluid treatment in the Erne, then is your view
15 that they too should have at least considered a report
16 to you?
17 A. That is correct.
18 THE CHAIRMAN: If they understood that there had been
19 a report to you as a result of which a decision had been
20 taken that this was not a case for your office but was
21 a case which could be dealt with by hospital
22 post-mortem, in other words if they thought that you had
23 somehow turned the case away, what would your
24 interpretation be of their duty in those circumstances?
25 A. I think Dr Hanrahan would have had to have said to them

1 that he had spoken to me personally --
2 THE CHAIRMAN: Right.
3 A. -- and that I'd said "death certificate". But that
4 hadn't happened. It's not uncommon for a reporting
5 doctor having spoken to a member of the staff to say,
6 "I would like to speak to Mr Leckey personally about
7 this".
8 THE CHAIRMAN: Can you remember cases over these years,
9 Mr Leckey, in which you've had a report from a doctor,
10 akin to Dr Hanrahan's report, and you then have
11 a subsequent communication from another doctor
12 expressing concerns?
13 A. It has happened. I can't remember the ones, but it's
14 not common.
15 THE CHAIRMAN: Okay. Do you have any recollection of having
16 reports from different hospitals, in this case the Erne
17 as well as the Royal?
18 A. No. The report tends to come from the last hospital
19 in the chain of treatment.
20 THE CHAIRMAN: Right. Thank you.
21 A. But I have had reports from -- if there's a consent
22 post-mortem, I have had reports from the pathologist,
23 saying, "This needs to be a coroner's post-mortem".
24 THE CHAIRMAN: Thank you.
25 MR GREEN: Sir, may I interject? It may be helpful at this

1 stage if the coroner is asked for his view of Dr Dolan's
2 analysis of the position on this aspect of the case.
3 And the reference is 303-052-731. It's paragraph 4.35
4 first, and I'll read it into the transcript:
5 "In both Northern Ireland and England and Wales,
6 there is no general statutory or common law duty of
7 disclosure to a coroner. The duty to report a death to
8 a coroner does not extend to requiring other persons to
9 volunteer information about the wider circumstances of
10 a death once the death has already been reported.
11 Specifically once a death has been reported and an
12 inquest is to be held, there is no legal duty upon
13 doctors to draw any concerns they might have about the
14 medical management of the deceased to a coroner's
15 attention after a report has been made by another
16 person."
17 And that's the first of two passages I would invite,
18 through you, sir, Mr Leckey's comment on.
19 THE CHAIRMAN: Let's pause at that one, Mr Green, rather
20 than go into your second passage. There are really two
21 points in that, aren't there? The first point is,
22 in the second sentence, about how many people report
23 a death. And the point in the second sentence is that,
24 once an inquest is to be held, there's no legal duty to
25 draw any concerns about medical management to your

1 attention.
2 If we deal with the first one about second and third
3 doctors perhaps volunteering information about wider
4 circumstances once a death has already been reported to
5 you; do you agree with Dr Dolan on that?
6 A. Well, if a death has been reported, it would not be
7 uncommon once statements come in for concerns to be
8 raised by other doctors involved.
9 THE CHAIRMAN: Right.
10 A. That would be a relatively common feature.
11 THE CHAIRMAN: Okay. Then do you agree with her second
12 sentence? And this, I think, goes back to some of the
13 discussion this morning about what should be in
14 a doctor's witness statement to the coroner. Because
15 what she is saying here is that there's no legal duty on
16 the doctors to draw any concerns they might have about
17 medical management and what you were saying this morning
18 in answer to various questions was that you're unhappy
19 about doctors who restrict the information they give you
20 to factual information and do not raise concerns which
21 they have about medical management.
22 A. Yes, I stand by that.
23 THE CHAIRMAN: Does that mean you disagree with Dr Dolan
24 about that or do you agree with her that there's no
25 legal duty but it is something that you still expect?

1 A. She doesn't quote any authority for that proposition.
2 THE CHAIRMAN: No. No, she doesn't. Would you query
3 whether that assertion is right?
4 A. Well, if she was here, I suppose I would do the lawyer's
5 thing and ask what is her authority.
6 THE CHAIRMAN: Okay.
7 MR GREEN: Then the next passage, 4.36:
8 "There is no duty to provide opinion evidence from
9 third parties who have at some later stage become
10 appraised of the facts surrounding the death (for
11 example, where healthcare staff learn of facts which
12 lead them to suspect medical mismanagement by others, or
13 where an expert opinion on the case has been obtained by
14 an interested party prior to the inquest)."
15 I don't think I need to go any further for these
16 purposes, sir. Once again, may I invite, through you,
17 the coroner to indicate if he disagrees with any part of
18 that analysis?
19 A. I suppose I'd make the same point. There's no authority
20 quoted for that proposition.
21 THE CHAIRMAN: Okay. Let's look at it the other way. Where
22 do you think that the duty comes from to provide -- and
23 let's phrase it in this way. If Dr Dolan is right, then
24 there would not be an obligation on the Royal Trust --
25 as it was, on the Belfast Trust as it now is -- to

1 provide you with Dr Warde's report. Sorry, that would
2 be the Altnagelvin Trust. But there would be no
3 obligation to provide Dr Warde's report, which was
4 obtained for the purposes of Raychel's inquest, and then
5 withheld.
6 A. Well, I understand that it was withheld because legal
7 privilege was claimed.
8 THE CHAIRMAN: Yes.
9 A. But I came across -- and I can't remember if it was in
10 a case within the past few weeks -- the proposition
11 that, bearing in mind that the circumstances of a death
12 are being investigated, that a trust with its own report
13 or someone else is not in a position to withhold that
14 report from the coroner, who is charged with
15 investigating the circumstances of a death. It's a bit
16 like withholding evidence.
17 THE CHAIRMAN: I'm sure you don't have it to hand, but if
18 you do come across that case in the next few days,
19 could you refer me to it, please?
20 A. I will, yes.
21 THE CHAIRMAN: On a narrower legal approach, would that in
22 your eyes prevent a trust which had that expert report,
23 which was against them, say in proposition X, would that
24 prevent the trust from running a case to the contrary of
25 proposition X?

1 Let me put it more simply. If there was an area in
2 which the Trust had an expert report, saying there was
3 mismanagement, and they don't produce that report to you
4 because they say, "This report is privileged, we don't
5 have to", they don't even have to disclose it then, does
6 that in your eyes prevent the Trust from arguing that
7 there was no mismanagement in that area? Because in
8 that event they're arguing for a proposition which is
9 directly contradicted by an expert report which they
10 have obtained.
11 A. That's an interesting proposition and I'd be very
12 interested to hear legal argument both ways before
13 plumping one way or the other.
14 MR GREEN: Sir, if it's permissible as voluntary good
15 practice to make wider disclosure than that required by
16 section 7 of the 1959 Act and if Dr Dolan's analysis of
17 that provision in these paragraphs is right, does the
18 senior coroner for Northern Ireland agree that that's
19 a crack that is for the legislature to fill?
20 A. Well, I suppose I can answer that two ways. First of
21 all, yes, that is something the legislature could look
22 at and hopefully will look at, bearing in mind the
23 coroner's legislation is in serious need of a major
24 overhaul. Secondly, the common law position in relation
25 to a disclosure, I think, has evolved considerably since

1 the 1959 Act, despite the fact that the coroner's
2 legislation makes no provision at all for disclosure.
3 And I think that is a point Lord Justice Girvan referred
4 to within the last year or two in a judicial review
5 decision.
6 MR GREEN: Thank you, Mr Chairman. Thank you, Mr Coroner.
7 MR HANNA: Sir, I didn't appreciate it might be appropriate
8 to interrupt, but there is a point that has caused me
9 some concern for quite some time this afternoon and that
10 is the possibility of confusion and ambiguity in the use
11 of the word "report". I'm quite sure that
12 Ms Anyadike-Danes didn't mean to use it in an ambiguous
13 way, but there is a difference, in my submission,
14 between reporting in what I would call an informal sense
15 and a report that comes within section 7 of the
16 Coroner's Act. Because section 7 of the Coroner's Act
17 is the provision which imposes a duty to notify, to use
18 the precise word of the section, the coroner of facts
19 and circumstances relating to the death when certain
20 conditions exist, and that would be the checklist that
21 we find in section 7, and it's repeated word for word at
22 the beginning of the death certificate form in the bold
23 type at the top of the page.
24 THE CHAIRMAN: Yes.
25 MR HANNA: So far as reporting is concerned, there can be an

1 informal report when a death is brought to the attention
2 of the coroner or his office, even though it may not be
3 a death in respect of which the person making that
4 report is saying in effect, "In my opinion, there are
5 circumstances which give me cause to believe that this
6 is within section 7". In other words, it could be an
7 informal report or a formal section 7 report. And there
8 is a difference between the two.
9 THE CHAIRMAN: Just to tease it out, the informal report, is
10 it perhaps better characterised as a request for advice
11 or for a steer?
12 MR HANNA: Yes. In other words, while nobody is aware of
13 precisely what was said when Dr Hanrahan made his
14 contact, it could well be the case that Dr Hanrahan was
15 not making a section 7 notification, but was contacting
16 the coroner's office to say a death has occurred and has
17 given some information about that death, which is not
18 a section 7 notification. All I'm submitting, sir,
19 is that it is necessary to be careful that one is clear
20 as to which type of report one is dealing with, and it
21 does seem that on occasions the word "report" has been
22 used in the course of the afternoon in a way which in
23 some cases is referring to a section 7 notification and
24 in some cases is simply referring to a report in the
25 sense of making the coroner's office aware and perhaps

1 seeking some information.
2 THE CHAIRMAN: And the senior coroner would welcome informal
3 reports to the extent that that improves the prospects
4 that all deaths which should be reported end up being
5 formally reported.
6 MR HANNA: But an informal report is not a duty. There's no
7 duty on the individual to do it.
8 THE CHAIRMAN: In a way it's perhaps a doctor exploring
9 whether this is a case in which he does have a section 7
10 duty.
11 MR HANNA: Yes. And the point is if he doesn't have
12 a section 7 duty, if he does not have reason to believe,
13 to use the wording of section 7, one of the
14 circumstances exists, then he is free to issue the death
15 certificate. And it is his decision and his decision
16 alone whether to issue the death certificate. In other
17 words, he has a binary decision: do I issue the death
18 certificate or, alternatively, is it a case where I'm
19 under the duty to notify the coroner under section 7?
20 If the answer to that is "yes" he may not issue the
21 death certificate. It's one or the other. And in
22 a sense it's the practitioner's decision at the end of
23 the day and it's only if there's then a section 7
24 notification that the coroner has to address the
25 question and make a decision whether he should hold an

1 inquest, which requires him to address the section 7
2 question and to decide then whether there should be an
3 inquest.
4 THE CHAIRMAN: On that analysis, there may not have been
5 a decision made without Mr Leckey's knowledge
6 in April 2000.
7 MR HANNA: Precisely. If one is doing a strict legal
8 analysis. There was certainly an informal process where
9 everyone is trying to be helpful, but I just wish to
10 flag up that there is a distinction between informality
11 and the formality imposed by section 7.
12 THE CHAIRMAN: Thank you very much.
13 MS ANYADIKE-DANES: Thank you very much. I wonder if
14 I might address that with the coroner in this way.
15 Sir, of the section 7 requirements which impose
16 a statutory obligation to notify you, one of them is if
17 there are circumstances that require investigation.
18 A. Yes.
19 Q. That's one, isn't it?
20 A. Yes.
21 Q. In fact, I took Dr Hanrahan through -- and although he
22 readily acknowledged that he wasn't familiar with the
23 full provisions of section 7, he did believe that this
24 was a case which required further investigation for the
25 sorts of reasons that I read out in those matters. And

1 if I may ask you this then: if there is a section 7
2 notification, where is that recorded in the coroner's
3 office?
4 A. It'd be recorded in the same manner that Mrs Dennison
5 did.
6 Q. It would be recorded on the main register of deaths?
7 A. Yes, that's my understanding.
8 Q. If I might help --
9 A. And now we have IT for recording reports of deaths, but
10 it'd be recorded on our IT system.
11 Q. I understand. If I might just pull up 170-001-036.
12 This is from the regulations. You see at 34:
13 "A coroner shall keep an index --
14 THE CHAIRMAN: Is it page 36 you wanted?
15 MS ANYADIKE-DANES: Sorry, we're one out of sync. My
16 reference is 170-001-036.
17 THE CHAIRMAN: What rule or section is it you're going to?
18 MS ANYADIKE-DANES: Paragraph 34. Regulation 34:
19 "A coroner shall keep an indexed register of all
20 deaths reported to him or to his deputy which shall
21 contain the particulars specified in the second
22 schedule."
23 A. Yes.
24 Q. And then if we go to -- and I'm hoping this pagination
25 is going to be correct -- 170-001-040. No, let's go on

1 to the next one. This is the second schedule. And this
2 is the register of deaths reported to the coroner. So
3 if a death is reported to the coroner for the purposes
4 of section 7, there is a duty to maintain a register of
5 that and this is the register upon which those details
6 are to be included, would you accept that --
7 A. That's correct.
8 Q. -- or one like this?
9 A. Yes.
10 Q. This is what it says in the schedule. So I specifically
11 asked Mrs Dennison whether, in addition to what she had
12 referred to as the main register of deaths, whether
13 there was any other schedule in which she would record
14 a report of a death. And she said no, where she had
15 recorded it in relation to Lucy was the only document in
16 which that would be recorded. It doesn't have precisely
17 that formulation, but you're familiar with it. All
18 deaths which were, let's use the proper expression then,
19 notified to the coroner, will be recorded on there and
20 that, ultimately, those details will be put into the
21 coroner's database and the fact that that had happened
22 would be indicated by a tick, which is what you see
23 in relation to the record for Lucy.
24 So if there was to be a system whereby you had an
25 informal reporting of a death, where in the coroner's

1 system, if I can put it that way, would that be
2 recorded?
3 A. It would be recorded.
4 Q. It would be recorded?
5 A. Yes.
6 Q. On this?
7 A. Or in something equivalent to it.
8 Q. Yes. So does that mean that in the coroner's office
9 there is one register and in that register are recorded
10 formal section 7 notifications of death --
11 A. Yes.
12 Q. -- and informal reportings of deaths to the office?
13 A. That is my understanding, but to assist the inquiry what
14 I could do is to confirm that that remains the position.
15 I'll ensure that the secretariat is notified.
16 Q. If that's the case, sir, how do you distinguish between
17 the section 7 notification and the informal reporting?
18 A. Normally, a note is added, for example "Death
19 certificate issued".
20 Q. But that could happen with a section 7 notification.
21 A. It could.
22 Q. Because if you receive a section 7 notification, then
23 the coroner can direct the issuance, notwithstanding
24 that, of a death certificate. He can also direct
25 a form 14 or he can say that he wishes to have carried

1 out a post-mortem. Those are the three options.
2 A. All I can say is my understanding is that every phone
3 call relating to a death that comes into the office is
4 recorded.
5 Q. So does that mean that we're in the situation where from
6 the paperwork, if I can use it loosely in that way,
7 in the coroner's office, it's not possible to
8 distinguish between the informal communication of
9 a death and the formal section 7 notification?
10 A. I personally do not look at the record for each death
11 that's reported, bearing in mind that we are getting an
12 excess of 4,000 per year. But my understanding is that
13 all deaths that come into the office are recorded with
14 a note. For example, "death certificate", "pro forma",
15 "post-mortem".
16 Q. I appreciate that, but it is important, is it not, to be
17 able to distinguish between an informal report and
18 a section 7 notification, which brings with it all the
19 statutory obligations?
20 A. Well, if I could answer it this way by saying that
21 I will ensure an enquiry is made to see if clarification
22 on that particular issue can be provided. I will notify
23 the secretariat.
24 THE CHAIRMAN: Thank you very much.
25 MS ANYADIKE-DANES: Thank you. That's very good of you, and

1 I think it's Dr Dolan's report, though, that also deals
2 with, once there is a report, what the outcomes are.
3 I'll turn it up for you in a moment since you are being
4 good enough to go back.
5 The outcomes, she records, are those three
6 consequences that I put to you. If it's a formal --
7 let's call it the notification under section 7, then
8 there are three ways in which that can end up, if you
9 like. Two of them are within the control of the
10 coroner: the coroner specifically authorises a form 14,
11 having been assured of matters from the clinician;
12 alternatively, the coroner says, "I want a post-mortem",
13 after which he may or may not decide he's going to
14 proceed with an inquest. Those are the coroner's
15 issues. On the other hand, for the clinician, the
16 coroner may say, "Just go ahead with your death
17 certificate". But once that notification is made under
18 section 7, that's the only way to proceed because it
19 then becomes a matter of coronial decision.
20 A. Correct.
21 Q. And that's why, sir -- and I'm very grateful that you're
22 going back -- it's important to find out whether you do
23 have a way in your office of distinguishing between
24 those that bring with it statutory obligations and
25 something else for which, all very helpful, but no

1 statutory obligations attach?
2 A. Yes.
3 MS ANYADIKE-DANES: I'm very grateful.
4 Sir, if we may, five minutes for the stenographer?
5 THE CHAIRMAN: Yes. Mr Leckey, we'll take a break for five
6 or ten minutes and then complete your evidence.
7 (3.47 pm)
8 (A short break)
9 (4.04 pm)
10 MS ANYADIKE-DANES: I have been asked to clarify with you,
11 given that there was a little bit of discussion there
12 about informal reportings and section 7 notifications
13 and so forth, if a section 7 notification is made --
14 forgetting about how it's recorded anywhere, on
15 principle, if a section 7 notification is made do you
16 accept that thereafter decisions as to what should
17 happen in relation to that death are a matter for the
18 coroner to make?
19 A. That is correct.
20 Q. And therefore, if the practice which you said you didn't
21 appreciate, but if the practice that Mrs Dennison had
22 described was happening in relation to section 7
23 notifications, that was inappropriate?
24 A. Dr Hanrahan should have asked to speak to me and
25 I agree, the decision was mine, for me.

1 Q. Yes, exactly, thank you very much.
2 Then allied with that, because I had asserted it,
3 that if a section 7 notification is made, there are
4 certain ways of dealing with that, and I had referred
5 you to Dr Dolan's report. What I should have told you
6 is where it comes is in appendix 12 to her report, which
7 happens to be the guide issued by the Coroner's Service
8 for Northern Ireland. I'm sure you're very familiar
9 with it, it's called "Working with the Coroner's Service
10 for Northern Ireland".
11 A. Yes.
12 Q. If we can pull up 315-025-029, it says:
13 "What happens after the report is made: the coroner
14 may agree that a death can be dealt with by a medical
15 certificate of cause of death once the cause of death
16 has been agreed."
17 In this case, leaving aside whether this was
18 informal or a section 7 notification, it would seem from
19 the record that a cause of death was agreed by some
20 means and that cause of death was gastroenteritis and
21 a medical certificate of cause of death was ultimately
22 issued with gastroenteritis. So that's one route --
23 A. Yes.
24 Q. -- but a coroner would have to decide that. Then,
25 alternatively -- all these things are prefaced by "The

1 coroner":
2 "The coroner may decide to deal with the death
3 administratively under the form 14 pro forma letter."
4 And Mrs Dennison explained what that was: it applies
5 both to GPs and to hospital doctors, but basically it's
6 in circumstances where, at the time, they couldn't issue
7 a medical certificate of cause of death, but they assure
8 you that nonetheless it is a natural death and you then
9 can authorise that this form is sent and it's sent to
10 the registrar of deaths.
11 A. That is correct.
12 Q. And then the other alternative is -- in fact we see it
13 over the page, 030, and that's that you can direct
14 a post-mortem. And arising out of that you may decide
15 that that is something that you do need to proceed to an
16 inquest with or the result of the post-mortem may
17 disclose that you don't.
18 A. Yes.
19 Q. And would you accept that those are the options once
20 a section 7 notification is made?
21 A. That's correct.
22 Q. Thank you very much. Can I then just ask, having
23 addressed Mrs Dennison's evidence -- as you know,
24 Dr Curtis gave his evidence. One of the things I asked
25 him and, in fairness, if I ask you what you meant, it

1 comes in your witness statement 277/1, page 4. Just
2 while it's coming, it says:
3 "The pathologist would have been acting on my behalf
4 as HM Coroner for Greater Belfast."
5 You see it at (g). If you were in the chamber, you
6 would have heard me put it to him. All of this was on
7 the assumption, which is the assumption that you had,
8 that Dr Curtis had spoken to Dr Hanrahan, and if that is
9 what was happening, you were being asked on whose behalf
10 was the pathologist, Dr Curtis, acting when he engaged
11 with Dr Hanrahan in a consultation. And your answer
12 was:
13 "The pathologist would have been acting on my behalf
14 as coroner for Greater Belfast."
15 Can I ask you what you meant by that?
16 A. I think the way I phrased that was rather clumsy.
17 I agree with Dr Curtis that his role would be that of
18 adviser.
19 Q. An independent adviser?
20 A. Independent adviser. But any decision following the --
21 the need for any decision following on from that advice
22 would be mine alone.
23 Q. Yes. Thank you. In the way that you've characterised
24 those decisions, the decisions made by you, albeit you
25 may gain some assistance both from the clinician and

1 from the State Pathologist's department, in this
2 dispensation now when you have the benefit of a medical
3 adviser, how does that fit into the matrix of decision
4 making?
5 A. Well, before the medical adviser came into post, it was
6 left to the coroners or the staff to instigate the
7 seeking of advice from the State Pathologist's
8 department. Now the medical adviser is in post, she can
9 often be the source of advice, but on occasions she
10 would feel the need to speak to State Pathology. So she
11 is part of the conduit between the coroners and
12 State Pathology.
13 Q. I understand. So what you've got now is a better system
14 for being better appraised as to the relevant medical
15 circumstances --
16 A. Yes.
17 Q. -- but the decision would still be yours?
18 A. Oh that's right, and the medical adviser would really
19 act as a filter and not all the sort of queries that
20 in the past would have gone to State Pathology now do
21 so.
22 Q. Is that part of the answer to the concern that you
23 expressed to Professor Jack Crane about the appropriate
24 questions being asked? Is the introduction of your
25 medical adviser part of an answer to that?

1 A. To some extent, because I keep going back to Dr Sumner,
2 and what he told me, and I have enormous respect for
3 Dr Sumner's opinion.
4 Q. Yes.
5 A. He was so firmly of the view that hyponatraemia was
6 outwith the expertise of a general practitioner.
7 Q. Yes.
8 A. He had no doubt about that. So the medical adviser --
9 because we've discussed this -- is aware of that and
10 I suppose she would not hold herself out to be an expert
11 on fluid management.
12 Q. If you get to those circumstances where, although she's
13 obviously considerably more advanced than Mrs Dennison
14 trying to work out the appropriate questions --
15 A. Oh yes, absolutely.
16 Q. -- but if you get to a situation where the medical
17 adviser perhaps feels this is not in their comfort zone
18 in terms of understanding what's happened here, it is
19 open, is it not, leaving aside the facility of the
20 State Pathologist's office, to the medical adviser to
21 seek independent expert guidance?
22 A. Absolutely correct. Before she would do that, she would
23 discuss that with either myself or one of my colleagues.
24 But now part of her role is to identify suitable experts
25 and to arrange for reports.

1 Q. Yes. Thank you. Then if I take you to a point that was
2 being made in relation to Dr Dolan and where you were
3 being asked about the opinion evidence and so forth.
4 I wonder if I juxtapose this obligation from the GMC and
5 if you might help us with what you regard as its
6 significance and implications.
7 This is the GMC's "Good Medical Practice", which was
8 applicable to the period in time, I think it covered
9 1998 to 2001. We can pull it up, 315-002-009.
10 Paragraph 19:
11 "You must cooperate fully with any formal inquiry
12 into the treatment of a patient. You should not
13 withhold relevant information. Similarly, you must
14 assist the coroner or procurator fiscal when an inquest
15 or inquiry is held into a patient's death."
16 If I firstly ask you: what reliance do you place on
17 that for the duty of candour that you are expecting or
18 hoping to come from the clinicians?
19 A. I would attach very considerable weight to it.
20 THE CHAIRMAN: And you assume that doctors attach weight to
21 it?
22 A. I beg your pardon?
23 THE CHAIRMAN: And you assume doctors attach weight to it
24 because it's the obligation imposed on them by their
25 regulatory body?

1 A. I would certainly hope they would.
2 MS ANYADIKE-DANES: Yes. And then the point that was being
3 put to you in terms, which is: well, if a third party is
4 proffering an opinion, that's not something that
5 necessarily has to be brought to your attention.
6 Leaving aside all that you have been exchanging with the
7 chairman about that, from your point of view does it not
8 really depend on what the opinion is about? And the
9 reason I put it to you in these terms is because the
10 particular instance that I had given you an example of,
11 which was Dr Warde, and Dr Warde forming the view that
12 there had been prolonged and extensive vomiting, that's
13 going to be a conclusion that anybody has to reach.
14 Whether it's the clinicians or nurses who are reporting
15 to you what happened, anybody's got to reach that. So
16 I suppose what I'm asking you is: are you expecting the
17 Trust and the clinicians to err on the side of providing
18 relevant information to you, if I can put it that way,
19 as opposed to parsing whether a particular thing
20 constitutes an opinion or a statement of fact?
21 A. I would like to think there would be complete
22 transparency.
23 Q. Thank you. Then one of the things I was asked to take
24 up with you. This is something that comes from Claire's
25 case and I had mentioned certain aspects of Claire's

1 case to you before and the provision of information
2 particularly in relation to Dr Webb's statement --
3 A. Yes.
4 Q. -- which arrived to you changed, if I can put it that
5 way. The other matter I'm being asked is, when you are
6 provided with an opinion from an expert and that is
7 being proffered to you by the Trust, what is your
8 expectation in terms of the independence of that
9 opinion?
10 A. Well, expert opinions now contain a declaration in which
11 the expert states that their overriding duty is to the
12 court.
13 Q. Yes. If I pause you there, sir, would you expect that
14 any expert opinion tendered to you now would incorporate
15 that kind of declaration?
16 A. Yes, it would. I don't have to ask for it, it comes
17 automatically, I find, with the reports.
18 Q. So it would come with that, but leaving that aside,
19 what's your expectation as to its actual independence?
20 A. Well, I would certainly expect that it would be
21 completely independent.
22 Q. And if, as may be the case, may legitimately be the
23 case, there is any connection between the expert and the
24 Trust or, for that matter, any of the clinicians,
25 am I understanding you that you would expect that to be

1 made clear either in the report or to you in some other
2 way?
3 A. Very much so.
4 Q. The reason why I've asked you this is Professor Young,
5 who you may recall in relation to Claire's case was --
6 when the parents went back to the Trust having seen the
7 UTV documentary and asked about the circumstances of
8 their daughter's death, more or less the first port of
9 call was for Professor Young to be asked to do a review
10 of the notes, which he did do, as a result of which
11 there was a meeting between the parents and him and
12 Dr Steen, who was the consultant paediatrician.
13 The parents were of the view that Professor Young
14 was entirely independent. They were told that he was
15 from the university, Queen's University, and he was an
16 entirely independent expert and therefore they could
17 repose some confidence in the views that he expressed.
18 As the investigation continued and the documents came
19 out, it transpired that Professor Young had been meeting
20 with Dr Steen with the view of reaching a measure of
21 agreement about the role of hyponatraemia, which is,
22 of course, a very important aspect of an investigation
23 into Claire's condition. The reference for that -- we
24 don't need to pull it up -- is 139-153-001.
25 That alone may not be enough to trouble you at all,

1 that that had happened, but is it something that you
2 would want to know?
3 A. Well, expert reports that I see now, normally in
4 a preface, set out the documents that the expert
5 referred to.
6 Q. Yes.
7 A. And normally, they rely on documents. I can't remember
8 an instance where they relied on an interview with one
9 of the clinicians. But I would have thought that the
10 standard applicable to the use of documents would be the
11 standard that would apply to interviews with clinicians,
12 and if there was an interview with a clinician, I would
13 have thought that also should be referred to.
14 Q. As sort of part of the chronology or something, that
15 these meetings had taken place?
16 A. That's correct, yes.
17 Q. Thank you. This is part of the issue that the chairman
18 was raising with you, the whole issue of transparency
19 and candour. Well, it's not candour, really; it's
20 transparency so that you understand the context in which
21 the documents are being provided to you. I may have
22 asked you this and I apologise if I have already asked
23 you, sir: what can you do now to try and improve that?
24 Apart from you saying the climate may have changed, the
25 pressure from patients' families and so forth, but from

1 yourself to try and ensure you're getting the
2 information in its purest form, if I can put it that
3 way. What can you do now?
4 A. Well, I've been here for most of the day and I've heard
5 a lot of information that I didn't know previously. So
6 there's a lot of food for thought. I don't feel,
7 sitting in the witness box now, I could give a measured
8 response. I think it's something I'd want to reflect
9 on, not only with my legal advisers who are with me, but
10 also my colleagues and the office staff.
11 Q. Yes. I take it you found it troubling, these matters
12 that did not emerge in the course of some fairly
13 thorough investigations that you conducted as inquests?
14 A. Yes, I agree entirely. I have heard matters that are
15 troubling. But can I just say also that I am only able
16 to do so much because I'm dependent on resources
17 provided to me by a government department. And
18 secondly, it is always open to the legislature to look
19 at the coroner's legislation and bearing in mind what
20 have been widely recognised as excellent reports by
21 Tom Luce and by Dame Janet Smith, the Shipman inquiry,
22 which identify ways in which the coronial service can be
23 improved, there's an opportunity for the legislature to
24 run, perhaps not with all of them, but with some of
25 them.

1 Q. I understand. I don't have very many questions left for
2 you, sir, but I do have some in relation to the
3 post-mortems.
4 A particular issue arose in relation to Lucy's case
5 about the order in which post-mortems -- I'm talking
6 about hospital post-mortems now, sir -- are conducted in
7 relation to the production of the death certificate. If
8 I may explain it in this way: Professor Lucas -- and
9 it's worth pulling this up so that you see it.
10 A. Can I just say I have read this?
11 Q. Yes. So we can see how you comment on it, 252-003-001.
12 Oh, that's not what that's supposed to be. Sorry. Give
13 me one moment and I'll find the correct reference for
14 it. That is a reference, but it's further on in that
15 document. (Pause).
16 I think it's 252-003-011. The issue is that -- in
17 fact, you see it there. If we start at the note, he
18 says:
19 "The date of this certificate is given [this is the
20 medical certificate of cause of death] as 4 May 2000.
21 Very irregular that it should follow much later after
22 the autopsy. The norm is that a doctor writes a natural
23 cause of death, which is then registered officially, at
24 which time the consented autopsy can go ahead ... To
25 apparently wait for the autopsy before writing the death

1 certificate is (at least) inappropriate and possibly an
2 infringement of the law."
3 And he refers to the order:
4 "... which although is silent on the chronology of
5 cause of death/registration of death/autopsy, it does
6 require the treating doctor to sign and give forthwith
7 to a qualified informant the certificate. The current
8 wording from the department is even clearer: medical
9 practitioners have a legal duty to provide without delay
10 a certificate of cause of death. So the proper sequence
11 is as the historical standard practice: the death
12 certificate is completed before commencing the process
13 of obtaining a consented autopsy."
14 And then he had an additional question put to him,
15 and really what he was being given was the autopsy
16 procedures that had been provided in the guide from the
17 Children's Hospital, and that includes:
18 "The pathologist will telephone the ward with the
19 result and a death certificate can be issued if this has
20 not already been done."
21 With the clear implication that you may not have
22 done it and be awaiting, in fact, the autopsy result.
23 And he was asked whether that was an appropriate
24 practice. If you can pull up 012 as well, he says:
25 "[He finds] this increasingly bizarre. In addition

1 [and this is the important part and why I'm putting it
2 to you] it perverts the whole coronial referral system
3 for queried unnatural death. For following consented
4 autopsy, more people, i.e. including the pathologist,
5 could more readily conspire to hide a genuine unnatural
6 death from public notice."
7 At the moment nobody's suggesting that is what
8 happened; he's just saying this is part of the danger
9 for having a system like that:
10 "The usual process, natural death certificate or
11 referral to the coroner, makes the doctors think
12 promptly about why someone died and what to do next.
13 This is a very serious issue and could be examined in
14 more detail at the hearings."
15 So do you have a view as to whether that concerns
16 you, that order?
17 A. I don't think it does concern me because if it's
18 a hospital consented post-mortem, I'm not involved, and
19 coroners are not told if that is happening.
20 Q. No, the part that Professor Lucas is getting at -- yes,
21 at that stage you wouldn't be told.
22 A. Yes.
23 Q. His concern is that the doctor or the clinician should
24 be required very promptly to focus his or her mind as to
25 whether this is a case in which a death certificate can

1 issue. If he can't, then a report needs to go to the
2 coroner and you will exercise ultimately your discretion
3 as to how you deal with such a report. What he is
4 flagging up is that if you don't do that but wait for
5 the post-mortem result, then the possibility is,
6 somewhere in there, a true issue that should go to the
7 coroner may not happen. And what's required is that the
8 clinicians make their stand first. That was his concern
9 and he expressed himself in quite robust terms about it.
10 So if I may ask you in this way: firstly, are you ever
11 aware of whether things happen in that order or not?
12 A. The answer's no. My understanding was that it was along
13 the lines referred to by the doctors from the
14 Children's Hospital, that bearing in mind the promptness
15 with which contented post-mortems are carried out after
16 the death, practice was to wait for the pathologist
17 ringing the ward and giving the cause of death.
18 Q. Yes. The inquiry also has another expert who took
19 a slightly different view to Professor Lucas, but there
20 was a slightly mixed response from the clinicians in
21 their evidence about that. Dr Hicks, the paediatric
22 clinical lead, her view was that you can wait for the
23 initial anatomical summary, which is the thing that
24 comes out if not that day, within a day or so, and
25 that's all right, that still constitutes promptly, but

1 you certainly shouldn't be waiting for the autopsy
2 result itself. In her view that would not be promptly,
3 and that wouldn't be appropriate. So that was her
4 evidence.
5 A. Yes.
6 Q. Dr Crean's evidence was slightly different. His view is
7 the clinician needs to know whether he or she can issue
8 a death certificate. If he or she cannot at that time
9 issue a death certificate, even though they don't know
10 all the full chain of how a natural death arose. If
11 they can't issue a death certificate, that's a coroner's
12 matter. If they can issue a death certificate, they get
13 on and issue a death certificate. And all that happens
14 later on is just edification, better learning of the
15 mechanism of death. So there is a difference of view
16 there. And for completeness, if I give you Dr Keeling,
17 Jan Keeling, who's the inquiry's other expert,
18 308-020-299. She says:
19 "When a post-mortem has not been instructed, a death
20 certificate may be issued by the responsible clinician
21 on instruction from the coroner or by the clinician
22 taking into account information from the pathologist
23 when a hospital post-mortem has been performed."
24 So her view was that the clinician could wait,
25 although she hasn't expressed herself as for how long

1 a period of time, for something to come back from the
2 pathologist. So if I wrap that up, because this is what
3 I'm being asked to put to you: can you see the force of
4 the concern that Professor Lucas has expressed?
5 A. Yes. I can see both sides. Which is the better one
6 will first of all -- as I said, it doesn't concern me,
7 but as we all know, if the pathologist carrying out
8 a consented post-mortem found something untoward, a duty
9 would rest with him or her to report the death to me.
10 MS ANYADIKE-DANES: Yes. Sir, I did have a number of
11 matters I was asked to take up. I have reached what
12 I think is the end, but I'd like to take a couple of
13 minutes just to make sure I have got everybody else's
14 issues.
15 THE CHAIRMAN: We're almost there, Mr Leckey.
16 MS ANYADIKE-DANES: Thank you very much.
17 (4.35 pm)
18 (A short break)
19 (4.49 pm)
20 MS ANYADIKE-DANES: Really, a very few points to make, sir.
21 If I take them the reverse way. The last point
22 I think I had raised was a matter concerning
23 Professor Young. I was putting to you that he had had
24 some discussions with Dr Steen in a way to try and agree
25 their views and I was asking you whether you would want

1 to know that such a thing had happened, and I think your
2 answer, in summary, was you would want that kind of
3 discussion treated in the same way as you would want
4 documents, so that that was disclosed to you.
5 A. Yes.
6 Q. I'm very grateful to my learned friends there. They've
7 got Professor Young's deposition, which had escaped my
8 attention. I knew he had made one, but I didn't realise
9 he had given this declaration. I want to correct what
10 might be considered to be an inaccurate statement or an
11 unfair one, but also as part of you reflecting on these
12 sorts of issues, it's appropriate that you have this.
13 This is the deposition that Professor Young made to
14 you. I don't have its reference, although I can provide
15 it in due course, but what he says is, it's literally
16 after he says "I am a fellow of the Royal College" and
17 so on:
18 "I was asked to review the medical records of this
19 9-year-old girl by Dr Michael McBride, medical director
20 of the Royal Group of Hospitals. I was asked to give my
21 opinion on whether hyponatraemia may have contributed to
22 Claire's death. This statement is based on my
23 inspection of the medical and nursing notes relating to
24 her hospital admission in 1996. In addition, I spoke to
25 Dr Heather Steen, Dr Andrew Sands, Dr Nichola Rooney and

1 to Claire's parents. I have provided an honest and true
2 opinion based on my reading of the notes. However,
3 I did not have access to comments from all of the other
4 medical practitioners involved in Claire's care."
5 So that's how he has framed it. I do have the
6 reference, it's 091-010-062. So I understand your
7 acknowledgement when you nodded there if an expert, or
8 for that matter a clinician, has had that kind of
9 discussion, then you would want to have some sort of
10 declaration to put you on notice that it's taken place?
11 A. Yes.
12 Q. Thank you very much indeed. That's on the one hand. On
13 the other hand, I was asked, because there's been an
14 expression of, I suppose, gratitude really that you are
15 going to take these matters back and reflect on the
16 implications of them. This relates to Dr Jenkins, who
17 was also an expert tendered for the Trust and that was
18 in relation to Raychel's case. I had explained to you
19 that he had provided three reports, only one of which
20 you saw, and the one that you saw didn't make any
21 reference to any caveats he may have had about
22 information in relation to the extent of Raychel's
23 vomiting. I've been asked to clarify with you, just so
24 that you have it, that first report that included that
25 reference, "I'm waiting for you to tell me whether this

1 fell within normal bounds", report is dated
2 12 November 2002. Dr Jenkins then saw Dr Warde's report
3 and he wrote a report in response to Dr Warde's report.
4 And that report is dated 22 January 2003.
5 He then wrote the report that you saw --
6 A. Yes.
7 Q. -- and that's a report dated, I believe,
8 30 January 2003. The reference is 012-023-133. What
9 has exercised the family is, in that report, he makes no
10 reference to the fact that there were these other
11 reports, these two previous ones, where he'd
12 specifically addressed another expert's view as to the
13 likely incidence of prolonged and sustained vomiting.
14 And that is something that you don't know when you read
15 his report. They're not asking you to give an answer
16 about that, but they're asking me to provide that to you
17 so that you have the full context when you're looking at
18 these issues and questions of transparency and your
19 expectations as to what the Trust should do in these
20 circumstances.
21 A. I think I -- knowing the way you have put forward this
22 issue, I would like to reflect on it, including
23 reflection on it from a legal basis, to see whether
24 I would have any right to such reports to assist in the
25 investigation of the death in a situation where legal

1 privilege is being claimed.
2 Q. Yes.
3 A. There's a legal issue and I would like an opportunity to
4 explore that.
5 Q. Of course.
6 THE CHAIRMAN: There is, but there would be nothing in
7 principle which would prevent you asking two things.
8 One is: does the Trust have reports which it is not
9 putting before me?
10 A. Yes.
11 THE CHAIRMAN: And secondly, when a witness does come before
12 you with an expert report, you can ask him if that is
13 his original report --
14 A. Yes.
15 THE CHAIRMAN: -- or whether it's been altered in light of
16 other views expressed, including views expressed by an
17 expert witness who's not being brought before the
18 inquest.
19 A. Yes.
20 THE CHAIRMAN: In that, it would then be a matter for you
21 what inferences you draw from the fact that a trust has
22 obtained expert reports which it chooses not to put
23 before you.
24 A. Yes. Thank you very much, chairman.
25 MS ANYADIKE-DANES: This is a statement that you made in

1 your PSNI statement in relation to Lucy. The reference,
2 which I don't think we need to pull up, but I'll give it
3 you, is 115-034-001. You are really talking about the
4 receipt of Mr Millar's letter and for the first time
5 appreciating, after Raychel, that there was another case
6 preceding Raychel where some of these issues may have
7 been identified. You say that once you were put on
8 notice, you obtained a copy of the post-mortem report,
9 that's Dr O'Hara's report, and considered the findings
10 of the pathologist. Then you go on to say:
11 "These indicated to me that the deaths of Raychel
12 and Lucy might have common features and it would be
13 necessary to obtain a further specialist report."
14 And then if we just pause there because you'd
15 mentioned the fact that Dr O'Hara's first report, which
16 was dated June 2000, did include a reference to
17 hyponatraemia and you're right about that, sir. It's
18 142-001-003. It says:
19 "Clinical diagnosis: dehydration and hyponatraemia,
20 cerebral oedema, acute coning and brainstem death."
21 So you're right, it did include that reference. And
22 what you then go on to say in your police statement
23 is that:
24 "With the benefit of hindsight, it would have been
25 helpful if I had been advised of the post-mortem

1 findings at an early stage."
2 The question that I'm being asked to put to you
3 is: in the evidence that you have given here today,
4 you have said that whole question of hyponatraemia was
5 very much in your mind, and I think you've described
6 that the inquest that you carried out into Adam's death
7 was, for you, possibly the most important inquest you've
8 carried out, so all those issues to do with the
9 hyponatraemia and the evidence that Dr Sumner gave
10 you were very much in your mind. The question I'm being
11 asked to put to you is: if you had seen a report, albeit
12 four years after the inquest that you carried out into
13 Adam's death, and it included, as it does, that
14 reference to hyponatraemia, then is that something that
15 would have better enabled you to see the potential
16 significance of Lucy?
17 A. Well, the answer is yes, and I think in that post-mortem
18 report Dr O'Hara gave his cause of death as cerebral
19 oedema.
20 Q. Yes.
21 A. That's the terminal event. He didn't give an underlying
22 cause.
23 Q. No.
24 A. And if I'd got the report, I would have been on the
25 phone to Dr O'Hara, asking if he could identify an

1 underlying cause for the cerebral oedema.
2 Q. So that would have triggered --
3 A. Yes.
4 Q. -- action from you before ever we got to Raychel's
5 treatment and death?
6 A. Yes. And I think in one of my statements to the inquiry
7 I said that, in my view, Dr O'Hara should have
8 telephoned me at the time of the post-mortem and asked
9 me to agree that it should be a coroner's post-mortem.
10 Q. You did indeed say that. Is that because in your
11 view -- and you have described him as
12 a highly-experienced paediatric pathologist -- having
13 not been able to find a conclusive cause of death, but
14 having got himself to cerebral oedema and hyponatraemia,
15 he should have appreciated that is something that should
16 have come to you?
17 A. I would have thought so.
18 Q. Thank you very much. And then just finally --
19 THE CHAIRMAN: Just before you go on from that, I have to
20 say, Mr Leckey, this rather suggests to me that the
21 person who learnt most about death from hyponatraemia
22 from Adam's inquest was you, not people within the
23 Royal. Because you're the one who's making the link or
24 would have raised a query about Lucy's death if you'd
25 had the information provided by Dr O'Hara, who is

1 working within the Royal.
2 A. Well, I feel -- and again I refer back to Dr Sumner.
3 I learnt an awful lot about this from Dr Sumner, but I'm
4 upset that others really haven't or didn't take forward
5 the evidence Dr Sumner gave in a constructive way to
6 inform other hospitals within Northern Ireland.
7 THE CHAIRMAN: Or even to spread the word within the Royal
8 itself?
9 A. Yes.
10 THE CHAIRMAN: Thank you.
11 MS ANYADIKE-DANES: Then the final point is a point that you
12 yourself had mentioned earlier, which is the Shipman
13 inquiry third report point, and we can pull the passage
14 up, it's 315-026-002. You see it starts off at 19.1:
15 "The present systems of death and cremation
16 certification failed to detect that Dr Shipman had
17 killed any of his 215 victims."
18 And then it goes on as to the circumstances and, in
19 particular, that:
20 "Many of those deaths should have been reported to
21 the coroner, yet Shipman managed to avoid any coronial
22 investigation in all but two of the cases in which he
23 had killed. He did this by claiming to be in a position
24 to certify the cause of death and by persuading
25 relatives that no autopsy and therefore no referral to

1 the coroner was necessary."
2 Then if we go on to the point that I was being
3 particularly asked to put to you:
4 "The present system is almost completely dependent
5 upon the professional integrity and competence of the
6 medical profession. In general, the profession can be
7 relied upon, but not always. The Shipman case has shown
8 that the present procedures fail to protect the public
9 from the risk that, in certifying a death without
10 reporting it to the coroner, a doctor might successfully
11 conceal homicide, medical error or neglect leading to
12 death."
13 Then she goes on to say that although some might
14 think that Shipman is unique, and she certainly hopes
15 so, that may not necessarily be the case and it's not
16 possible to determine how many errors by a health
17 professional have gone undetected and certification of
18 the cause of death by a single doctor is no longer
19 acceptable, and so on.
20 And then you referred, sir, to the proposed change
21 in the certification of fact of death. And that is to
22 be found at appendix G to that report at 315-026-060.
23 A. The reason I wanted to refer to it is that
24 Dame Janet Smith took a very robust approach to how she
25 felt the coronial system and death certification could

1 be improved. She included that the families should
2 always be consulted to see what their views were about
3 how death was formulated, so she believed that the
4 families should be included in the death certification
5 process and also, I think it is clear, she believed that
6 the present form of death certificate was really too
7 simplistic, and a form was needed that reflected more
8 a mini report of the medical history and the analysis of
9 why the person died.
10 Q. Yes, and I think when I asked you about that in relation
11 to the present -- because the system has not yet changed
12 in Northern Ireland.
13 A. No.
14 Q. And I think your view was that the present certification
15 we have in terms of the actual certificate was
16 formulated decades ago.
17 A. Yes.
18 Q. And it calls into question whether it is still
19 appropriate for circumstances that we have now. From
20 what you have said, does Dame Janet capture some of the
21 concerns you have in that paragraph of 19.2?
22 A. She does. I think her report should be widely read and
23 reflected on. But as I've indicated before, at the end
24 of the day, it's up to the legislature to decide whether
25 to let it gather dust on some shelf or to do something

1 constructive with it.
2 Q. You mentioned the families there. There is something
3 that I think your office, I believe, has tried to do,
4 which is to signal that one of the things they wish to
5 hear from the reporting or notifying clinician is the
6 extent to which the families have any complaint or
7 concerns. In fact, I think it was when I was reading
8 out to you -- it's from that document "Working with
9 the Coroner's Service for Northern Ireland". One sees
10 it at 315-025-028.
11 You can just see, I think it's the fourth bullet
12 from the bottom:
13 "Concerns expressed by family members."
14 I had put that to Dr Hanrahan and, in fairness, he
15 said that subsequently he has been asked that question
16 when he's had communication with the coroner's office as
17 to whether the families do. Even though the system has
18 not changed to the sort of thing that Dame Janet had in
19 mind, do you regard that as an important issue?
20 A. Very important, because I've lost count of the number of
21 inquests I've held that have been informed by views
22 expressed by the family.
23 MS ANYADIKE-DANES: Thank you very much indeed. I have
24 nothing further, Mr Chairman.
25 THE CHAIRMAN: Any questions from the floor? Mr Hanna, have

1 you any questions?
2 Thank you very much, Mr Leckey. Food for thought on
3 both sides. I hope you have had a chance to say
4 everything you want. If there's anything you want to
5 say before you leave, you are welcome to do so, but
6 don't feel obliged to.
7 A. No, no, there's nothing I want to add. Thank you.
8 (The witness withdrew)
9 THE CHAIRMAN: Thank you very much indeed. We've got
10 Dr Ian Carson tomorrow to finish his evidence and we'll
11 sit tomorrow at 10.15. Thank you.
12 (5.07 pm)
13 (The hearing adjourned until 10.15 am the following day)
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1 I N D E X
2

3 DR MICHAEL CURTIS (called) 1
4 Questions from MS ANYADIKE-DANES 1
5 MR JOHN LECKEY (called) 50
6 Questions from MS ANYADIKE-DANES 50

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