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2 (10.00 am)  
3 (Delay in proceedings)  
4 (10.13 am)  
5 THE CHAIRMAN: Good morning.  
6 Mr Quinn, do I understand correctly that the issues  
7 which you referred to yesterday afternoon about Claire's  
8 death, you want those to be put back until next week?  
9 MR QUINN: Yes, that would be suitable, Mr Chairman.  
10 Tuesday morning would be suitable for that.  
11 THE CHAIRMAN: Okay, we'll do that.  
12 Then so far, Mr Uberoi, as the issues about  
13 Professor Kirkham are concerned, I will deal with them  
14 later on today, but I have two witnesses who have come  
15 to give evidence and I want to get through their  
16 evidence and facilitate them before we get into that  
17 debate. Okay?  
18 MR UBEROI: Thank you, sir.  
19 THE CHAIRMAN: Thank you very much.  
20 Ms Anyadike-Danes?  
21 MS ANYADIKE-DANES: Could I please call Dr Hicks?  
22 DR ELAINE HICKS (called)  
23 Questions from MS ANYADIKE-DANES  
24 MS ANYADIKE-DANES: Good morning. Do you have there your  
25 CV?

1 A. Yes, I had a senior registrar post in paediatrics, which  
2 was a five-year training post, and I was seconded for  
3 a year to the neurology departments in the  
4 Royal Victoria and also Claremont Street Hospital which  
5 also part of the neurology service at that time.  
6 Q. Yes. And then you had a position as a clinical fellow  
7 in neurology for about two years in the  
8 Children's Hospital in Boston; is that right?  
9 A. Well, I had a one-year fellowship -- one year paid from  
10 here on a salary from the Northern Ireland Postgraduate  
11 Council and then the second year was funded in Boston.  
12 Q. And that was 1980 to 1982?  
13 A. Correct.  
14 Q. Then in 1983 you became a consultant in paediatrics with  
15 an interest in neurology, and that was at the  
16 Children's Hospital.  
17 A. Yes.  
18 Q. So although you weren't a consultant neurologist,  
19 certainly you have got that interest, and that makes you  
20 a consultant for about 17 years by the time of Lucy's  
21 admission in 2000?  
22 A. Yes.  
23 Q. And you became a consultant paediatric neurologist in  
24 1993 at the Children's Hospital.  
25 A. Yes. The title of the post changed. As the hospital

1 A. I do.  
2 Q. Thank you. I'm going to ask you if you adopt your  
3 witness statements that you have previously made in this  
4 matter, subject to anything that you say now in  
5 evidence.  
6 You have made two previous witness statements  
7 in relation to Adam's case and Claire's case.  
8 A. Yes.  
9 Q. You gave evidence in relation to those at an earlier  
10 time. Some of that might become relevant now, but in  
11 any event you have already spoken to those. The one you  
12 made for Lucy's case, the series for that is 338, and  
13 it's dated 13 May 2013. Do you adopt that, subject to  
14 anything that you might say today?  
15 A. I do.  
16 Q. Have you discussed Lucy's case or even revisited Adam's  
17 or Claire's case with anyone prior to today, other than  
18 legal representatives?  
19 A. No.  
20 Q. Thank you. Then if we go to your CV, it's 311-013-001.  
21 If we can pull up alongside it 002. We can see from  
22 that that you qualified as a doctor in 1972.  
23 A. Correct.  
24 Q. In 1979, I think, begins your time in neurology and you  
25 were a registrar in neurology at the Royal.

1 became a Trust, the job descriptions were slightly  
2 amended to take account of changes that had occurred.  
3 Q. Does that mean in 1993 you focused more on paediatric  
4 neurology than you might have done in your time from  
5 1983?  
6 A. I focused less on general paediatrics, so there was more  
7 time for paediatric neurology.  
8 Q. More time for the neurology aspect of your work?  
9 A. Yes.  
10 Q. Thank you. You also are a member of a number of  
11 professional bodies. In terms of those that you were  
12 a member of before Lucy's admission in 2000, you were  
13 a fellow of the Royal College of Physicians from 1994,  
14 and also a founder fellow of the Royal College of  
15 Paediatrics and Child Health from 1997.  
16 A. Yes.  
17 Q. And in addition, you're a member of the British  
18 Paediatric Association from 1997 until --  
19 A. 1977.  
20 Q. I beg your pardon. Yes, 1977, until the foundation of  
21 the RCPCH, and when did you become a member of the  
22 British Paediatric Neurology Association?  
23 A. 1983.  
24 Q. Also before Lucy's admission?  
25 A. Yes.

1 Q. Thank you. In addition to that, you were a member of  
2 the Specialty Advisory Committee in Paediatrics from  
3 1994 to 2006; is that correct?  
4 A. Yes, I think so.  
5 Q. We can just pull that up so that you see that because  
6 you didn't seem to be sure. 320-002A-001. (Pause).  
7 For some reason that doesn't seem to be coming up.  
8 A. I certainly was a member of that group at the Department  
9 of Health. If the dates are written down, I'll accept  
10 that.  
11 Q. In any event, you're aware you were a member of it at  
12 the time of the admission of the children that this  
13 inquiry is investigating?  
14 A. I believe so, yes.  
15 Q. Thank you. The terms of reference of that, which are  
16 helpful to see, can be found at 320-110-001. We'll come  
17 back to that because, Mr Chairman, it's actually quite  
18 important to see what that group was charged to do.  
19 In any event, the CMO has a number of these special  
20 advisory committees; that's correct, isn't it?  
21 A. Yes.  
22 Q. And she has one in paediatrics, for example, one in  
23 anaesthetics and another in surgery; you'd be aware of  
24 those?  
25 A. Yes.

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1 establishment or the movement of the paediatric  
2 nephrology service from the City Hospital to the  
3 Children's Hospital; would that be a forum for that?  
4 A. Yes, I suppose it would have been.  
5 Q. Yes. And therefore, if there were any difficulties  
6 associated with that move, there were concerns about or  
7 issues arising out of the fact that the surgeons were  
8 coming from the City Hospital, but the anaesthetists  
9 were being supplied by the Children's Hospital and any  
10 difficulties that might arise in relation to that, is  
11 this a forum where that could be discussed?  
12 A. Well, that -- it might be discussed in outline. It  
13 wouldn't be discussed in detail at this forum because  
14 not all people representing those groups would be  
15 present at this particular meeting. So this meeting  
16 wouldn't have gone, by my memory, into the fine detail.  
17 That would have been done by the task groups or the --  
18 Q. But the policy issues associated with that, that might  
19 be discussed?  
20 A. Might be discussed, yes.  
21 Q. And then if, for example, we see a little later on  
22 in that same meeting, 320-049-012, under "Any other  
23 business", you see that:  
24 "Dr Brown asks that paediatricians consider  
25 a standard age limit for transfer from paediatric to

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1 Q. That was a forum for discussion of -- well, it could  
2 have been a forum for a discussion of more general  
3 matters of learning that could have come out of Adam and  
4 Claire and, for that matter, Lucy?  
5 A. It could have been.  
6 Q. Yes, it could have been. I sincerely hope we have these  
7 up. I'm going to the minutes of some of these meetings  
8 just to illustrate that point. If we go to 320-049-004.  
9 There we are.  
10 So this is a minute, if we pull up the first page of  
11 this minute to orientate you. 320-049-002. That's the  
12 first page of it. So this is a minute of a meeting  
13 dated 8 November 1994, so it pre-dates Adam's admission  
14 and you see those who are present. You actually weren't  
15 there at that particular meeting.  
16 The part that I wanted to pull up, just to indicate  
17 the sort of things that are discussed, under the  
18 paediatric nephrology service, you can see there that:  
19 "Dr Beattie said a group had now been established  
20 with membership comprising of board reps and  
21 a representative of the Royal Group of Hospital Trusts  
22 to examine the regional aspects of the paediatric  
23 workload and prepare service profiles."  
24 Does that mean that is a place or this is a meeting  
25 where there might have been a discussion about the

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1 adult services since there was at present a range from  
2 14 to 18 years. Members agreed that a lack of standard  
3 agreement often caused problems with adolescents."  
4 In fact there's an action point there:  
5 "Provincial specialty group to consider standard age  
6 for transfer."  
7 That's an issue that arises in a case that the  
8 inquiry's going to look at, Conor. But that sort of  
9 thing was discussed?  
10 A. Yes.  
11 Q. And to your knowledge were any standards produced even  
12 for consideration?  
13 A. On that issue, I don't remember any. I know that issue  
14 was discussed a lot in a significant number of different  
15 fora, but I don't recall any definite standards being  
16 set --  
17 Q. I see.  
18 A. -- at my time.  
19 Q. When the sheet comes up that I can show you, you were a  
20 member of it, I think, up until at least 2004, which  
21 would post-date Conor's case, which is 2003. Then there  
22 was an issue that I had asked Dr Taylor about and we see  
23 that at 320-050-003.  
24 This relates to the transfer arrangements from  
25 referring hospital into the Children's Hospital, it

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1 being the specialist centre. You were present at this  
2 meeting, which was on 12 November 1996, pre-dating by  
3 some years, of course, Lucy's transfer and then  
4 Raychel's transfer. This minute records that:

5 "Professor Halliday, together with Dr Taylor, have  
6 examined the need associated with it and tabled  
7 a paper."

8 Dr Taylor said, ultimately, arrangements were put in  
9 place, but you're clinical lead at this time for  
10 paediatrics in the Children's Hospital: what were you  
11 aware of in terms of any difficulties that there might  
12 be about arranging for transfer for very sick children  
13 from the outlying hospitals?

14 A. Two aspects to that. One is I was aware that there was  
15 a group set up to look at transport services for adults,  
16 children and neonates, which are separate to that.

17 Regarding the transfer of children in -- do you mean to  
18 intensive care or generally?

19 Q. Well, generally to the Children's Hospital, but  
20 probably, for our purposes, into intensive care.

21 A. Yes. I mean, the standard practice, I think for all the  
22 services, specialist services including intensive care,  
23 was that this was arranged by consultants, by  
24 a consultant in the transferring hospital in direct  
25 contact by telephone with a consultant in the intensive

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1 my memory, had a checklist that was -- a written  
2 checklist that was gone through for every transfer.

3 Q. At the PICU end?

4 A. Yes, at the PICU end, that they went through with the  
5 transferring hospital.

6 Q. We haven't seen one of those. If you could help us,  
7 what sort of thing was on that checklist?

8 A. The clinical details, the details -- now, the paediatric  
9 intensive care had a separate IT system of their own,  
10 and I think it was generated by that system. My memory  
11 is that there was a clipboard that was kept by the phone  
12 and this list was compiled, so it would have had  
13 clinical details, treatment being given, investigations  
14 already performed, and the observations, the treatments  
15 instituted, and then advice would be given by the  
16 consultant anaesthetist prior to transfer --

17 THE CHAIRMAN: Do you have any recollection, doctor, about  
18 when that list-and-clipboard system might have been  
19 introduced?

20 A. Well, I think it was before I was clinical director.

21 THE CHAIRMAN: Thank you.

22 MS ANYADIKE-DANES: So before Lucy's admission in 2000?

23 A. Yes.

24 Q. So if I ask you in this way: the call would come in --

25 A. Mm-hm.

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1 care unit, a consultant anaesthetist. And that's my  
2 memory from all the time I practised that transfers both  
3 internally and externally into paediatric intensive care  
4 were arranged by direct contact with the consultant on  
5 call.

6 Q. Did paediatric intensive care come within your remit as  
7 clinical lead or the director of paediatrics?

8 A. It did, yes. Although the anaesthetists were managed in  
9 a different directorate.

10 Q. They were from ATICS, yes. Who had the primary  
11 responsibility, if anybody did have, for PICU?

12 A. PICU was in the paediatrics directorate.

13 Q. So that would be you?

14 A. Yes.

15 Q. And you therefore -- not you personally, but PICU -- had  
16 an interest, I would suggest, in ensuring that there was  
17 some sort of consistency and appropriate standard of how  
18 those children were being stabilised, transported, and  
19 the information, including charts and investigations,  
20 and so forth, that was being brought with them.

21 A. Yes.

22 Q. So until any formal guidelines had been produced, how  
23 were you ensuring that in the interests of these  
24 children?

25 A. Well, the paediatric intensive care unit, according to

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1 Q. -- for the sake of argument, from the Erne, to say that  
2 they have a very sick child that they would like to  
3 transfer to the Children's Hospital.

4 A. Mm-hm.

5 Q. Whoever's receiving that, is that the person who's going  
6 through the checklist or do they get a more senior  
7 clinician to deal with that?

8 A. The doctor who would be in the unit would start  
9 immediately to get the information and then -- I mean,  
10 at times the anaesthetist might be at home, so they  
11 might have to take a couple of telephone calls and they  
12 might then have to come in. So the most senior doctor  
13 in intensive care, an experienced safety net doctor,  
14 experienced senior house officer or a registrar or  
15 fellow -- we had a clinical fellow eventually -- would  
16 take that information if it was out of hours. During  
17 hours, it might be the consultant on call.

18 Q. If you're going through that checklist does that mean  
19 you have knowledge of what investigations are being  
20 carried out and does that mean you're in a position to  
21 make clear what charts and records you want to see?

22 A. I'm not sure whether that would follow directly. My  
23 personal practice in transfer was always to ask for all  
24 information to be sent with the patient or a photocopy.

25 Q. Ahead of the work that Dr Taylor was doing, finding its

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1 way into some sort of guidelines or guidance, ahead of  
2 that, was it your expectation that these children would  
3 come either with the relevant part of their notes or  
4 copies of that would be sent on, maybe by being faxed?  
5 A. Yes. I think -- it didn't always happen and we would  
6 have to seek it afterwards, but that should have been  
7 part of it, and I cannot remember now whether it was  
8 clearly written down as part of their documentation.  
9 Q. But in any event, you're fairly clear that there was  
10 a checklist like that which was a system in operation?  
11 A. I do remember a checklist from earlier on.  
12 Q. Thank you. And then if we go to 320-052-006, this is  
13 part of a minute dated 29 September 1998. You can see  
14 there at item 14 that the issue there is "Clinical  
15 quality and clinical governance", and the paper is  
16 actually tabled. I am not sure that you actually  
17 attended this one, but you can see that the CMO is  
18 explaining that new structures were being formulated to  
19 drive the quality agenda. She's informing members that:  
20 "Clinical governance will focus on the overall  
21 service performance rather than just on individual  
22 performance standards."  
23 Were you aware of that?  
24 A. I must have been. I would have received the minutes of  
25 it. Well, sometimes the minutes didn't appear until

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1 directorate meeting -- we had weekly meetings -- and  
2 there was usually at least one person who was a member  
3 of this committee on it. It was me for a while, but  
4 I then came off, and we would normally expect that prior  
5 to the meeting we would discuss any issues that we  
6 thought were going to be relevant to be discussed at the  
7 department, the SAC meeting, and that then we would feed  
8 back any issues that had come up.  
9 If there were -- one of the frustrations, I don't  
10 want to sound as if I'm explaining, but one of the real  
11 frustrations at the coalface, as it were, was putting  
12 a lot of time and effort into projects that never got  
13 anywhere. So we always wanted to make sure,  
14 particularly, that if we were going to do something,  
15 that it was going to fit in with the regional -- not  
16 imperative, but a regional project so as to be sure it  
17 fitted in with regional plans. I don't know whether I'm  
18 explaining that well.  
19 Q. No, no. If you take this one, the issue of clinical  
20 governance, which was an important question --  
21 A. Mm.  
22 Q. -- and part of a gradual move towards developing better  
23 governance structures. A paper that has been tabled  
24 in relation to it, the CMO has made her intentions  
25 clear. When you go back to the Children's Hospital, how

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1 quite a bit later, so if I was at the meeting I would  
2 have heard the discussion.  
3 Q. But even if they didn't come until quite a bit later,  
4 ultimately you got them?  
5 A. Yes.  
6 Q. What would that have involved doing? If the CMO is  
7 explaining that is what she wants to see, how does that  
8 translate into anything at the Children's Hospital?  
9 A. Um ... I suppose, from the point of view of overall  
10 service performance, it's looking at the service, not  
11 simply from the point of view of the activity and the  
12 information that had become customary for the  
13 commissioning or purchasing process; it'd be looking at  
14 the services from the point of view of the quality  
15 indicators.  
16 Q. When you've attended a meeting like this and any of  
17 these issues that I have just been taking you through  
18 are being discussed, what do you do about that when you  
19 get back to the Children's Hospital?  
20 A. I would have normally taken time to report back to the  
21 team in the Children's Hospital, on occasion the medical  
22 director or the Trust team as well.  
23 Q. That would be Dr Carson?  
24 A. Mm-hm, particularly if there were particular issues.  
25 During my time as clinical director or at the

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1 is that going to be translated into anything in relation  
2 to clinical governance for the Children's Hospital?  
3 A. Well, it will have to fit in with the overall Trust, but  
4 we would look at it from the point of view of what each  
5 service might need to do.  
6 Q. And the mechanism for doing that will be what?  
7 A. It would be done through the Trust audit department,  
8 I guess. I'm not sure -- I'm not answering this right.  
9 The first mechanism, I guess, would be to promulgate  
10 it, to make people aware of what we were going to need  
11 to be doing and what we'd need to be looking at in  
12 specific for each service. One of the other things that  
13 complicates this is that, particularly the specialty  
14 services, they all had systems within their own UK  
15 specialty organisation as well, so they would dovetail  
16 into that, and the clinical quality and clinical  
17 governance came into that eventually. It wouldn't have  
18 had earlier on.  
19 So we would be -- so some services might have  
20 been -- I'm not sure that I can think of a precise  
21 example -- further on with this through their specialty  
22 organisation.  
23 Q. I see. But in any event, this initiative, am I right in  
24 saying this initiative is something that you'd have  
25 taken back and reported to the medical director?

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1 A. Yes. I would normally have.  
2 Q. Thank you. Then just to finish matters to see where --  
3 320-055-006. This is a minute of a meeting dated  
4 30 October 2001, so this is after Raychel's death, and  
5 one sees at item 12, headed up "hyponatraemia":  
6 "Dr McCarthy summarised the brief guidelines on the  
7 prevention of hyponatraemia in children receiving  
8 intravenous fluids and members welcomed the guidelines,  
9 which will be published soon."  
10 What I wanted to ask you about that is that, prior  
11 to that, the Children's Hospital had had some experience  
12 of the risks associated with inappropriate use of  
13 low-sodium fluids, or IV solutions, and you will be  
14 aware from your evidence previously that, for example,  
15 in relation to Adam, that had actually generated  
16 a statement that was provided to the coroner as to how  
17 the Trust was going to address that.  
18 It's unclear how the position in relation to  
19 hyponatraemia with Claire was developed. But certainly,  
20 hyponatraemia and its risks, by 2000, was something that  
21 the hospital, through its clinicians, was aware of.  
22 Would that be a fair way of putting it?  
23 A. Yes.  
24 Q. You certainly were aware of it?  
25 A. Well, I'd been aware of hyponatraemia through my

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1 MS ANYADIKE-DANES: In any event, the point that I'm making,  
2 is you're saying that clinicians throughout the  
3 Children's Hospital would be aware of that.  
4 A. I would hope so, yes.  
5 Q. And if they were aware of that and if some of them  
6 recognised that that was not something perhaps as well  
7 appreciated in the district hospitals, is there any  
8 reason why that couldn't have been brought to this  
9 committee so that something might have started much  
10 earlier about disseminating in a more consistent way  
11 that message?  
12 A. No, I think probably not.  
13 Q. The point I'm putting to you is: given the knowledge  
14 that was already there, surely you didn't have to wait  
15 until Raychel's death to refer matters and get it on the  
16 agenda, if I can put it that way, to be dealing with it?  
17 You, as the regional centre, could have done that. You  
18 had representatives on this committee -- this was  
19 a paediatric one, but there was also one for  
20 anaesthetists -- and the Children's Hospital  
21 representatives could have raised that and had that  
22 matter developed at this level.  
23 A. Yes.  
24 Q. Yes.  
25 A. Yes.

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1 neurology training well before that.  
2 Q. Exactly. And the risks posed by inappropriate use of  
3 low-sodium fluids; you'd be aware of that?  
4 A. Yes.  
5 Q. And when Dr Crean was giving his evidence, he talked  
6 about a difference perhaps between anaesthetists and  
7 paediatricians. He was of the view that anaesthetists  
8 were very well tuned-in to the risks associated with  
9 using, for example, low-sodium fluids as both  
10 maintenance and replacement, and that when children came  
11 in, when he could see that inappropriate use of  
12 low-sodium fluids had been used in the referring  
13 hospital, that he quite often would telephone the  
14 relevant clinician and, in his own way, raise that  
15 matter with them.  
16 So this is something that the Children's Hospital  
17 was aware of before 2000; would I be right in saying  
18 that?  
19 A. That would be right, although there was an issue about  
20 the aftermath of Adam Strain being, if you like, spread  
21 throughout the hospital.  
22 Q. Yes.  
23 THE CHAIRMAN: The issue being that it wasn't spread  
24 throughout the hospital?  
25 A. Yes.

18

1 Q. Can you think of why that didn't happen?  
2 A. Other than thinking ... Other than thinking that or  
3 believing that the awareness of the issue was better  
4 than in fact it has been shown to be, I can't --  
5 THE CHAIRMAN: But it wasn't regarded as problematic?  
6 A. I think that's correct.  
7 THE CHAIRMAN: Because Adam's death had been wrapped up in  
8 a very tight circle among the paediatric anaesthetists,  
9 Claire's death had been passed over completely, and  
10 Lucy's death was passed over completely, so the degree  
11 to which hyponatraemia was regarded as problematic,  
12 which might lead it to be referred to this group, is  
13 highly questionable; is that not right?  
14 A. I think that's right.  
15 MS ANYADIKE-DANES: Sorry, doctor, I didn't mean it quite  
16 in that way. I recognise what was said about the  
17 restrictions in terms of the utility of the learning  
18 coming out of Adam, that it was thought that that was  
19 mainly confined to the Children's Hospital, and  
20 of course Claire's investigation really didn't go  
21 anywhere at all. The point that I was making was that  
22 when Dr Crean gave his evidence, his evidence was that  
23 they did recognise, or at least the paediatric  
24 anaesthetists recognised, that there was a potential  
25 problem out in the district hospitals as to how

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1 low-sodium fluids were being used. And he did recognise  
2 that in some of those hospitals, clinicians were using  
3 Solution No. 18 not just for maintenance, which was  
4 popular, but also for replacement. And for him, he  
5 thought that could be inappropriate and had its risks.  
6 His evidence was, when he saw that, he would telephone  
7 the relevant clinician and point that out to them.

8 So what I was asking you is: if he could see that  
9 there was knowledge that the Children's Hospital had  
10 that wasn't necessarily understood or well appreciated  
11 by those less specialist in the district hospitals,  
12 is that not the very thing that could have been brought  
13 to a committee like this?

14 A. It could have been.

15 Q. Yes.

16 A. But I don't think that that issue was well -- what  
17 I have already said. I don't think that issue was well  
18 recognised elsewhere in the Children's Hospital. If it  
19 wasn't brought by the anaesthetists to others in the  
20 Children's Hospital, then how are you to know? We  
21 didn't scrutinise -- the clinical director and the  
22 directorate team didn't scrutinise the details of every  
23 single admission. There is an issue. I know we have  
24 learnt through this about how individual cases -- where  
25 there had been problems.

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1 we set up a group looking at services for children with  
2 epilepsy and how we could improve that in  
3 Northern Ireland. It's not directly related to this.  
4 And, by my recollection, it went absolutely nowhere  
5 in the end. We needed a few more staff and we needed  
6 help and resourcing for a system. Not a huge thing.  
7 And we had study days and groups who looked at it and  
8 gathered evidence, gathered evidence from elsewhere, and  
9 for whatever reason that I never quite understood, it  
10 didn't go anywhere. So there were examples like that  
11 that I think were frustrating for people.

12 Q. Just so I understand it: is this that the clinicians  
13 have an initiative, something that they see a need that  
14 can be met, they're prepared to discuss how that can be  
15 done, there's a plan for how it might be done? Why does  
16 it peter out? What more is required to allow action to  
17 take place?

18 A. Well, I mean, the big thing is that money is required to  
19 get a lot of these things to happen, and one of the  
20 problems in regional services, particularly very small  
21 regional services such as we had in the  
22 Children's Hospital, was, to get developments, we had to  
23 have input, we had to have resourcing from all of the  
24 four boards, and ultimately, the community trusts. So  
25 we needed a lot of people to agree that they were going

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1 Q. Perhaps if I put it this way: if Dr Crean thought that  
2 was happening, did he know that he could bring that to  
3 you and get something like that, if you thought it was  
4 appropriate, tabled at this kind of meeting?

5 A. I believe so.

6 Q. Sorry?

7 A. I believe so.

8 Q. And how would he know that?

9 A. Well, he was a member for a while of the sub-directorate  
10 structure that met with the clinical director every  
11 week, and raised all sorts of issues to do with problems  
12 around the hospital or things that needed to be done.

13 Q. So if he had thought there was that kind of disparity in  
14 learning, this issue could have got on to the agenda  
15 earlier?

16 A. I think, yes, if we had realised about it.

17 Q. Thank you. Was it an effective forum?

18 A. The specialist --

19 Q. Yes.

20 A. I think many of us were not convinced that it was as  
21 effective as it might have been.

22 Q. And why was that?

23 A. Well, I'm not sure. There were a number of issues that  
24 just didn't seem to go anywhere, you know. You would be  
25 set up -- I mean, one example was from my own specialty:

22

1 to resource something and there was a definite  
2 resistance to resourcing services based in Belfast and  
3 based in the Royal, for example, as opposed to  
4 resourcing services in their own local communities,  
5 which is understandable that services were to be built  
6 up in the local communities.

7 And that epilepsy example, if I may use it, is we  
8 never got the funding to appoint a regional epilepsy  
9 nurse specialist, but epilepsy nurse specialists were  
10 appointed in other areas within the Province by the area  
11 or the local commissioners or trusts. And that's just  
12 an example of how frustrating that could be when trying  
13 to drive forward regional services and keep them up to  
14 scratch in the modern world.

15 Q. I understand. I want to ask you a little bit about, as  
16 we've sort of started into it, the knowledge of  
17 hyponatraemia and lessons learnt and how one deals with  
18 that.

19 If I can start first with the hospital-produced  
20 Paediatric Medical Guidelines. We can pull that up at  
21 319-067A-001. You contributed to this edition; is that  
22 correct?

23 A. I am not sure that I contributed very much to that  
24 edition. I know I contributed to the first edition.  
25 I see my name is listed there. By that time, I had

24

1 a colleague, Dr Webb, who had been appointed, and  
2 I think he took over the editing and preparation of the  
3 neurology section rather than myself.  
4 Q. Sorry, we can see it at 319-067A-006. There we are.  
5 A. Yes.  
6 Q. So it's a:  
7 "Handbook of guidelines for the management of many  
8 common paediatric medical conditions."  
9 It's compiled with the assistance of staff. We can  
10 see some of those who have previously given evidence  
11 in relation to other cases. There's Dr Bartholome, then  
12 there's yourself, Dr Hicks. We see Dr O'Connor,  
13 Dr Savage, Dr Steen, Dr Webb. And they've all been  
14 previously involved in Claire and Adam's cases.  
15 Who actually was this targeted at?  
16 A. It was targeted at the paediatric staff in training  
17 mainly.  
18 Q. Does that mean everybody below consultant level?  
19 A. More or less, yes.  
20 Q. How did the clinicians get access to it? Did it form  
21 part of an induction? Was it there available on the  
22 wards? How did they know about it and get access to it?  
23 A. It was available on the wards. It should have been  
24 available on every ward. I can't recall if every new  
25 member of staff was given a copy, but they would have

25

1 A. No.  
2 Q. And it does have a section on autopsy. We can go to  
3 that at 319-067A-030. We can pull up the next page  
4 because that goes on to deal with the coroner, 031.  
5 This is something else that Dr Hanrahan had no real  
6 knowledge about. If one sees it, firstly there's  
7 nothing in there about, so far as I could tell, help  
8 with how you fill in a death certificate. It's really  
9 quite brief as to the information being provided.  
10 If you look at the hospital autopsy part, there was  
11 quite a bit of evidence as to the information that  
12 should be provided to the pathologist and the  
13 discussions that it would be helpful to have by way of  
14 clinicopathological correlation and so forth when the  
15 clinicians involved in that were giving their evidence.  
16 It doesn't seem to reflect any of that.  
17 I will give you a comparator. This is the  
18 Altnagelvin's doctors' handbook. If one pulls up, in  
19 substitution for page 26, 316-004A-025. We'll come back  
20 to that.  
21 Just so that you know why I'm going to it, their  
22 handbook is dated August 2001, so just after Raychel's  
23 death, which was in June. But no law, if I can put it  
24 that way, had changed in relation to reporting to  
25 the coroner a death, so still under the same

27

1 been made aware of it at induction. Certainly all the  
2 consultants were provided with a copy.  
3 Q. All the consultants were?  
4 A. Yes.  
5 Q. The reason I ask you is Dr Hanrahan seemed to know  
6 nothing about it.  
7 A. It may have gone out of print by the time he was  
8 appointed. I'm not sure about that.  
9 Q. Given that it is dated 1999, to what extent did this  
10 reflect anything that might have been learnt in relation  
11 to Adam and Claire's cases? I don't necessarily mean  
12 just about hyponatraemia. There were issues in both  
13 those cases about record keeping. There were issues,  
14 for example, in Claire's case about hospital  
15 post-mortems. To what extent, given that it came  
16 a number of years after those deaths, was it intended to  
17 incorporate any learning? Not just from those two  
18 deaths, but just generally learning.  
19 A. It was intended to incorporate --  
20 Q. It was?  
21 A. It was intended to incorporate learning, I believe.  
22 Q. So it would have been a good vehicle for disseminating  
23 any learning from that? You see, I can't actually find  
24 anything in there about record keeping and its  
25 importance.

26

1 legislation. But the information there as to what to  
2 do, how to do it, is much more detailed.  
3 Dr Hanrahan, when he was giving his evidence about  
4 reporting to the coroner, seemed to be quite unclear,  
5 apart from in very basic terms, as to what he should be  
6 doing and what might be the result of it.  
7 Were you aware of how doctors should be assisted  
8 with their statutory and professional duties in relation  
9 to the reporting of deaths to coroners?  
10 A. Well, I was aware that they needed to know the duties of  
11 a doctor, the General Medical Council guidance.  
12 It would have been part of their, I suppose, appointment  
13 and initial orientation to ensure that they were aware  
14 of that. And subsequently, also, during appraisal,  
15 annual appraisal.  
16 Q. When you say orientation, you mean that's part of an  
17 induction that they would get that?  
18 A. They should do, yes.  
19 Q. They should do?  
20 A. Yes.  
21 Q. Did you know that that actually happened?  
22 A. Well, the Trust -- I have to say, for new consultants,  
23 the Trust held -- took charge of the induction, and  
24 I can't -- I'm afraid I can't remember exactly the  
25 details of that. I personally, as clinical director,

28

1 would have met with the new consultants in the  
2 directorate and reviewed a number of things, but in  
3 a way that was less formal. But the Trust induction was  
4 led by the medical director, and all new consultants to  
5 the Trust, as far as I am aware, went through a Trust  
6 induction.

7 Q. Does that mean that the person who is in charge of  
8 ensuring that there is an appropriate induction is  
9 actually the medical director?

10 A. Well, that is as I remember it from when I was clinical  
11 director.

12 Q. Since it may not happen very often for a clinician,  
13 would you regard the reporting of a death to the coroner  
14 as being quite an important thing to know it?

15 A. Yes.

16 Q. And to be clear on?

17 A. Yes.

18 Q. Equally, the provision of a death certificate?

19 A. Yes.

20 Q. The reason I raise that with you is that because, in his  
21 evidence, Dr Hanrahan said he was not aware there was  
22 any guidance -- he didn't get any guidance about what to  
23 do.

24 The other thing that I couldn't actually find in the  
25 Children's Hospital guidebook is anything in relation to

29

1 over to the next page, 091, this is getting right down  
2 to the actual calculation of the fluids to be used. So  
3 you can see the maintenance fluids, and it shows you how  
4 you can calculate those. Then there are sections for  
5 using [sic] normal serum sodium, and then very low serum  
6 sodium, and then the hypernatraemic dehydration. But  
7 I couldn't see any reference in there to hyponatraemia.

8 A. Well, low serum sodium is possibly what they mean by  
9 that.

10 Q. But not to the risks of it is actually the point I'm  
11 getting at, which is something that seemed to have been  
12 appreciated in the Children's Hospital, certainly by  
13 when this guide came out, which is 1999.

14 In your understanding, what would be the process of  
15 reflecting things that are coming up in the hospital,  
16 being discussed in mortality meetings, being discussed  
17 in the Critical Incident Review Groups? So these are  
18 themes and there is learning being generated; how would  
19 that get into a work like this for the benefit of the  
20 trainees?

21 A. If there's an issue about something like that, then it  
22 should -- what we would have developed through audit and  
23 clinical governance would be a system of asking --  
24 suggesting that a presentation be made at -- usually the  
25 audit meeting or sometimes a special session. We had

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1 the knowledge of the use of IV fluids that you are  
2 saying was current, if I can put it like that, in the  
3 Children's Hospital. One can see the section. There's  
4 about three pages of it, it starts at 319-067A-089.

5 This is headed up "Diarrhoea". This is the only  
6 place where one sees a reference to IV fluid regimes.  
7 If you look down at the possible causes, one of them is  
8 "prolonged oral rehydration therapy", which is not an  
9 issue that has arisen in particular to any of these  
10 cases, but if you look the third up from the bottom of  
11 that you have, "Anatomical defects and surgical  
12 conditions". And that, of course, was an issue that  
13 came out of Adam in terms about rehydration and the  
14 implications of SIADH and so forth. When I looked  
15 through that, it's the only place I could see  
16 a reference to surgical conditions. I couldn't actually  
17 see any reference in this to SIADH or hyponatraemia.

18 As we go down, it says, "Assess hydration levels"  
19 and then, if we go over the page to 090, you can see  
20 that all this about fluid regime happens in this  
21 section, so far as I can tell from your guidebook, on  
22 diarrhoea, which is one of the reasons maybe one doesn't  
23 find the things that came out of those two cases.

24 So that's the next section, and that talks about the  
25 hydration and how you manage that. And then if one goes

30

1 a -- we used to have a weekly clinical meeting and, on  
2 occasion, those meetings were used for someone to  
3 present an issue of importance. Normally it was  
4 rotating through the units, you presented cases of  
5 interest or cases with a learning point. So it could be  
6 done in either of those fora and ideally with some sort  
7 of written handout provided as well on the issue.

8 Q. I see that. One of the issues that the chairman had  
9 asked before is: how do you get an output, if I can put  
10 it that way, from your audit meetings and your mortality  
11 meetings and so forth? So when these things have been  
12 discussed, people appreciate that matters could be  
13 handled slightly better. Is there a way in saying,  
14 "That's really something that we should put in the next  
15 edition of the guidelines"? Is that something that can  
16 happen, or is it just a matter of somebody who's got  
17 a particular interest in it taking it up, so in an ad  
18 hoc way?

19 A. No, it should be more systematic than that, clearly.

20 Q. That's why I am asking you. How is it more systematic  
21 than that?

22 A. So that could be fed back and brought so that if there's  
23 an issue like that in a presentation, then there could  
24 be a publication which is sent right round to everyone  
25 in the hospital, even those who haven't been at the

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1 meeting.  
2 THE CHAIRMAN: Can you give me an example, doctor, of  
3 a publication being sent round the hospital on foot of  
4 a mortality meeting?  
5 A. I can't. I'm trying to think ... I can't just at the  
6 moment.  
7 THE CHAIRMAN: If you do think of one either before your  
8 evidence finishes or at some point over the next week or  
9 two, could you advise the Trust's lawyers and they can  
10 bring it to my attention?  
11 A. I will.  
12 THE CHAIRMAN: Because at least it would show that something  
13 came out of a mortality meeting.  
14 MS ANYADIKE-DANES: Then if I just move on to an issue that  
15 I have put to almost everybody that's given evidence  
16 from the Children's Hospital, which is any knowledge  
17 that you might have about the change in use of  
18 Solution No. 18 and I mean up until Lucy's admission in  
19 2000 and perhaps for a little bit after that as well,  
20 but around about 2000. Have you any knowledge of the  
21 use of Solution No. 18 having changed? Its incidence,  
22 I should say.  
23 A. I have been given some pieces of paper this morning with  
24 examples -- with data about supplies of this particular  
25 solution.

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1 other fluids available?  
2 A. I can't think of anything. I can't remember anything  
3 that would have produced that change.  
4 THE CHAIRMAN: Do you remember Solution No. 18 being  
5 a standard IV fluid?  
6 A. Yes.  
7 THE CHAIRMAN: Okay. I was told last week that if it ceased  
8 to be a standard IV fluid and if it was faded out as  
9 dramatically as these statistics show, that is  
10 a decision which would have had to have gone up through  
11 the hospital hierarchy.  
12 A. I would have thought so.  
13 THE CHAIRMAN: Yes. You're the latest witness to say to me  
14 that you don't understand or you can't remember anything  
15 about this. I have to say, as I said yesterday, I don't  
16 accept that nobody in the Trust can give me an  
17 explanation. If this is a change, a change from  
18 a standard solution which had been used for years, used  
19 across the world, is used by many doctors in many  
20 circumstances, and a decision was taken in the Royal to  
21 fade it out, I don't understand how doctor after doctor  
22 after doctor comes to me from the Royal and says,  
23 "I don't know why that happened"; do you understand my  
24 bemusement?  
25 A. Yes.

35

1 Q. Let me pull it up and see if this is what you've been  
2 given. 319-087c-003, although this information seems  
3 now to have changed. That was information that we had  
4 until fairly recently, but it seems that the Trust has  
5 gone back and found some other information. This may  
6 not be entirely correct. In any event, if you look at  
7 that it looks as if there was a change, a reasonably  
8 dramatic change, in the instance of the use of  
9 Solution No. 18 that looks as if it happened some time  
10 from about the beginning of 2001, as it has a slightly  
11 recovery, and certainly was on a pretty steep downward  
12 trend from about March on that chart.  
13 A. I can see that, yes.  
14 Q. Were you aware of its use being reduced in that way?  
15 A. I have not been able to think of why that might be.  
16 Q. Well, were you using it less?  
17 A. My practice -- we didn't use it at all that much anyway.  
18 That's not what we dealt with. I don't remember any  
19 change in my practice, but it wouldn't have been a major  
20 practice with IV fluids.  
21 Q. I understand. Then as clinical director, because you're  
22 now clinical director for the whole of paediatrics, were  
23 you aware of any discussion amongst the clinicians that  
24 this was an IV fluid that perhaps they wished to use  
25 less and perhaps use more of Hartmann's or any of the

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1 THE CHAIRMAN: You can't help me either?  
2 A. I'm sorry, I can't.  
3 MS ANYADIKE-DANES: Do you know Dr Nesbitt from Altnagelvin?  
4 A. No.  
5 Q. Dr Nesbitt was a consultant anaesthetist at Altnagelvin.  
6 How this started, insofar as the inquiry knows about  
7 it, was that shortly after Raychel's death, he rang  
8 around hospitals to see what was their practice, to see  
9 the extent to which Altnagelvin was out of kilter or not  
10 with what others were doing. The result of all of  
11 that is that, as he ultimately he says in a statement to  
12 the PSNI, he says that he was told by Dr Chisakuta --  
13 are you aware of Dr Chisakuta?  
14 A. Yes.  
15 Q. That the Children's Hospital use of Solution No. 18 in  
16 post-operative surgical children had changed about six  
17 months prior to Raychel's death, which would take you to  
18 the beginning of 2001 or the end of 2000. And the  
19 reason it had changed was because of concerns about the  
20 possibility of low-sodium fluids. We don't need to pull  
21 it up, but the reference where he says that is  
22 095-010-040. That's one clear piece of information that  
23 Dr Nesbitt conveyed.  
24 The other thing he said, and he wrote this in  
25 a letter to his medical director very shortly after

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1 Raychel's death, was that another reason he was told for  
2 the change of use was because there had been a number of  
3 deaths associated with low sodium. He didn't say when  
4 those deaths were, I'm not sure that he knows whether  
5 he was told that, but in any event he associated the use  
6 of low sodium with risk, if I can use it in that way.  
7 So he's very, very clear about that, and yet  
8 Dr Chisakuta and -- as the chairman's just told you --  
9 all the other witnesses simply don't recall that at all.  
10 So far as you're concerned, in the Children's  
11 Hospital, were there clinicians who were beginning to  
12 associate the use of low-sodium fluids with some kind of  
13 risk for certain children? Maybe not all, but certain  
14 children. Were you aware of that?  
15 A. No, I don't think so.  
16 Q. Well, did you associate it with risk if used  
17 inappropriately?  
18 A. As a neurologist, I did, yes.  
19 Q. Sorry?  
20 A. As a neurologist, yes.  
21 Q. You did?  
22 A. Yes.  
23 Q. And do you think you were alone in that or could your  
24 colleagues also, your fellow neurologists, also have  
25 formed that view by 2000?

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1 careful about that?  
2 A. I don't know. I can't account for it.  
3 Q. Would that not be an appropriate thing to put in there?  
4 A. Yes.  
5 Q. Yes. And do you think that, apart from the  
6 neurologists, other disciplines were as well aware or as  
7 attuned to that risk? Other paediatricians, might they  
8 be?  
9 A. I certainly thought the specialists were, yes.  
10 Q. The specialists were?  
11 A. Yes.  
12 Q. But those who weren't specialists might not be?  
13 A. They might not be. They seemed not to be.  
14 THE CHAIRMAN: The trainees wouldn't be?  
15 A. Um ... Well, the trainees -- it depends at what stage  
16 of their training. It would be part of their training  
17 to teach them about --  
18 THE CHAIRMAN: Weren't these guidelines to help the  
19 trainees?  
20 A. Yes.  
21 THE CHAIRMAN: So if you don't put it in the guidelines,  
22 then the trainees are going to have to go somewhere else  
23 for the assistance they need?  
24 A. They do also get training during their induction on  
25 fluid.

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1 A. I would have thought neurologists would have been aware  
2 of the risks, particularly in neurological practice.  
3 Q. Yes. And what is the risk that you were aware of by  
4 2000?  
5 A. That rapid lowering of serum sodium can be associated  
6 with adverse events. Seizures is the number one I can  
7 think of.  
8 Q. How would you achieve a rapid lowering?  
9 A. Well, it can be achieved as part of disease process --  
10 Q. Yes.  
11 A. -- or it can be achieved by excessive dilute fluid.  
12 Q. Yes. It's correct, isn't it, that trainees -- and by  
13 that I mean everybody short of a consultant --  
14 administer IV fluids to children in the  
15 Children's Hospital?  
16 A. Yes.  
17 Q. Yes. So they could do that inadvertently, reduce  
18 a child's serum sodium level too quickly?  
19 A. Yes.  
20 Q. That could happen?  
21 A. Yes.  
22 Q. Why is that not in the guidebook as a warning? When  
23 you've got that section dealing with the administration  
24 of IV fluids, why isn't there a warning, if the  
25 neurologists appreciated that, that one has to be

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1 THE CHAIRMAN: But if you leave it at that, then you  
2 wouldn't bother writing the guidelines. If you are  
3 going to say they are going to get their training  
4 somewhere else, they're going to get their training in  
5 induction or they're going to get their training  
6 day-to-day on the ward with consultants, then you  
7 wouldn't bother writing guidelines. So when you are  
8 writing guidelines, you must be trying to bring together  
9 any issues which seem to bear repetition or emphasis;  
10 right?  
11 A. Yes.  
12 THE CHAIRMAN: So if low sodium can cause seizures as  
13 a result of either excessive dilute fluid or as  
14 a natural consequence of other diseases, that's  
15 something that the trainees need to know.  
16 MS ANYADIKE-DANES: And would you have said that, within the  
17 Children's Hospital, you had there those who were most  
18 likely to know about the developments in that area as to  
19 electrolyte imbalances and the effect of the use of  
20 low-sodium fluids, SIADH and so forth? Would you think  
21 that you had a better chance of knowing the developments  
22 in that than your colleagues in the district hospitals?  
23 A. Yes, to some extent certainly.  
24 Q. Were you aware of the two Arieff papers, for example?  
25 A. I don't remember them.

40

1 Q. You don't remember them?  
2 A. No.  
3 Q. If you're more aware of that sort of risk, quite apart  
4 from what you do for your own trainees in the  
5 Children's Hospital, because you're the regional centre  
6 isn't that the sort of thing that you could have been  
7 communicating to your colleagues in the district  
8 hospitals, who are putting IV drips up for children  
9 almost day and daily and are less likely to be aware of  
10 some of the risks than you would be?  
11 A. Yes.  
12 Q. Is there any reason why the Children's Hospital couldn't  
13 have done that?  
14 A. I don't think so.  
15 Q. In 2000 -- so not now but in 2000 -- did the  
16 Children's Hospital have any way in which it got out, if  
17 I can put it that way, the message of its own learning?  
18 A. As an organisation?  
19 Q. Yes.  
20 A. We did, from time to time, run study days and study  
21 sessions about various issues. For example, a day on  
22 epilepsy or other specialties. We would contribute to,  
23 or members of staff would contribute, to other regional  
24 groups -- the Ulster Paediatric Society, the regional  
25 group of the college, the RCPCH -- and other meetings --

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1 communication for how we might do that?" It doesn't  
2 sound as if you were doing that.  
3 A. No, I don't think so.  
4 Q. But did you think you could be doing that?  
5 A. I don't recall whether we discussed that.  
6 Q. Does that seem like something that the  
7 Children's Hospital, being a regional centre, it would  
8 be reasonable for it to be doing?  
9 A. It sounds reasonable.  
10 Q. Sorry?  
11 A. It sounds reasonable.  
12 THE CHAIRMAN: If I took the view, doctor, that  
13 a significant decision had been taken in the Royal to  
14 stop the use of Solution No. 18, but that that decision  
15 had not been communicated to the district hospitals,  
16 like Altnagelvin and the Erne and so on, do you think  
17 it would be unfair of me to criticise the Royal, as the  
18 regional paediatric centre, for having made  
19 a significant change in its practices without advising  
20 the other hospitals?  
21 A. No, I think that would be reasonable.  
22 THE CHAIRMAN: Thank you.  
23 MS ANYADIKE-DANES: Thank you.  
24 When you gave evidence before, you said that you had  
25 no knowledge of the cases of Adam and Claire; isn't that

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1 and contribute to other meetings and teaching sessions,  
2 and there would be individual projects. I talk about  
3 epilepsy because that's the particular thing that I was  
4 involved with in teaching, both in Ireland,  
5 Northern Ireland and the UK. So there were  
6 opportunities to do that.  
7 Q. I see there were opportunities, but whilst you were  
8 there as the clinical lead, did you think there might be  
9 some way in which you could standardise that so that, in  
10 a more planned and systematic way, the  
11 Children's Hospital could perform that sort of service  
12 really?  
13 A. We did do some sessions, but there weren't many and they  
14 weren't regular.  
15 Q. But the way you've described it, it doesn't sound as if  
16 there was some sort of -- like you would have an  
17 editorial board of a journal decide what are the up and  
18 coming things that we need to disseminate. It sounds  
19 more -- and correct me if I'm wrong -- as an ad hoc  
20 thing -- and I don't mean to disparage it in that way --  
21 but people who had a particular interest would develop  
22 something in their own way, but not that the  
23 Children's Hospital was seeing systematically, "Now,  
24 what would be useful for us to be getting out there to  
25 the district hospitals and let's find a channel of

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1 right?  
2 A. Correct.  
3 Q. Apart from those who were directly involved, the  
4 witnesses from the Children's Hospital that I've asked  
5 have no knowledge of either of those cases.  
6 A. I'm sorry, I didn't hear.  
7 Q. Apart from those who were involved in some way directly,  
8 none of the witnesses from the Royal that I have asked  
9 that question of have had any knowledge of Adam or  
10 Claire.  
11 A. Right.  
12 Q. One of the things that the statement to the coroner said  
13 it was going to do, or the Trust was going to do, was to  
14 make sure that all the anaesthetists would be alive to  
15 the issues that arose out of Adam's case. So  
16 I particularly asked Dr Chisakuta, for example, if, when  
17 he came to the Children's Hospital, he had any knowledge  
18 of Adam's case, and the short answer was he didn't. For  
19 that matter, neither did you, and you were clinical lead  
20 at that time.  
21 A. Well, not at the time he died.  
22 Q. I beg your pardon.  
23 A. It was later.  
24 Q. Yes. But to make good that statement to the coroner,  
25 something would have to have been instituted to make

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1 sure that the anaesthetists did know about the lessons  
2 from Adam's case; are you aware of what that mechanism  
3 would be?  
4 A. Well, it would need to be a mechanism that reported,  
5 reviewed the case, and reported the problems and  
6 generated some recommendations for management, I would  
7 think, and that would need to be agreed by the  
8 anaesthetists and shared in the hospital; is that what  
9 you mean?  
10 Q. Not exactly, although that would have been a start. You  
11 were the clinical director of paediatrics from 1996 to  
12 2002.  
13 A. Mm-hm.  
14 Q. 1996 was the year of Adam's inquest. That's when the  
15 statement was made. The statement was provided to  
16 the coroner as part of Dr Taylor's evidence. So you, so  
17 far as I can tell from your CV, were actually clinical  
18 lead at the time that statement was being provided to  
19 the coroner.  
20 A. Right. I don't know. I took over on 1 October.  
21 Q. You took over on 1 October, his inquest was in the  
22 summer. So just after then you would have been clinical  
23 lead. And you were never even made aware of that case?  
24 If some system was going to be established to  
25 disseminate, to at least the anaesthetists, all the

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1 a certificate and so on.  
2 Q. I see.  
3 A. I would personally engage -- I had a number of different  
4 types of consultant in the directorate who were signed  
5 on for CPD with different colleges, surgeons,  
6 psychiatrists, paediatricians and so on. So it was, to  
7 be honest, quite difficult to really scrutinise their  
8 development programme and it was an evolving process so  
9 that it became, I think, more meaningful in the  
10 discussion one had about identifying people's needs  
11 vis-a-vis various aspects of their practice.  
12 Q. How did that work across directorates? Because some of  
13 those who are in PICU, which is within your directorate,  
14 are also in ATICS, those are the anaesthetists. So how  
15 did that work? Because presumably at that level you  
16 don't have -- I don't want to say control over them --  
17 but they're not within your remit, or are they?  
18 A. No. It didn't work very well, to be honest. It was  
19 a problem between directorates and it was a problem  
20 between hospitals as well.  
21 Q. Have you seen Dr MacFaul's report? He's the inquiry's  
22 expert.  
23 A. I haven't seen his most recent one. I read part of the  
24 report for Claire Roberts.  
25 Q. Have you seen his report for Lucy?

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1 lessons, as the clinical lead, would you have been  
2 involved in whatever was established to achieve that?  
3 A. Yes.  
4 Q. So for that to happen, you would have to know about it?  
5 A. Yes.  
6 Q. And you never knew about it?  
7 A. No, never.  
8 Q. How do you or did you, when you were clinical lead,  
9 ensure that the consultants in paediatrics were keeping  
10 up-to-date with current practices, particularly  
11 in relation to the management of fluid balance? How did  
12 you do that?  
13 A. Initially, when I took over, I don't think there was  
14 a system for doing that. The process of appraisal, when  
15 it began, included a review of continuous professional  
16 development.  
17 Q. When did that start?  
18 A. About 2000, 1999 or 2000. 2000 or 2001, I think, was  
19 the first formal year that we did it in the Royal.  
20 Q. How would that process have assessed whether any given  
21 clinician was keeping up-to-date with current practices?  
22 A. The process -- you would examine or review evidence that  
23 the consultant would bring of what courses and study  
24 days and so on that they had attended because you would  
25 go to a course and you would be issued with

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1 A. No. I haven't been able to access anything online for  
2 personal reasons for the last few weeks.  
3 Q. Did you know he provided a report for Lucy?  
4 A. I'm not sure whether I was aware of that. I knew he had  
5 done one for Claire.  
6 Q. Yes. Right. In the course of that report, he makes  
7 a number of criticisms of some of the clinicians, not  
8 singling them out in any way, but reviewing what  
9 happened and then indicating what he thought might have  
10 been problematic. In relation to Dr Hanrahan, it really  
11 starts, I think, at 250-003-007.  
12 This should help you. Under (xiii) -- in fact it  
13 starts really above that, but you can see that, in terms  
14 of the clinical shortcomings, he says of Dr Hanrahan at  
15 (xiii):  
16 "He did not review the case records and the fluid  
17 regime and did not appreciate the volume overload with  
18 hypotonic fluid. He was aware of the low blood sodium,  
19 but concluded this as insufficient in severity to cause  
20 the cerebral oedema. This point is reasonable given the  
21 knowledge of the time as a cause of cerebral oedema. He  
22 did not consider that this level of hyponatraemia could  
23 also be a sign of the fluid overload nor take account of  
24 the weight gain [which he thought was another sign], nor  
25 that the severity of hyponatraemia at the time of Lucy's

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1 collapse could have been greater than was measured after  
2 the high volume of normal saline had been given."  
3 And so on. So he makes a number of discrete points  
4 in relation to Dr Hanrahan's involvement in Lucy's care  
5 at the hospital and the aftermath of her death. Are  
6 those the sort of things that you would have wanted to  
7 know about?  
8 A. About a consultant?  
9 Q. Yes.  
10 A. I think so.  
11 Q. And if you were going to hear about them as the clinical  
12 director, how would that information come to you?  
13 A. Well, they might volunteer it.  
14 Q. And if they don't, how does it come to you?  
15 A. Another member of staff might bring it to my attention,  
16 although, frankly, that's pretty unusual.  
17 Q. Yes.  
18 A. It certainly was then.  
19 Q. So what then is the system that you have, other than  
20 somebody just knocking on your door and saying, "Look,  
21 I think, in retrospect, I could have done things  
22 better"? Other than something like that, what's the  
23 system for being able to identify and pull up  
24 deficiencies?  
25 A. I think the systems at that time -- and I'm not sure

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1 system, you wouldn't necessarily be aware of that  
2 either, and I think as you just said a moment ago, your  
3 phrase was, I think: in terms of doctors reporting  
4 concerns to you, you said another member of staff might  
5 bring it to your attention, although frankly that's  
6 pretty unusual.  
7 A. Yes.  
8 THE CHAIRMAN: So in effect, there was no system of any sort  
9 for monitoring the standard of care provided?  
10 A. Well, there wasn't at that time.  
11 THE CHAIRMAN: And when we say "at that time", we're not  
12 talking about some ancient history; we're talking about  
13 2000?  
14 A. Mm.  
15 THE CHAIRMAN: Thank you.  
16 MS ANYADIKE-DANES: You said you just didn't think of it,  
17 but you are part of Specialty Advisory Committee that's  
18 established by the CMO, which in 1998 is saying, "I want  
19 a big push for clinical quality and clinical  
20 governance". So it was coming down the track what the  
21 CMO wanted. So how could you, in 2000, not have  
22 realised at the very least, "I must put in a system  
23 whereby I know all the child deaths"? Because if you  
24 don't know them, you can't even begin to see in  
25 a systematic way what might have gone wrong.

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1 what's in place now -- were not good for doing that.  
2 For example, there was no system -- it's one of the  
3 things I've come to realise in my part in this inquiry,  
4 that there was no system for the clinical director to  
5 really be informed of all deaths, and certainly to be  
6 informed about deaths that were referred to the coroner.  
7 It simply didn't exist. And I have to admit that  
8 I didn't think about that. I hadn't thought of that at  
9 that time as being an issue.  
10 THE CHAIRMAN: Is that, doctor, because you assumed that if  
11 there was a clinical death in paediatrics, that you  
12 might be told about it?  
13 A. Sorry?  
14 THE CHAIRMAN: You said there was no system in place for  
15 telling you about clinical deaths.  
16 A. About deaths. What I mean is there wasn't a system for  
17 notifying you -- for notification on an individual  
18 basis. We did see statistics, of course.  
19 THE CHAIRMAN: But if you're the paediatric lead and  
20 therefore, for so long as you hold that position,  
21 you have some additional responsibility in this area.  
22 So you were not necessarily made aware of the deaths of  
23 children, even if they went to the coroner?  
24 A. No.  
25 THE CHAIRMAN: So that if anything came out of the coroner's

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1 A. Well, we did know the deaths through the mortality  
2 reporting system, through the mortality meetings ...  
3 THE CHAIRMAN: Sorry, with all due respect, that's pretty  
4 meaningless, isn't it, because the deaths that you learn  
5 of through the mortality system might be an unavoidable,  
6 inevitable death on the one hand, or it might be a death  
7 which results from inadequate treatment in the Royal or  
8 in the Erne, or in Altnagelvin or wherever; right?  
9 A. Yes.  
10 THE CHAIRMAN: How do you distinguish between the two?  
11 A. It's very difficult looking at them in bulk, as it were.  
12 THE CHAIRMAN: Is the mortality meeting not supposed to be  
13 the meeting at which all these issues are brought out  
14 and there's intense debate and it's not minuted because,  
15 I am told, that would discourage debate. So if debate  
16 is encouraged by the fact that there's no minutes, are  
17 you telling me that in fact the debate never really took  
18 place?  
19 A. No, debate did take place.  
20 THE CHAIRMAN: And the outcome? Or no outcome?  
21 A. Well, you've asked me to think of that and I'll try.  
22 THE CHAIRMAN: Yes.  
23 MR UBEROI: Sir, for clarification, can I remind you of  
24 a couple of pieces of evidence? I entirely understand  
25 why you're scrutinising whether a mortality meeting took

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1 place in the case of Lucy Crawford. But on day 67  
2 during his Claire Roberts governance evidence, Dr Taylor  
3 said:

4 "I can give you some examples of things that did  
5 change because of these mortality meetings, and there  
6 are several I remember during my short time as the audit  
7 lead. Several cases came through, if you like, to say  
8 there was a cluster of deaths around meningococcal  
9 disease, meningitis. These were reported during that  
10 and the cause of death was known. During a discourse of  
11 that review, people would perhaps say, 'I remember  
12 previous deaths similar to this', and maybe putting the  
13 system together, doctors in community practice would  
14 say, 'I'm meeting mummies who are concerned about their  
15 child developing a rash and developing neck stiffness',  
16 so they would want to know what they could tell their  
17 parents, and together we got together and made  
18 a Northern Ireland guideline on meningococcal disease."

19 And the second point, sir, was the evidence from  
20 Tuesday of a meeting being stopped and the quality of  
21 a consultant's care effectively being referred to the  
22 medical director.

23 THE CHAIRMAN: Thank you.

24 MS ANYADIKE-DANES: One way for you to see, it wouldn't  
25 necessarily catch it all, but for you to see deaths that

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1 A. I don't know. I don't think -- there's no reason why  
2 I didn't do it.

3 Q. I wonder if I could ask you something now about  
4 consultant responsibility and record keeping? From the  
5 evidence that you gave in relation to Claire, you'll  
6 realise that that was an issue in that case.

7 A. Yes.

8 Q. Leaving aside whether anybody had picked up on the  
9 issues to do with hyponatraemia in Claire's case, what  
10 any discussion of her case would have highlighted was  
11 that there was some vagueness as to who was the  
12 consultant who had overall responsibility for her care;  
13 would that be fair?

14 A. There seems to have been, yes.

15 Q. So it wasn't entirely clear whether it was Dr Steen or  
16 through with Dr Webb then providing specialist input  
17 from his neurological specialism or whether at some  
18 point, because Dr Steen didn't actually see the child  
19 and he was the one that did, that he in some way had  
20 taken over her care. That was an issue. You'll  
21 remember that out of the evidence.

22 A. Yes.

23 Q. There was also an issue about the quality and standard  
24 of record keeping; do you remember that?

25 A. I do remember that.

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1 perhaps you could look at more closely and more  
2 particularly distil any lessons are those that are  
3 referred to the coroner because, almost by definition,  
4 they are problematic. Coming out of that Special  
5 Advisory Committee, did you not think, "Well, at the  
6 very least, what I could do is Institute some sort of  
7 requirement that whatever, else was happening, I was  
8 notified of all deaths which were being reported to  
9 the coroner"?

10 A. I didn't.

11 Q. Why not?

12 A. I don't know. I don't remember a discussion about that  
13 at the Special Advisory Committee.

14 Q. No, but you saw it in the minutes.

15 A. Mm.

16 Q. Yes. But even leaving aside whether it's in the minutes  
17 or not, clinical governance was something being  
18 developed at that stage, so when it happens, you happen  
19 to be the clinical director at that time, so what I was  
20 putting to you is: at the very least, one way of  
21 identifying some of these cases that might be worth  
22 greater scrutiny, from your point of view in your  
23 position, is if you were notified of all those that were  
24 being reported to the coroner, and is there any reason  
25 why you didn't at least institute that?

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1 Q. So as I say, even if she hadn't come across the radar  
2 for hyponatraemia because people weren't entirely sure  
3 about that, those are clinical issues that, would you  
4 agree, are worth trying to ensure don't recur?

5 A. Yes.

6 Q. That the standard of record keeping is improved and that  
7 there is some clarity brought as to who is in overall  
8 charge of the child's treatment?

9 A. Yes.

10 Q. When we get to Lucy, so four years later on, there is  
11 also an issue about who is in overall charge of Lucy's  
12 care. That arises because she comes straight into PICU.  
13 And the evidence that we have heard so far is there can  
14 be a system of joint care with the intensivists or the  
15 anaesthetists on the one hand and then the specialist,  
16 perhaps a neurologist or paediatrician or a surgeon, on  
17 the other hand, sharing care.

18 Can you help us with actually what was the system  
19 for identifying who had overall care of the child's  
20 treatment in PICU, from your standpoint as clinical  
21 director?

22 A. This was an issue that went back in time, all my time as  
23 a consultant. It was an issue that occurred while I was  
24 training in Boston Children's Hospital, exactly the same  
25 issue. And it's quite a difficult one, although it may

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1 seem simple. Children in PICU generally, most of them,  
2 require respiratory support, and that requires them to  
3 have a consultant anaesthetist who is responsible for  
4 that care in whatever way the consultant anaesthetist  
5 organises their responsibilities. But most, if not all,  
6 other children will have respiratory problems because of  
7 an illness that would be appropriately looked after by  
8 a different -- another consultant, and this issue would  
9 arise. So there would always be a consultant's name,  
10 and I think it was always the same name, from the  
11 administrative point of view --  
12 Q. Dr Crean has said that.  
13 A. -- that tended to go on. I didn't understand why it  
14 always had to be Dr Crean's name, and this was discussed  
15 at our meetings before my time as clinical director and  
16 it was an ongoing administrative issue.  
17 Q. When you came to your position as clinical director,  
18 that system was still in place?  
19 A. That system was in place.  
20 Q. If you didn't understand it, what were you able to do  
21 about changing it?  
22 A. I'm not sure I managed to change whatever was the IT  
23 issue behind putting the name on. But what we certainly  
24 did was insist that there must be a consultant  
25 anaesthetist and it should be the relevant consultant

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1 it like that, you can see that continuity of care would  
2 require a reasonable degree of communication between all  
3 of those; would you accept that?  
4 A. Yes.  
5 Q. That might mean it would be more than usually helpful to  
6 have clear notes or clear record keeping.  
7 A. Yes.  
8 Q. And how, in the notes or the record keeping, do you  
9 identify at any given time who the consultants are who  
10 have the overall responsibility for the child's care?  
11 A. Well, the anaesthetist will make notes each day  
12 according to whoever's on.  
13 Q. Yes. Let me help you with why I put it in that way.  
14 Because although there is an anaesthetist on duty, it  
15 may be that another anaesthetist perform a procedure to  
16 help out. In this case, actually, Dr McKaigue would  
17 have been the anaesthetist as she came in, handing over  
18 to Dr Crean, but he was called away for an emergency,  
19 and so Dr Chisakuta, who was not going to be on duty on  
20 that day in relation to Lucy, stepped in to perform  
21 a procedure. So you would see his note in her records.  
22 A. Mm.  
23 Q. But that doesn't necessarily mean that he is going to be  
24 her consultant for that day in relation to anaesthesia.  
25 So that's why I'm asking you. If you're going to work

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1 anaesthetist and another consultant who should be  
2 notified immediately.  
3 THE CHAIRMAN: The relevant consultant anaesthetist  
4 presumably is the person who's on -- if it's Dr Crean on  
5 Monday and then, say, Dr Taylor on Tuesday and the child  
6 is still in intensive care on Tuesday, it's not Dr Crean  
7 on Tuesday because he's not there, it becomes Dr Taylor?  
8 In effect, the identity of the relevant consultant  
9 anaesthetist changes as the shift changes; is that  
10 right?  
11 A. It has to, apparently, yes, because they change.  
12 THE CHAIRMAN: Yes. And that's how the system worked, that  
13 there was one at a time who was dedicated to PICU, so  
14 whoever was dedicated to PICU on a particular day was  
15 the identified consultant anaesthetist responsible for  
16 the care of the child on that day.  
17 A. Yes.  
18 THE CHAIRMAN: And that then depends on effective  
19 communication between the outgoing anaesthetist and the  
20 incoming anaesthetist as to what the problem is, how the  
21 child's progressing --  
22 A. And the other consultant or consultants, depending on  
23 how many of those there are.  
24 MS ANYADIKE-DANES: And if you're going to have a system  
25 like that, which even for the chairman just to describe

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1 a system like that, how do you record who the relevant  
2 consultants are?  
3 A. Well, for each day there should be a note made, a record  
4 made of who was on that day. They would normally do the  
5 ward round in the morning.  
6 Q. And is that kept in the child's notes so if, after the  
7 event, you want to try and see who we should be talking  
8 to in relation to a child, is that rota or that note  
9 kept anywhere in the children's notes?  
10 A. It should be within the body of the notes.  
11 Q. Yes. And when I was asking Dr Hanrahan about that,  
12 because Dr Hanrahan had acknowledged that -- I think his  
13 expression was a degree of vagueness over the consultant  
14 with overall responsibility. And that vagueness had  
15 left him in the position of not really knowing whether  
16 he was the one who should have been, for example,  
17 writing the discharge letter, whether that was his role  
18 or it was the role of Dr Crean. His description of  
19 events was:  
20 "As far as I was concerned, I was brought in to give  
21 a specialist neurological report. I did a few other  
22 things as well to help out, but that was primarily what  
23 I was brought in to do."  
24 He did not regard himself as taking on jointly, in  
25 a formal way, the overall care or responsibility for

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1 Lucy's care.  
2 When I pressed him a little bit on that, he  
3 acknowledged that there was a bit of vagueness about who  
4 would be or should be having overall responsibility and  
5 said that things have been tightened up now.  
6 If I go back to you, were you aware that there were  
7 occasions when it wasn't entirely clear who the  
8 consultant or consultants were who had overall  
9 responsibility?  
10 A. I might have been aware that it occurred from time to  
11 time. I wouldn't have been aware that it was a regular  
12 problem. As far as I'm concerned, it was unacceptable  
13 for there to be uncertainty.  
14 Q. So if Dr Hanrahan, on reflection, had thought that there  
15 probably was a bit of vagueness and that was unfortunate  
16 because it meant that effectively certain jobs fell  
17 between two stools, is that something that you would  
18 expect to know about so that you could monitor that sort  
19 of thing?  
20 A. I'm not sure that there would have been a system for  
21 telling me that at that time. But if there was concern,  
22 if someone had noticed that or felt it was a concern,  
23 then they would let me know. I'm trying to think if  
24 I can think of another example of that, but I can't.  
25 But from time to time -- certainly from time to time

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1 Lucy's case, perhaps, highlights the confusion that can  
2 arise when there are difficulties about what has to be  
3 explained to the parents, who reports to the coroner and  
4 what is reported to the coroner; would that seem fair?  
5 A. I think that's fair enough and I think when there's  
6 another hospital involved, it's even more complicated.  
7 MS ANYADIKE-DANES: I can give you a concrete example of  
8 that, which is to do with a discharge letter. It turns  
9 out that a discharge letter was not sent to either  
10 Lucy's GP or the Erne Hospital, and certainly  
11 Dr Hanrahan thinks that that should have happened.  
12 I don't think there was any disagreement amongst the  
13 clinicians who have given evidence that certainly  
14 a discharge letter to the GP ought to have happened,  
15 and, more to the point, they said that the practice was  
16 that the GP would receive a phone call because sometimes  
17 it took time for the discharge letter to be produced.  
18 So just so that the GP was alerted to what had happened  
19 and had information that he could assist the family with  
20 if the family came and saw the GP.  
21 Dr MacFaul, the inquiry's expert, at 250-003-117 at  
22 paragraph 600, says that failure to send the discharge  
23 letter to either Lucy's GP or the Erne Hospital -- he  
24 says that that was a significant deficiency not to do  
25 that, and in his view that was a task for Dr Hanrahan

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1 there were issues about who was in charge of a child,  
2 and it would come to the clinical director.  
3 THE CHAIRMAN: I'm not so sure, doctor, how concerned I am,  
4 because I can see how in any situation a bit of  
5 uncertainty might develop. For instance, if you have,  
6 as in this case, paediatric anaesthetists, a number of  
7 them, who are looking after Lucy and then they call in  
8 Dr Hanrahan -- so the extent to which he becomes  
9 involved influences a decision about whether he becomes  
10 the consultant in charge or not. And it might be  
11 difficult sometimes to identify the point at which his  
12 involvement is significant enough for him to be in  
13 charge or whether he is assisting the anaesthetists, and  
14 then, even if he does become the responsible consultant,  
15 the anaesthetists stay involved obviously because Lucy  
16 stays in PICU. So I can see how the grey area emerges  
17 and I'm sure, when you say that this was an issue when  
18 you were in Boston, that there's nothing novel about  
19 this.  
20 A. No.  
21 THE CHAIRMAN: I think the problem comes primarily  
22 afterwards when, after Lucy dies, there's an issue about  
23 the death certificate. There's an issue about who  
24 speaks to the parents, what the parents are told, and  
25 there's an issue about what the parents are told and,

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1 because of the level of his involvement in the latter  
2 stages of Lucy's care. One of the reasons he says it's  
3 so significant is, he said, because writing a letter  
4 like that offers an opportunity for the treating team to  
5 review the management of a particular case. So that's  
6 an opportunity to again see what happened, what went  
7 wrong, and for learning points to emerge.  
8 I will ask you the question in a minute, but just so  
9 that you have the information. Professor Scally, who is  
10 also an expert for the inquiry, he says that the  
11 Children's Hospital ought to have informed  
12 Sperrin Lakeland in a formal manner, so over and above  
13 the communication with the GP, hospital to hospital,  
14 Trust to Trust, they ought to have informed them that  
15 Lucy had died and that there were concerns among some of  
16 the clinicians as to the quality of the treatment that  
17 she had received in the Erne. Okay? So that's what the  
18 inquiry's experts are saying.  
19 How this comes about is, when we asked Dr Hanrahan  
20 about it, he said, "Well, I didn't think that I had to  
21 do that because I hadn't assumed formal responsibility,  
22 so it wasn't my task". We don't need to pull it up, but  
23 he goes into that in the transcript of 5 June at  
24 page 23. Dr Crean, on the other hand, was of the view  
25 that the responsibility for Lucy's care had indeed

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1 passed to Dr Hanrahan. So then you see the problem.  
2 An important thing that should have happened, so far as  
3 the inquiry's experts say, didn't happen because there  
4 wasn't anybody taking ownership of that particular task.

5 Firstly, how could that problem or that deficiency  
6 come to you? How could you get to hear of it?

7 A. I suppose one or other of those people, the consultants  
8 involved, might have brought it to me, or more likely  
9 somebody in the clerical line who's -- the chart's not  
10 meant to be filed until all the documentation is  
11 complete. One of the problems here is that the child  
12 went for a post-mortem and the notes go to the pathology  
13 department. There had been a historical problem of  
14 notes not coming back in a timely manner, which was  
15 a difficulty for writing timely letters and summaries.

16 But it was standard practice that the notes after an  
17 admission should not be filed, and that was standard  
18 practice in all the wards and departments, as far as I'm  
19 aware, until there was a discharge letter and summary,  
20 and there was a pro forma that had to be completed.

21 Q. We have seen that, yes.

22 A. There should be a letter as well. There were times of  
23 extreme resource constraint where some patients, not  
24 PICU patients, I don't think, only had a handwritten,  
25 self-copying pro forma go because there simply wasn't

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1 A. Correct.

2 MS ANYADIKE-DANES: Does this pro forma on the right-hand  
3 side go out as well?

4 A. Yes, but it goes and gets counted and I'm not quite --  
5 we're sometimes a little uncertain how long this took to  
6 go out. That is why in some people this one on the left  
7 was sent as a holding measure, straight from the ward,  
8 plus a phone call. In the case of a child who died,  
9 I would reiterate that a phone call to the general  
10 practitioner was standard practice.

11 Q. Essential, did you think?

12 A. Yes, essential.

13 Q. And in Lucy's case, from what you know of it, who did  
14 you think should have been making that call?

15 A. I don't feel strongly that -- it didn't need to be the  
16 consultant. Actually, quite often, it was the registrar  
17 or senior trainee on the ward who would make the call.

18 Q. But how does anybody know it's down to them to do it?

19 A. By communication, by discussion about who's going to do  
20 it, and then a note made in the chart.

21 Q. So if a case goes to a hospital post-mortem, so things  
22 get slightly delayed, who is keeping track to make sure  
23 that these things get done? Whose responsibility is it?

24 A. It should be -- it's normally a clerical responsibility  
25 to check that all that documentation when the chart

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1 the clerical support to provide typed discharge  
2 summaries. But that wouldn't, in my view or in my  
3 memory, have applied to PICU patients.

4 Q. Would you agree that a discharge summary is an important  
5 document?

6 A. Yes.

7 Q. Just make sure we're talking about the same thing.

8 061-004-011; is that what you're talking about?

9 A. Well, that's a handwritten version.

10 Q. Is there another type?

11 A. Well, a fully-typed letter. A typed letter which gives  
12 the full course. But at the very least, this should go.  
13 Is that the one you mean? There is another pro forma,  
14 which has self-copying.

15 Q. 061-012-036. There. Is that what you mean?

16 A. Yes. And there's a clerical trail, if you like, for  
17 those, for coding and for statistics and everything.

18 Q. So that we're clear on what you're saying: for a child  
19 who dies in PICU, what goes out to the GP so far as  
20 you are concerned?

21 A. Well ...

22 THE CHAIRMAN: I think what you would prefer to go out, or  
23 what normally went out, was a typed letter, explaining  
24 what had happened, rather than restricting it to a pro  
25 forma; is that right?

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1 eventually comes back. So for a PICU case it would be  
2 the ward clerk or secretary in the paediatric intensive  
3 care unit. For the wards, it would be the ward clerk.

4 Q. Okay. Do you agree or not with what Professor Scally  
5 said, which is that the Children's Hospital should have  
6 informed Sperrin Lakeland Trust in a formal manner?  
7 This is about Lucy's death. And he says that arises or  
8 that requirement to do so arises out of a general  
9 obligation in the case of a death that may have been  
10 caused by inadequate treatment. Then he goes on to say:

11 "And that is re-enforced by the Children's Hospital  
12 role as a regional centre of excellence."

13 We find that at 251-002-017. It's under his  
14 additional observations. If you take 1, this is all  
15 about the role that you had been helping us with earlier  
16 of the Children's Hospital. You see the reference to  
17 being notified in a formal manner under 1. Do you  
18 accept that, that the Children's Hospital should have  
19 communicated that to Sperrin Lakeland?

20 A. Well, that is -- I mean, he's saying that death was due  
21 to inadequate treatment. It isn't always immediately  
22 clear if that's the case.

23 Q. Let's say that it is because --

24 THE CHAIRMAN: Let's suppose it is, doctor. Let's just take  
25 a working hypothesis that it is because I've heard at

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1 least three doctors who say they believed it was. Okay?  
2 But let's assume for the moment that it is the case.  
3 A. So that if it's believed that treatment was  
4 inappropriate or inadequate, then --  
5 THE CHAIRMAN: Or even let's suppose that Lucy didn't die  
6 because of the defective treatment, but that there was  
7 defective treatment. So whether she died or not, if  
8 there is a solid view that there was defective,  
9 negligent treatment in the Erne, do you agree with  
10 Professor Scally that the Royal was under a duty to  
11 formally report that to Sperrin Lakeland Trust in 2000?  
12 A. I wouldn't have been aware of that duty.  
13 MS ANYADIKE-DANES: Well, would you have sought to do it in  
14 such circumstances?  
15 A. If that circumstance was definitely present, then --  
16 Q. Sorry, let me try and give you a scenario.  
17 THE CHAIRMAN: It's okay. If that circumstance was  
18 definitely present?  
19 A. Then I think, as clinical director I would have probably  
20 had to seek the advice of the medical director in doing  
21 so, but that would have been my track to do that, to  
22 say, "Something has gone seriously wrong here, we need  
23 to communicate this formally".  
24 MS ANYADIKE-DANES: Would you have formed the view that even  
25 if you didn't think necessarily perhaps you had you had

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1 referring hospital would do that.  
2 Q. And do they know that that is what is expected of them  
3 by you?  
4 A. I don't know.  
5 Q. Well, how would they know that?  
6 A. Well ... I mean, I ... We always would have -- I'm  
7 sorry, I just need to think about this. We always would  
8 have expected consultants to communicate back to  
9 referring hospitals whatever happened. So I think --  
10 and that regularly happened. I don't know that it  
11 ever --  
12 Q. But how does any given consultant know that is expected  
13 of them, whatever he or she does in their own hospital,  
14 about that death, over and above that that they're  
15 expected to communicate with the referring hospital?  
16 How does any consultant know that?  
17 A. I don't know that they -- that we had a way of expecting  
18 them to do that.  
19 Q. But you're saying that is what you would have expected  
20 them to do.  
21 A. Yes, I'm saying that as part of the communication that  
22 I would have expected them to have with the referring  
23 hospital.  
24 THE CHAIRMAN: I know in this case that there were  
25 discussions between different consultants in the Royal

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1 the authority to do it, would you have formed the view  
2 that you would want to let other trusts know that?  
3 A. Yes, I think so.  
4 Q. Having formed that view then, are you saying you would  
5 take that to your medical director as to how that is to  
6 be achieved or --  
7 A. Yes.  
8 Q. -- whether he accepts that?  
9 A. Yes.  
10 Q. Then if a death is reported to the coroner and there is  
11 going to be an inquest or there's a decision about that,  
12 but the treatment actually originated in the referring  
13 hospital -- so, like Lucy, the child arrives in  
14 a moribund state, in due course brainstem death is  
15 certified, the case is notified to the coroner and  
16 a decision is made, do you think it appropriate that the  
17 referring hospital is told that the case has been  
18 referred to the coroner and also advised as to whatever  
19 is the decision that's made?  
20 A. Yes.  
21 Q. Routinely?  
22 A. Yes, I think so, yes.  
23 Q. And who has the duty to do that?  
24 A. Um ... Well, I would normally expect that the  
25 consultants involved who had communicated with the

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1 and the Erne. There was some toing and froing between  
2 them by phone, but what is not clear is that the Erne  
3 was told that Lucy's death had been referred to the  
4 coroner or what the outcome of that was. I think  
5 there's some suggestion that it did happen, though the  
6 circumstances around it are a bit vague, maybe because  
7 it's so long ago, but you would have expected that to  
8 have happened in any event?  
9 A. Yes.  
10 MS ANYADIKE-DANES: Mr Chairman, I think a break is  
11 required.  
12 THE CHAIRMAN: Doctor, we'll stop until 12.15. Thank you.  
13 (12.03 pm)  
14 (A short break)  
15 (12.20 pm)  
16 MS ANYADIKE-DANES: Dr Hicks, what I'm really trying to do  
17 is to see the extent to which the treatment of Lucy gave  
18 rise to any concerns, now that you have the information  
19 in front of you, as I realise that you didn't have that  
20 information at the time. Because what I'm trying to  
21 explore with you is whether there are things that came  
22 out of her treatment and care that should have come to  
23 you through some system or other, if they are concerns.  
24 All right? So we've been going through a number of  
25 them.

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1 Another one that the clinicians have mentioned  
2 is that they've all, in one way or another, said that  
3 they were unclear about whether they did read all of  
4 Lucy's notes at the time they were actually treating  
5 her, and if they did, some of them recognise now that  
6 they missed certain details in them.

7 One obvious one is in the nursing note. They're not  
8 alone in having missed this, but some of them have  
9 acknowledged that they did. In the nursing note,  
10 there's a sequence of events which allows you to know  
11 when the second set of bloods are taken for the serum  
12 sodium and potassium tests in relation to the  
13 administration of normal saline. So that becomes  
14 an issue because some believed that the sodium result of  
15 127 was actually the result before that happened, and  
16 therefore that was her lowest point, as opposed to  
17 a result that might be affected by the administration of  
18 normal saline. Okay?

19 So all this comes out of some of them conceding and  
20 acknowledging that they didn't look at her notes as  
21 closely as they might and get the information that was  
22 there to be had, or know that they needed to be raising  
23 queries with the clinicians at the Erne. If that comes  
24 to light to you, is that a concern?

25 A. That they're not reading the notes?

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1 Q. From what you have heard about her treatment and her  
2 death, would you agree with that, that that was a case  
3 that should be reported to the coroner?

4 A. From what I know, yes.

5 Q. Is that a process which should give rise to a reviewing  
6 of her notes?

7 A. Yes.

8 Q. Before you do that?

9 A. Yes.

10 Q. And if you're going to do that, can you help us with  
11 this: who does it? Is that something that gets done by  
12 the team who treated her so that they have a general  
13 discussion about what they think happened and then  
14 somebody makes the report to the coroner, or is that all  
15 just down to whichever consultant is going to be the one  
16 to report?

17 A. A consultant in charge should be responsible for doing  
18 that. On occasion, they may devolve some responsibility  
19 for that to a senior trainee, you know a senior  
20 specialist registrar, for doing the post-mortem result,  
21 but it's basically a question of sitting down with the  
22 notes, the charts, with all the information, and going  
23 through them.

24 Q. At this stage I'm not at the post-mortem, I'm thinking  
25 about two of the consultants in charge, one the

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1 Q. Yes.

2 A. Yes.

3 Q. And how would you expect to learn of something like  
4 that?

5 A. I don't know. I'd speculate that they may not have  
6 recognised this until they were giving evidence. In  
7 other words, that what they did was put under scrutiny.

8 Q. But is there not supposed to be a place when a child  
9 dies to put what happened under scrutiny?

10 A. That's supposed to be at the mortality presentation,  
11 at the mortality meeting.

12 Q. Is that where that happens or is there any other place  
13 where that can happen?

14 A. Well, in reviewing the notes for, as we have just heard,  
15 a discharge letter or reviewing the notes for the  
16 post-mortem summary, the summary for the pathologist --

17 Q. Yes.

18 A. -- would be the first opportunity to do that, in which  
19 one would be expected to go right back to the beginning.

20 Q. If we come to that now. Well, maybe there's a step  
21 further, isn't there? You help me if you think there is  
22 one. Because we know that both Dr Hanrahan and  
23 Dr Chisakuta thought that Lucy's death is one that  
24 should be reported to the coroner.

25 A. Right.

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1 anaesthetist and the other, the neurologist, have  
2 decided that this is a death that needs to be reported  
3 to the coroner, so they've decided that and you have  
4 agreed that that's a moment when you start looking  
5 through the charts and forming in your mind the  
6 information you're going to give to the coroner. The  
7 point I was asking you is: is that something that would  
8 be a shared activity, so the two consultants would do  
9 it, or is that something that just the lead consultant  
10 who's going to make the report would do?

11 A. It could be either, but it's more likely to be, because  
12 of time constraints and one thing and another, to be one  
13 consultant doing it.

14 Q. And then in your view, is it a sort of counsel of  
15 perfection to say they review the notes and formulate in  
16 their minds what they're going to say to the coroner, or  
17 is that what you actually expect to happen?

18 A. No, I would expect them to review it. I mean, I should  
19 say at this point, I would expect anyone coming to  
20 a case like this would sit down and review all of the  
21 notes from the beginning when they take on the case. So  
22 it shouldn't be the first time that's done.

23 Q. Yes.

24 A. But certainly if I was -- if you're to ring the coroner,  
25 then I think you need all the information at your

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1 command, so you need to review the case and formulate  
2 why you're ringing him and what your concerns are from  
3 the information you have.

4 Q. Can I now pull up the document I was trying to pull up  
5 to you before, which is the guidance at Altnagelvin by  
6 comparison to that which the Children's Hospital  
7 provides? It is 316-004a-025. If we pull up alongside  
8 that the guidance from the Children's Hospital, which is  
9 319-067A-030.

10 I should say that the information from Altnagelvin  
11 goes over to the other page and we'll look at that, but  
12 you can see that this is a much more detailed guide as  
13 to what happens. Not only does it set out and make it  
14 quite clear that it's a statutory duty, it sets out the  
15 circumstances, more or less capturing the language of  
16 the legislation. Then it gives you some guidance:

17 "Before notifying the coroner, the advice of an  
18 experienced colleague should be sought."

19 Dr Hanrahan had said that he had been a consultant  
20 for only two years before Lucy died, and this actually  
21 was the first time he'd reported a death to the coroner.  
22 He also went on to say, as I've told you, that he had  
23 received no guidance at all as to how to do this. But  
24 this is telling you that you should really seek the  
25 advice of an experienced colleague and:

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1 Q. But presumably the guide is provided because you think  
2 that something over and above that would be helpful?

3 A. Yes.

4 Q. Otherwise, as the chairman pointed out, you wouldn't  
5 have the guide. And the only point is if something more  
6 detailed would be helpful, exactly what that detail  
7 should be, and perhaps warnings as to what you're doing  
8 is actually embarking on something that has legislative  
9 requirements and how this is important, so you should  
10 seek guidance if you're not absolutely sure. All of  
11 that I'm sure people can work out for themselves. But  
12 having it there in a guide just emphasises the  
13 significance of it, would you not say?

14 A. Yes.

15 Q. It also seems to give a very clear-cut thing as to  
16 whether you are reporting a death or whether you're just  
17 maybe seeking to discuss the possibility of it. If you  
18 know the sequence of events in Lucy's case, firstly  
19 neither Dr Hanrahan nor Dr Curtis, who was the assistant  
20 state pathologist, can actually recall the conversation  
21 that they had. That's the first point. And therefore,  
22 neither really knows exactly what was going on during  
23 it. But there is a record made in the coronial office  
24 in the main register of deaths that Lucy's death was  
25 reported and that there is then a description. Have you

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1 "A member of medical staff should also inform the  
2 consultant in charge of the patient. A clinical summary  
3 must be prepared for the state pathologist."

4 That's for when you know that's going to happen.

5 Certainly there seems to be a much greater emphasis  
6 on the seriousness and the detail of what you are doing  
7 in the Altnagelvin guide than you see in the  
8 Children's Hospital guide; would you accept that?

9 A. Yes.

10 Q. Is there any reason why you couldn't have provided that  
11 kind of more detailed guide for the doctors in the  
12 Children's Hospital?

13 A. No. No, I don't think there is. I'm not sure who  
14 prepared the information for the guidelines. I suspect  
15 it may have been the paediatric pathologists, but that's  
16 not to say it couldn't have been done in more detail.

17 Q. Yes.

18 A. Could I add, it's my memory -- and I may be wrong about  
19 this -- that the booklet in which the death certificates  
20 are contained contains all this information.

21 Q. You're absolutely right. There is a booklet and it  
22 contains it in bold at the top, the incidence and the  
23 circumstances or the criteria for reporting.

24 A. So it's there every time you go to sign a death  
25 certificate.

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1 seen that, as to what was being reported?

2 A. No.

3 Q. Okay. Then what else is put down, this is  
4 gastroenteritis, dehydration and cerebral oedema are the  
5 three main things that are recorded there. And then  
6 there is a record that a death certificate may issue.

7 When Dr Hanrahan had formed the view and  
8 Dr Chisakuta agreed with him, to report this to  
9 the coroner, in his view it was because gastroenteritis  
10 is a very rare thing for a child to die of, she  
11 collapsed and became moribund really quite quickly --  
12 she's admitted at about 7.30 in the evening to the Erne  
13 and, by 3 o'clock in the morning, she has her seizure  
14 and she never really recovers from that. So events move  
15 very quickly without very much having been done to her  
16 other than the administration of low-sodium fluids. So  
17 those were the two things that concerned them, but over  
18 and above that, Dr Hanrahan is very clear he had no idea  
19 what the cause of death was. He had some differential  
20 diagnoses, but he had no real idea as to why Lucy had  
21 died, and for those reasons he thought it was  
22 appropriate that he report that case to the coroner.  
23 Would you agree with that?

24 A. That it was reasonable, yes.

25 Q. Yes. What in your view should have happened thereafter

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1 if Dr Hanrahan is given no further information to help  
2 him formulate a cause of death to put on a death  
3 certificate? What do you think should have happened?  
4 THE CHAIRMAN: I'm not sure that question will be clear to  
5 Dr Hicks --  
6 MS ANYADIKE-DANES: Sorry.  
7 THE CHAIRMAN: -- who hasn't necessarily been following  
8 what's been going on here for the last week and a half.  
9 MS ANYADIKE-DANES: I beg your pardon.  
10 THE CHAIRMAN: Sorry, let me try to put it in context: as  
11 a result of whatever discussion took place, it was  
12 decided that there would be no coroner's inquest and it  
13 was then decided that there would be a hospital  
14 post-mortem instead. Then there was a delay for some  
15 time and the family's undertaker contacted the hospital  
16 from Fermanagh to say that they needed a death  
17 certificate. And at that point, a death certificate was  
18 issued by Dr Hanrahan. It is suggested to me that it  
19 was issued on Dr Hanrahan's instructions, but filled out  
20 by Dr Dara O'Donoghue.  
21 MS ANYADIKE-DANES: So the issue that I'm wondering if you  
22 can help us with is that Dr Hanrahan is clearly of the  
23 view that he doesn't really know why Lucy has died. So  
24 he reports that case to the coroner because, in his  
25 view, he can't write a death certificate at that stage.

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1 I mean, you can't sign a death certificate if you don't  
2 know what the cause of death was.  
3 Q. Yes. In any event, that's not what happens. Without  
4 knowing what the content of the discussion is, what  
5 happens is that it becomes clear that there isn't going  
6 to be an inquest, nor is there going to be a coroner's  
7 post-mortem. And because Dr Hanrahan still is of the  
8 view that he can't write a death certificate, he seeks  
9 a hospital post-mortem in the hope that that can give  
10 him sufficient information. Is that an appropriate use  
11 of the hospital post-mortem?  
12 A. Well, I mean, yes, I don't -- I think in the fullness of  
13 the situation, that might be questionable, but that's  
14 why post-mortems have always been done: to ascertain or  
15 confirm the cause of death and to seek further  
16 information.  
17 Q. When I put that point to Dr Crean, he was very clear on  
18 it, and he said that is not the purpose of a hospital  
19 post-mortem. In his view, you have to be able to write  
20 a death certificate. If you can't write a death  
21 certificate, then it's a report to the coroner. What  
22 the hospital post-mortem can do is for learning  
23 purposes, it can give you more information, clarify  
24 matters, but you need to be able to know the cause of  
25 death. Would you accept that?

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1 Okay? He reports the case, the upshot is that there is  
2 a discussion which neither person can recall what the  
3 content of that discussion is, but the result of it is  
4 there is to be no inquest, there's to be a hospital  
5 post-mortem if the parents agree, and ultimately a death  
6 certificate is written. But where I'm taking you to is,  
7 during that conversation that he has with somebody  
8 at the coroner's office, if he receives no further  
9 information to help clarify what the cause of death  
10 should be, what do you think he should have done as  
11 clinical lead? What would you expect him to have done?  
12 A. Go back to the coroner.  
13 Q. Sorry?  
14 A. Ring the coroner again and possibly get some senior  
15 advice in the hospital. But I think he needs to ring  
16 the coroner. If he'd asked me that day, that's what  
17 I would have told him.  
18 Q. If he had come back to you that day and said, "I have  
19 had a conversation at the coroner's office, I'm still  
20 none the wiser as to why this child died, what do you  
21 think I should do?", what would your advice have been?  
22 A. He should ring the coroner.  
23 Q. And why do you say that?  
24 A. Well, if you don't know why the person has died, if  
25 you're uncertain why someone has died, if you can't --

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1 A. Yes.  
2 Q. So if Dr Hanrahan did not know the cause of death coming  
3 out of that conversation with the coroner's office, he  
4 should not have been agreeing to a hospital post-mortem  
5 in the hope that that will clarify matters for him?  
6 A. Yes.  
7 Q. Sorry?  
8 A. Yes.  
9 Q. He shouldn't have been?  
10 A. He shouldn't have been.  
11 Q. How will he know that? Where does he get the  
12 information that explains these things to him?  
13 A. Well, that's part of undergraduate medical training and  
14 postgraduate medical teaching and experience as you go  
15 along. It's been my own personal experience and  
16 I realise things are different now. I had cause as  
17 a pre-registration house officer to call the coroner and  
18 be involved in these discussions and less often now  
19 perhaps than then.  
20 THE CHAIRMAN: I don't think we need to linger very long on  
21 this because, I'm afraid, what happened was clearly  
22 inadequate. But would it surprise you that Dr Hanrahan  
23 said he hadn't received any undergraduate or  
24 postgraduate training on his responsibilities in  
25 reporting a case to the coroner?

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1 A. It would surprise me.  
2 THE CHAIRMAN: And he also said, which I think is more  
3 directly relevant, that after he joined the Royal,  
4 he was given no instruction or induction about reporting  
5 to the coroner. Does that ring true?  
6 A. I'm not -- I mean, I spoke earlier about the induction  
7 for new consultants being a Trust-wide responsibility,  
8 and I cannot now remember the content of it, although  
9 I did, of course, know at one stage. I would have  
10 expected that, like induction generally, that would have  
11 included statutory duties.  
12 THE CHAIRMAN: Or might it have been assumed that somebody  
13 coming in as a consultant already knew the statutory  
14 duties?  
15 A. There might have been an assumption that you should  
16 already have knowledge of it. Once you're a registered  
17 medical practitioner, it's one of the duties you can  
18 perform.  
19 THE CHAIRMAN: Yes. Is there an issue that if you come in  
20 from outside Northern Ireland where the duties aren't  
21 identical --  
22 A. But he trained in the UK.  
23 THE CHAIRMAN: He did. Thank you.  
24 MS ANYADIKE-DANES: Sorry, that was a question I was going  
25 to ask you. I'm sure there are many who worked in PICU

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1 a child or the factors implicated in the death of  
2 a child, or would you have expected something a little  
3 more?  
4 A. I don't understand what this document is, I'm sorry.  
5 Q. This is the main register of deaths. When a report is  
6 made, as I understand it, to the coroner's office this  
7 is the report that's made. So a report is being made  
8 under the statutory obligation for cause of death and  
9 why the report is being made and this is what's  
10 recorded.  
11 A. Oh, in the coroner's --  
12 Q. This is the coroner's office document. It's called the  
13 main register of deaths.  
14 A. I have no knowledge of documentation within the  
15 coroner's office.  
16 Q. That's not the point I'm asking you. The point I am  
17 making is: one of your consultants, Dr Hanrahan, is  
18 reporting Lucy's death and the only factors from it that  
19 have been recorded are gastroenteritis, dehydration and  
20 brain swelling. What I'm asking you is: does that make  
21 sense just like that or would you have expected  
22 something more to have been communicated?  
23 A. Well, that doesn't follow clinically.  
24 Q. Thank you. And if that's the standard of reporting to  
25 the coroner, would that have been of some concern to

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1 who didn't do all that you are training in the  
2 United Kingdom. For example, Dr Chisakuta, I think his  
3 basic training was in Zambia and Dr Hanrahan's training  
4 was in the Republic of Ireland. What do you do with  
5 those who come from other jurisdictions to make sure  
6 that where their work involves a statutory obligation,  
7 that they recognise and know what it is and what's  
8 expected of them?  
9 A. Well, I think that needs to be taken care of at  
10 induction and during induction training.  
11 Q. And this is part of what you say that the medical  
12 director has oversight of?  
13 A. That's what was in practice at that time.  
14 Q. Yes. What I was looking for and have now found is this  
15 is what was recorded -- and I want to get your take on  
16 it. It's 013-053A-290. This is what's recorded, so  
17 this is actually, apart from a brief insertion into  
18 Lucy's notes, this is all that we have to help us with  
19 what might have been the subject of that discussion.  
20 You see there, as I told you:  
21 "Gastroenteritis, dehydrated, brain swelling."  
22 And then you see:  
23 "Gastroenteritis, DC [which is death certificate]."  
24 Would you have expected that to have been a report  
25 from one of your consultants of the cause of death of

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1 you?  
2 A. If that's what was reported, if that's what was  
3 reported, yes, I think it would, yes.  
4 Q. As would the fact, I presume, that still without having  
5 a clear view on the cause of death, one moves on to the  
6 post-mortem, hospital autopsy? Would that be of concern  
7 to you?  
8 A. Yes, rather than the coroner, yes.  
9 Q. It would be? In terms of the information, if you think  
10 that's inadequate, how much information do you expect to  
11 be given to the coroner's office? Do you have any view  
12 on that?  
13 A. Well, I think it will depend what the situation is. For  
14 example, if you're reporting a death because a person  
15 hasn't been seen by their doctor for 28 days, then  
16 that's fairly straightforward. I don't know whether you  
17 would give more information about that. But in the case  
18 of a somewhat complicated clinical course, then I would  
19 expect to discuss it in some detail.  
20 Q. Would you expect there to be a record of what had been  
21 told to the coroner's office kept at the  
22 Children's Hospital?  
23 A. I would expect a note to be made in the hospital chart  
24 by the person making the -- it's a telephone call ...  
25 Q. And if the decision is there's going to be no inquest,

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1 would you expect the reason for that to be recorded as  
2 well if the clinician had thought that that's what  
3 should happen?  
4 A. Yes.  
5 Q. Just one final point on the report to the coroner.  
6 Dr Carson said in his witness statement -- and we don't  
7 need to pull it up, but the reference is 306/1,  
8 page 3 -- and it's in answer to question 1(e), he says  
9 it was his expectation that:  
10 "If the coroner was notified about a death,  
11 Dr Murnaghan or Mr Walby would be informed by the  
12 responsible consultant."  
13 Did you know that?  
14 A. No.  
15 Q. He didn't tell you that?  
16 A. I don't remember any guidance as regards that.  
17 Q. If that was the medical director's expectation, where  
18 would you expect to find that?  
19 A. Somewhere in some guidance or instructions.  
20 Q. That's what I'm trying to ask. When the medical  
21 director says he has his expectations, this is what he  
22 would like to have done, how does that get communicated  
23 to you as the clinical lead, if that's the relevant  
24 clinical lead, and then on to the clinicians so that  
25 they know they are meeting the expectations of the

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1 like that. Sorry, is that ...  
2 THE CHAIRMAN: Yes.  
3 MS ANYADIKE-DANES: So that would happen, but you just don't  
4 remember it in relation to this --  
5 A. I don't remember it.  
6 Q. If I just ask you about the hospital post-mortem, the  
7 autopsy request form, because I think you were starting  
8 to embark on that before. When there's going to be  
9 a hospital post-mortem, there has to be obviously an  
10 autopsy request form. Who, in your view, should be  
11 filling in the autopsy request form?  
12 A. Either the consultant or a senior member of the team,  
13 junior -- you know, a senior junior doctor in training,  
14 specialist registrar.  
15 Q. For example his registrar?  
16 A. Yes.  
17 Q. So in this case it could be Dr Stewart?  
18 A. Yes.  
19 Q. Would she be sufficiently senior in your view?  
20 A. I think she would have been at that time, yes.  
21 Q. If that task is going to be done, what do you expect is  
22 the process of getting the information that is relevant  
23 for the pathologist?  
24 A. It's a process review of all the information  
25 available: the chart, all the --

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1 medical director? How does that happen?  
2 A. The way that that kind of thing, which was really  
3 a directive, was communicated was to send a written  
4 letter, signed written letter, to every member of staff,  
5 relevant member of staff, to all the consultants, and  
6 probably to all the junior doctors.  
7 Q. And did that happen in your experience?  
8 A. I don't recall that happening.  
9 Q. Do you ever recall the medical director having some  
10 expectation or some requirement that something happen  
11 and that being reflected in writing? Do you have any  
12 experience of that?  
13 A. I don't have any memory of that, no.  
14 Q. Well, how did he generally tell you what he wanted to  
15 happen?  
16 A. He would write.  
17 Q. And that's what I was asking you. You've got no  
18 recollection of him ever having written?  
19 A. I have no recollection of him having written and I have  
20 no recollection of him writing to me as a consultant or  
21 to me as a clinical director.  
22 Q. I don't mean about this point. I mean about anything.  
23 A. We'd get letters saying, "I require you to do this or  
24 this is a duty you need to do", and he would give the  
25 reference. If it was based on DHSS policy or something

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1 Q. If the registrar is doing it, do you expect the  
2 registrar to discuss that with the consultant?  
3 A. Quite often he would. That would not be uncommon.  
4 There would usually be a discussion about it, about who  
5 was going to do it. If the consultant was asking the  
6 registrar to do it and the registrar had any questions  
7 about it, they would ask.  
8 Q. Was there any training or guidance provided as to how to  
9 do that?  
10 A. Well, I have trouble remembering exactly whether there  
11 was anything, but I -- we did have sessions with the  
12 neuropathologists and possibly even the pathologists,  
13 speaking to us. I have a feeling there was a document  
14 about that, but I cannot -- I just cannot remember the  
15 details. Certainly in the neurology teams we had  
16 a weekly meeting and, once a month, there was  
17 a neuropathology review session, and from time to time  
18 they would cover other topics and one of them would be,  
19 you know, revising information or reminding people.  
20 Quite often, these topics were reviewed once a year when  
21 there was a new intake of trainee staff.  
22 Q. The accuracy of the summary, the clinical summary that  
23 gets sent, is something that you'll recall was an issue  
24 in Claire's case.  
25 A. Yes.

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1 Q. In this case it's not entirely clear that the notes,  
2 charts, went with the autopsy request form or with  
3 Lucy's body to the pathology department. So far as  
4 you're concerned, who has the responsibility for making  
5 sure that the pathologist has the information that is  
6 necessary?  
7 A. Well, the pathologist has the responsibility for  
8 ensuring they have all the information they need. So  
9 for example if the pathologists found they came to it  
10 and hadn't the notes, I would expect a phone call very  
11 rapidly to find out what had happened to them.  
12 Q. Do you expect at the clinical end for whoever's  
13 preparing this report, or somebody else for that matter,  
14 to routinely send the charts either with the autopsy  
15 request form or with the body?  
16 A. Well, this wasn't always so. Initially, when I was  
17 practising, it didn't happen and I can't remember the  
18 date when it became a requirement. But the pathology  
19 department insisted on that and quite rightly so  
20 I think.  
21 Q. So if they haven't gone for any reason, your expectation  
22 is that somebody from the pathology department should  
23 say, "Where are those notes?"  
24 A. Yes, "Where are those notes?", and you find where they  
25 were and you would get them couriered over.

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1 A. If you were putting them in order of importance, you'd  
2 put them in reverse, probably. To me, I don't quite  
3 understand why it says in order of importance. The  
4 important thing is to get all the information down and  
5 the pathologist can work on that.  
6 Q. Sort out what's important?  
7 A. Yes.  
8 Q. Did I understand you to say that what might have gone in  
9 there was some reference to the fluids?  
10 A. Yes.  
11 Q. Thank you. Then if we come to the medical certificate  
12 of cause of death itself, which is 013-008-022.  
13 That's the medical certificate of cause of death and  
14 it's signed by Dr Dara. He says he was asked to do that  
15 by Dr Hanrahan. Dr Hanrahan has conceded that  
16 essentially he made the decision that a death  
17 certificate could be issued.  
18 There is some guidance on the issuing of the death  
19 certificate, in particular a text was prepared or  
20 published by the coroner, along with Mr Greer. It's  
21 called "The coroner's law and practice in  
22 Northern Ireland". What it says at paragraph 3-07 is:  
23 "Where a medical practitioner believes a death is  
24 reportable to the coroner, a death certificate should  
25 not be issued unless, having reported the death and

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1 THE CHAIRMAN: Because they can't do their job unless they  
2 have the relevant information?  
3 A. Well, I think that's right.  
4 THE CHAIRMAN: Yes.  
5 MS ANYADIKE-DANES: Then if I pull up this for you,  
6 061-022-075. One of the reasons why I was asking you  
7 about any guidance on this is because Dr Stewart said  
8 she didn't have any guidance in it. What the form asks  
9 you to do is to put the clinical problems in order of  
10 importance. That's what it actually states. What she  
11 did in fact was to put the clinical problems in the  
12 order of their presentation. So Lucy starting off with  
13 vomiting and diarrhoea, becoming dehydrated, then she  
14 has hyponatraemia and then she's got seizure and  
15 unresponsiveness.  
16 So far as you're aware from what happened in terms  
17 of Lucy, does that list of problems there capture  
18 matters or do you think it could have been expanded  
19 upon?  
20 A. I think it's good as a summary. It's clear there's  
21 an issue about the fluids which could have been  
22 included.  
23 Q. You think at that stage it might have been helpful to  
24 put an issue about the fluids or rehydration or  
25 something?

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1 discussed the circumstances, the coroner directs that  
2 a death certificate may be issued."  
3 Were you aware of that in 2000?  
4 A. I was aware -- I'm sorry, I may have to ask you to say  
5 that again.  
6 Q. Let me give you it again. It's a direct quote from  
7 their textbook. It says:  
8 "Where a medical practitioner believes a death is  
9 reportable to the coroner, a death certificate should  
10 not be issued unless, having reported the death and  
11 discussed the circumstances, the coroner directs that  
12 a death certificate may be issued."  
13 A. I think there may be some circumstances where that can  
14 happen, where the medical practitioner is uncertain  
15 about the circumstances, because I've had experience of  
16 that happening --  
17 Q. Of what happening?  
18 A. Of ringing the coroner and them saying that -- going  
19 through it and saying, "That's okay".  
20 Q. Yes, sorry, the point I'm trying to get at is what that  
21 text seems to suggest is that once you have made the  
22 report, the decision is not your decision; it's  
23 the coroner who will make the decision.  
24 A. I was aware of that.  
25 Q. The reason I ask you that is because we asked

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1 the coroner about the decision over the issue of the  
2 death certificate. In his witness statement 277/1,  
3 page 7, he says:  
4 "The decision about the issue of the death  
5 certificate was made by Dr Hanrahan."  
6 What you have just described is: if you have  
7 reported it to the coroner, in your view it's  
8 the coroner who makes the decision, not the clinician.  
9 A. Yes. And that's normally -- my experience, which is  
10 some time ago, would be the last words would be,  
11 "Doctor, you can write the death certificate".  
12 Q. So if that doesn't happen and Dr Hanrahan takes it upon  
13 himself to issue the death certificate or, rather, the  
14 medical certificate of cause of death, would that  
15 concern you that he thought it was possible for him to  
16 do that, assuming that to be an accurate statement of  
17 the law?  
18 A. What concerns me is there's still not clarity of the  
19 accurate cause of death, yes. That would really --  
20 THE CHAIRMAN: That's a bigger issue. It's not whether  
21 the coroner has given the say-so because on the  
22 information which seems to have been in the air  
23 in April 2000, the coroner was not taking the case for  
24 a coroner's inquest. If Dr Hanrahan understood that to  
25 be the case, then he may have thought he could go ahead

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1 not completely explicit.  
2 Q. There are two things I wanted to ask you about that.  
3 One is, if Dr Hanrahan's view is, "I don't really know  
4 why Lucy died, I don't really know what her cause of  
5 death is". That's the first point I want to put to you.  
6 If he is in that state, would it concern you that he  
7 nonetheless directed and guided Dr Dara, his SHO/acting  
8 registrar, to issue the death certificate; would that  
9 concern you?  
10 A. Yes.  
11 Q. So that concerns you. If we come to what is actually on  
12 the death certificate. You said that you have no  
13 difficulty with the cerebral oedema because that is  
14 actually why she died. But then you have:  
15 "... due to or as a consequence of dehydration due  
16 to or as a consequence of gastroenteritis."  
17 What if anything concerns you there?  
18 A. Well, dehydration often causes -- gastroenteritis  
19 commonly causes dehydration, but that does not commonly  
20 in and of itself -- and many children die worldwide from  
21 gastroenteritis and dehydration still, but they haven't  
22 had abnormal fluids. So they die of dehydration, not  
23 cerebral oedema. So there's something missing.  
24 Q. Yes, something missing. The dehydration didn't  
25 naturally and in and of itself lead to the cerebral

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1 and issue the death certificate without --  
2 A. Despite not knowing the --  
3 THE CHAIRMAN: Well, no, he could issue the death  
4 certificate without the coroner's approval if  
5 the coroner had said he wasn't going to conduct an  
6 inquest. But even if that was the case, then he still  
7 had to know what the cause of death was to put into the  
8 certificate. So isn't that the more important point,  
9 what the cause of death was?  
10 A. Yes.  
11 THE CHAIRMAN: Because that's fundamental to completing  
12 a death certificate.  
13 MS ANYADIKE-DANES: I was just going to come to ask you  
14 that.  
15 THE CHAIRMAN: Let's get to that point.  
16 MS ANYADIKE-DANES: What Dr Hanrahan says is effectively he  
17 never, prior to this death certificate being issued,  
18 actually was clear about the cause of death. So does  
19 that concern you, that in those circumstances he  
20 nonetheless guided Dr Dara in having this death  
21 certificate issued?  
22 A. One of the things, if I may say, is that as a cause of  
23 death, cerebral oedema is quite acceptable, and actually  
24 that is what was her ultimate cause of death. The  
25 problem is the process or the course to that, that it is

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1 oedema?  
2 A. No.  
3 Q. No.  
4 A. And I can't think of any way that it would really.  
5 Q. In fact, that particular cause of death sequence has  
6 been described by the inquiry's experts as being simply  
7 illogical.  
8 A. Yes.  
9 Q. Are you concerned that a consultant directed his acting  
10 registrar to issue a death certificate with that cause  
11 of death?  
12 A. Yes.  
13 Q. And if that had come to your attention, what would you  
14 be wanting to do about that?  
15 A. I think we would have had to investigate how it had  
16 happened and the case.  
17 Q. What I had been putting to both Dr Stewart and Dr Dara  
18 is, if you put the intervening step that would link the  
19 dehydration to the cerebral oedema, which most of them  
20 seem to think is an inappropriate rehydration therapy  
21 regime, in other words something to do with the fluids,  
22 that then becomes an iatrogenic act, and that's the  
23 problem about issuing a death certificate without going  
24 back to the coroner.  
25 A. Yes.

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1 Q. So does that concern you that essentially what happened  
2 is that a death in which human error or human  
3 intervention is implicated is not disclosed on the death  
4 certificate, the death certificate is issued and nobody  
5 knows any more about that aspect of it until some  
6 considerable time later on, and that only inadvertently?  
7 Is that not a worry for you?  
8 A. Yes.  
9 Q. We're going to come to in a minute to where Lucy's death  
10 might be discussed. Wherever it was discussed, if there  
11 is a proper discussion of her death, would you have  
12 expected that to have come out?  
13 A. This?  
14 Q. Yes.  
15 A. Well, no, I would expect a full discussion. You would  
16 have got all the other information.  
17 Q. What I mean by that is, the medical certificate of cause  
18 of death is no longer on the file. It's gone so that it  
19 can go to the registrar. But would you have expected  
20 the fact that this was recorded as the cause of death to  
21 have come out in any proper review of Lucy's case?  
22 A. Yes.  
23 Q. And if that had come out, would you have expected there  
24 to have been a discussion as to how can that possibly  
25 be?

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1 Q. What has custom and practice been?  
2 A. Custom and practice has been, if there was to be any  
3 delay in the autopsy, in a consented autopsy, then you  
4 would go ahead and write the death certificate as here.  
5 But in general, things are set up so that the autopsy is  
6 done as soon as possible, the very next day, and there  
7 is an imperceptible delay because normally the body and  
8 the certificate are released when the undertakers come  
9 to collect the remains, the following day, which is not  
10 usually significantly delayed over when it might have  
11 happened anyway.  
12 Q. Well, in this case, what that sequence produced was --  
13 A. Sorry, if I could just add, the only delay is a case  
14 where you didn't have an autopsy and you were able to  
15 sign a certificate and give it to the family right there  
16 and then.  
17 Q. Yes. What happened here first is that there is  
18 a provisional anatomical summary, which was on 17 April,  
19 so that was very soon after her death. She died on the  
20 14th --  
21 THE CHAIRMAN: She died on the 14th. The autopsy is carried  
22 out, there's a provisional anatomical summary, and then  
23 the autopsy report becomes available in --  
24 MS ANYADIKE-DANES: In June, 13 June.  
25 A. Yes, we wouldn't wait for that.

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1 A. Yes.  
2 Q. Then I wanted to ask you a little bit about timing, and  
3 we had sort of almost got into that, which is that  
4 Professor Lucas, the inquiry's expert, is concerned  
5 about timing. In his view, the death certificate should  
6 not follow after the autopsy. It's pretty much what  
7 Dr Crean was saying. In fact, he regarded that as being  
8 irregular, inappropriate and possibly, he said, "an  
9 infringement of the law". 252-003-011.  
10 You see it almost in the middle of the page:  
11 "To apparently wait for the autopsy before writing  
12 the death certificate is (at least) inappropriate and  
13 possibly an infringement of the law ... It requires the  
14 treating doctor to sign and give forthwith to  
15 a qualified informant the certificate. The wording  
16 in the Northern Ireland legislation is even clearer than  
17 that in the English. Medical practitioners have a legal  
18 duty to provide, without delay, a certificate of cause  
19 of death. So the proper sequence is as per the  
20 historical standard practice: the death certificate is  
21 completed before commencing the process of obtaining  
22 a consented autopsy."  
23 Would you accept that?  
24 A. I accept that's what he says. I mean, it hasn't been  
25 what custom and practice has been.

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1 Q. The anatomical summary doesn't actually take matters  
2 very much further forward than the summary that's  
3 provided on the autopsy request form, and it didn't, for  
4 that matter, in Claire's case either. They relied very  
5 heavily on that clinical summary. So why would you be  
6 waiting for that anatomical summary? Why don't you just  
7 write the death certificate? Not you personally, but  
8 why isn't that the order of things?  
9 A. I suppose just in case something transpires that you --  
10 Q. But in case something transpires you tick the box of  
11 death certificate saying that if something transpires  
12 you will provide it, which is box A, which in fact was  
13 ticked for Lucy and, for that matter, was ticked for  
14 Claire. So what are you waiting for?  
15 A. I suppose you're waiting for the information from the  
16 anatomical summary, from the actual procedure.  
17 Q. Well, you see, what Professor Lucas says is that -- as  
18 I say, to some extent Dr Crean's evidence agreed with  
19 him. He says that's just the wrong way round and there  
20 are potential dangers in it. He's not suggesting that  
21 any of those led to anything in Lucy's case, but he says  
22 that there are potential dangers in it.  
23 Dr Crean's evidence, as I told you, was you either  
24 can write your death certificate, in which case you do,  
25 or you can't write your death certificate, in which case

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1 you go to the coroner's office. The autopsy, the  
2 post-mortem, is not intended to help you with that.  
3 It's intended for learning and so forth if you have  
4 a hospital post-mortem, but not to give you the cause of  
5 death; you're supposed to know that.

6 And where Professor Lucas goes on about the  
7 potential concerns over that is over the next page.

8 Having said he finds it increasingly bizarre, he  
9 says -- can we have the two pages side by side?

10 Thank you. You see he talks about it being bizarre.  
11 Then he says:

12 "It perverts the whole coronial referral system for  
13 unnatural death for following a consented autopsy more  
14 people, i.e. including the pathologist, could more readily  
15 conspire to hide a genuine unnatural death from public  
16 notice. The usual process -- a natural death  
17 certificate or a referral to the coroner -- makes the  
18 doctors think promptly about why someone died and what  
19 to do next."

20 And he regards it as a very serious issue which  
21 should be examined in more detail.

22 So in his view, you've got to be able to write  
23 a death certificate that does not trigger any of the  
24 criteria for referring to the coroner. In other words,  
25 if that death certificate had been accurate in the way

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1 saying that one always waited for the gross pathology to  
2 write a death certificate; on occasion you might write  
3 it straightaway. I'm not aware of that having changed  
4 during my time of clinical practice, although there were  
5 discussions, more discussions about probably -- maybe  
6 about the time all of this came to light about referrals  
7 to the coroners and how death certificates should be  
8 completed, the timing of them.

9 Q. Can you see the point Professor Lucas is making?

10 A. I can, yes.

11 Q. That hadn't struck you before?

12 A. No.

13 Q. When the post-mortem result comes back, Dr Hanrahan very  
14 fairly says even that actually didn't help me formulate  
15 a cause of death because it was unclear what exactly was  
16 being discussed there.

17 If one looks at two pages side by side, 061-009-016  
18 and alongside it 017, please. So the commentary section  
19 talks about what the results show. Then if we go over  
20 the top of 017, it says:

21 "The autopsy also revealed an extensive  
22 bronchopneumonia. This was well developed and well  
23 established and certainly gives the impression of having  
24 been present for some 24 hours at least."

25 Then he talks about the swabs taken from the lungs

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1 that you say, then that would have triggered a report to  
2 the coroner, you couldn't have proceeded any further  
3 with it, and that's the sort of thing Professor Lucas is  
4 concerned about. He says you've got to write it first  
5 and not wait for whatever might come out of the  
6 post-mortem. Do you have any views on that?

7 A. Well, I can appreciate the points he's making and I'm  
8 not sure whether the practice that was in place is still  
9 in place.

10 Q. Well, let me help you. We have the guidelines from the  
11 Royal College of Pathologists. If we pull up  
12 319-025bc-015 and highlight that bit where it says  
13 "Consented post-mortems". In particular you can see:

14 "If you agree to a consented post-mortem  
15 examination, the doctors [this is being directed towards  
16 the pathologists] will issue the medical certificate of  
17 death before the post-mortem so that you can proceed  
18 with the arrangements for the funeral."

19 So that's the order of things in that guideline. So  
20 if it was the practice in the Children's Hospital to do  
21 something different, can you help us with when it became  
22 that practice and who, if you know it, was in charge of  
23 it being that way?

24 A. The practice I've described was in place from when  
25 I qualified, that way of describing things, and I'm not

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1 were unsuccessful and didn't grow:

2 "There is no doubt that this pneumonic lesion within  
3 the lungs has been important as the ultimate cause of  
4 death, the changes being widespread throughout both  
5 lungs. The pneumonia could be possibly prior to the  
6 original disease presentation, but equally could have  
7 been induced during the time of seizure and collapse."

8 So if you were reading that, would you have been any  
9 the wiser as to actually what had caused Lucy's death?

10 A. Well, I would still have thought it was the swollen  
11 brain.

12 Q. It is, but what had led to that?

13 A. Not really.

14 Q. Does this scenario of bronchopneumonia, at whatever  
15 stage it was instigated, help you understand why she had  
16 cerebral oedema and coned?

17 A. No. I don't -- no.

18 Q. What should have happened once a post-mortem report  
19 comes back like this that you can't understand?

20 You have seen the CT scans. In your view they're clear,  
21 they show that she had cerebral oedema and coned and so,  
22 for that matter, does the -- there's a description of  
23 the fixation of the brain. That also refers to that.

24 If we pull that up very quickly.

25 THE CHAIRMAN: It's okay, we need to push on. When a report

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1 comes back in that form, which doesn't actually tell you  
2 what led to the cerebral oedema, what's an appropriate  
3 step to take?  
4 A. It's to get out the chart and go through it all again  
5 and review it. If necessary, with the team, to have  
6 a discussion with the pathologists and certainly to  
7 discuss it at a mortality meeting.  
8 MS ANYADIKE-DANES: That is what Professor Lucas and  
9 Dr Squier, when they were dealing with the brain-only  
10 hospital post-mortem in Claire, described as  
11 clinicopathological correlation.  
12 A. Mm-hm.  
13 Q. That there would be discussions between the pathologist,  
14 who has got as far as he can get, and between the  
15 clinicians, who have their own views and treated the  
16 child, and from those discussions should emerge  
17 a clearer idea, if it can be done, as to why the child  
18 and how the child died; would you accept that?  
19 A. Yes.  
20 Q. And from your point of view, when is the place or what's  
21 the forum for the clinicopathological correlation?  
22 A. The forum is a meeting with the relevant clinician and  
23 pathologists and all the other -- as many other  
24 clinicians, and ideally pathologists as can be present.  
25 Q. Should that happen routinely or only in problematic

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1 neurological cases where it's not a coroner's issue and  
2 there's still -- it's at the limit of knowledge,  
3 perhaps, but that's a different scenario.  
4 THE CHAIRMAN: Yes.  
5 MS ANYADIKE-DANES: Yes. On your evidence, this one  
6 actually didn't make sense, so that's a different  
7 scenario from feeling you're at the limit of clinical  
8 knowledge.  
9 A. Yes.  
10 Q. If I then turn to the fora where all this might come  
11 out. In your view is this an adverse incident, Lucy's  
12 death?  
13 A. I think, yes, it would qualify as one.  
14 THE CHAIRMAN: I think, doctor, if we're going to get into  
15 that area, we need to break for lunch. Do you mind  
16 if we abbreviate lunch until 2 o'clock; does that give  
17 you time? Thank you very much.  
18 (1.20 pm)  
19 (The Short Adjournment)  
20 (2.00 pm)  
21 (Delay in proceedings)  
22 (2.05 pm)  
23 MS ANYADIKE-DANES: Dr Hicks, I was asking you about the  
24 sequence of things and what I should have pointed out is  
25 what I have pointed out to others: although

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1 cases?  
2 A. No, it should happen routinely.  
3 Q. When I asked Dr Chisakuta that, his view was he had  
4 never attended a meeting like that and didn't actually  
5 know they took place.  
6 A. Maybe he didn't recognise the name clinicopathological  
7 meeting. I think "mortality meeting" is the word that's  
8 used now. Because we would try and do the same thing at  
9 the mortality meeting and certainly at the neurology  
10 rounds, the neurology scenario in the Royal, which is  
11 different from the paediatric one, it was a weekly  
12 meeting and oscillated between neurology, neurosurgery,  
13 and neuropathology, and the neuropathology week was  
14 autopsies, biopsies and a clinicopathological  
15 discussion.  
16 Q. Dr Mirakhr referred to grand rounds; is that what you  
17 mean?  
18 A. Yes, the same, I suppose.  
19 THE CHAIRMAN: If you have that meeting and the cause of  
20 death still isn't clear, what's the next step? I can  
21 put it bluntly to you: do you going back to the coroner  
22 and say: we did a hospital post-mortem and we still  
23 don't know why this child died?  
24 A. I think, yes. In that circumstance. There are still  
25 some cases where they're medically-complicated

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1 Professor Lucas had that view about that sequence, it's  
2 not a view that another expert of the inquiry had. Her  
3 name is Dr Keeling. She did a background paper for the  
4 inquiry titled "Dissemination of information gained by  
5 post-mortem examination following the unexpected death  
6 of children in hospital".  
7 In the course of that she expressed a view on that  
8 sequence and we can pull it up. It's 308-020-299.  
9 That's the citation that happens at paragraph 11, she  
10 says:  
11 "When a post-mortem has not been instructed, a death  
12 certificate may be issued by the responsible clinician  
13 on instruction from the coroner or by the clinician [and  
14 this is the part of it] taking into account information  
15 from the pathologist when a hospital post-mortem has  
16 been performed."  
17 So that would suggest that, in her experience, it is  
18 possible to wait for the hospital post-mortem. So there  
19 are two different views about that and obviously we're  
20 going to ask Professor Lucas to comment on it. But in  
21 any event, I think your evidence to the chairman had  
22 been that it's something that should be done promptly;  
23 would you accept that?  
24 A. Yes.  
25 Q. The actual timing we had is that Lucy dies on 14 April

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1 and her death certificate is eventually written on  
2 4 May. So that's very nearly three weeks. Can you  
3 comment on whether you think that's an appropriate  
4 period of time?  
5 A. That seems a delay to me.  
6 Q. That seems too long?  
7 A. Yes.  
8 Q. In fact, it would seem that what actually prompted it  
9 then is that the family were getting in touch with the  
10 hospital, not because the clinicians themselves took  
11 a decision, let's issue the death certificate, it was in  
12 response to a query from family members. So we don't  
13 exactly know how long they were waiting for, but whatever  
14 it was, you think three weeks is a bit too long?  
15 A. Yes. I would normally expect it to have happened the  
16 day of the post-mortem. At the bottom of that form you  
17 showed me that Dr Stewart had completed, there's a place  
18 for a telephone number to where the interim results of  
19 the gross findings will be telephoned to. I think, as  
20 I put in my witness statement -- and that's normally  
21 what would happen. After that discussion with the  
22 pathologist and the consultant in charge, they would  
23 write the death certificate -- or not, I suppose.  
24 Q. Thank you very much. So then I think I had just asked  
25 you, when we broke for lunch, whether you would have

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1 confused, could it happen then?  
2 A. Well, it could have. It wasn't designed for that to  
3 happen, which made it difficult to use, but it could  
4 have, I think.  
5 Q. And could it be the result of any review meeting that  
6 there might be -- for example, at the mortality  
7 meeting -- that it's reported as an adverse incident?  
8 A. Yes.  
9 Q. If a death is reported as an adverse incident, what are  
10 the consequences of it?  
11 A. Well, it would be followed up through a process. The  
12 form is completed and copies go to various places,  
13 a copy goes -- well, this is what came in -- I'm not  
14 sure exactly when it started because there was quite  
15 a lot of training and so on required about it. But  
16 a copy of the form would go to the clinical director and  
17 a copy of the form would go to the risk management  
18 office.  
19 Q. So you would have seen the form?  
20 A. Yes. Presumably. Presumably, if it had been an  
21 anaesthetist filling it in, they would have sent it to  
22 me rather than the clinical director of ATICS.  
23 Q. Once the form gets received, what happens then?  
24 A. You decide the action. I just cannot remember the exact  
25 details of the process, but the action will depend on

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1 expected Lucy's death to have been reported as an  
2 adverse incident.  
3 A. I think, taking into account all the findings of the  
4 case, yes. You know, the problem is that the issue of  
5 the fluids related to another hospital.  
6 Q. I was going to ask you about that. If you have a death  
7 in the Children's Hospital which would seem to relate to  
8 treatment from the referring hospital, what do you do  
9 about that?  
10 A. Well, I'm not sure what they're doing now.  
11 Q. What did you do in 2000?  
12 A. The incident reporting system was undergoing change at  
13 that time, if I recall right. We'd had a really very  
14 inadequate system of reporting clinical incidents, which  
15 was really underused, and a new reporting system came in  
16 somewhere around that time, I'm not exactly sure where,  
17 with an IRI form, I think it was called.  
18 Q. Yes.  
19 A. And even though that was inadequate for some  
20 circumstances, that's the form that you had to advise  
21 people, to use to trigger the adverse incident process.  
22 Q. If an adverse incident had not been reported pretty much  
23 at her death, but the post-mortem report had been  
24 received and it was thought that that really didn't  
25 advance matters and things were still really quite

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1 what the nature of the incident is because most  
2 incidents are in, comparison to this, relatively  
3 trivial, but they would need to be investigated in one  
4 or another way. For an incident like this, then the  
5 clinical director would need to undertake to set up an  
6 investigation, probably in liaison with the medical  
7 director.  
8 Q. Yes. As you've said, the treatment, the substantive  
9 treatment actually happened in a different hospital.  
10 Even if that's the case, is there still some merit from  
11 your point of view of looking at the circumstances for  
12 learning in your own hospital, even though those  
13 deficiencies didn't happen in your hospital?  
14 A. Mm, I think there is.  
15 Q. There is still?  
16 A. Yes.  
17 Q. And if you do that and you come out with some views, how  
18 does that, if at all, get transmitted to the referring  
19 hospital?  
20 A. I'm not sure what the system would be because I don't  
21 actually recall the system, even as it was latterly when  
22 I finished, including explicit guidance on that point.  
23 It may have been there. I simply don't remember.  
24 Q. I understand. I don't want to press you if you're  
25 unclear about it, but can you ever recall that

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1 happening, that as a result of an investigation like  
2 that, a decision was taken that we should really  
3 communicate some of this to the referring hospital?  
4 A. My mind's a bit of a blank about that. I'm sure there  
5 will have been. It won't happen often, obviously.  
6 I can't think of a specific example, I'm afraid.  
7 Q. When you say it wouldn't happen often, is that because  
8 the circumstances are just rare when you receive a child  
9 who dies in circumstances where the treatment that is at  
10 issue all really happens at the referring hospital, or  
11 is it because there's a certain reluctance to be seen  
12 perhaps to be critical?  
13 A. Well, I think there would have been a reluctance,  
14 certainly at that time.  
15 Q. In 2000?  
16 A. In 2000, to institute a critical incident report  
17 regarding another hospital. That's not to say people  
18 might not have done something individually. But to  
19 trigger the mechanism, I think people were still  
20 reluctant to do that, and the process of training and so  
21 on about that was ongoing for some time.  
22 Q. Were you aware of a group called the Critical Incident  
23 Review Group?  
24 A. Um, I probably -- is that within the Royal?  
25 Q. Yes, it's within the Children's Hospital. Dr Chisakuta

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1 and it was left, it would appear, to the clinicians  
2 themselves as to whether they thought it was an incident  
3 that should be reviewed. Would you have thought that  
4 sort of self-reporting -- not necessarily about  
5 yourself, but reporting in that way adequate if you're  
6 trying to establish a system?  
7 A. I think certainly nowadays that wouldn't be seen to be  
8 adequate, I suspect, because all the systems for review  
9 are strengthened and increased over what they were then.  
10 At the time it was a significant change in how things  
11 had been before. I would have seen it, I think, as part  
12 of an incremental process that would need to be built  
13 up.  
14 Q. So you're refining it and developing it?  
15 A. Yes, and it was led, obviously, by the Trust executive  
16 and by the department, and their indications about --  
17 and I suppose the law, the statutory duty of safety and  
18 so on.  
19 Q. Who was in charge of developing that whole system?  
20 A. Well, there was a clinical -- there was a Trust clinical  
21 risk committee, I think, or risk management committee  
22 led by the medical director. So they would, I think,  
23 have been in charge of doing that.  
24 Q. Was that something you had anything to do with?  
25 A. I was part of that committee, but I had great trouble --

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1 was a member of it and then latterly became a chairman  
2 of it.  
3 A. Yes, I do recall that when this whole process of  
4 critical incident reporting came in I initially, as  
5 clinical director, sort of led and then found that  
6 I simply couldn't do it, there was too much involved in  
7 reviewing it. So I believe it was Dr Chisakuta who  
8 undertook to lead that on behalf of the directorate at  
9 that time. I don't remember the name, but --  
10 Q. That's apparently what it was called. He said they  
11 looked at them periodically, sometimes weekly, the  
12 deaths that had happened, and in a multidisciplinary  
13 way.  
14 A. Yes.  
15 Q. That was part of it. He happened to be the clinician on  
16 it, but the intention was to see what lessons might be  
17 learnt out of the scrutiny of what had happened. But  
18 that couldn't happen unless a critical incident form had  
19 been completed and sent in, and he said no matter how  
20 much one might think so, unless you did it yourself or  
21 somebody else sent in a form, it didn't get to the group  
22 for them to consider it.  
23 A. Yes.  
24 Q. He also went on to say there wasn't actually any  
25 definition of what was an appropriate critical incident

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1 one of these things when you have a busy clinical load,  
2 timing of meetings is sometimes impossible and I think  
3 Dr Chisakuta took over from me in attending that because  
4 I simply could not make it to all the meetings because  
5 of clinics and things.  
6 Q. I understand. Let's go on to the mortality meeting.  
7 That is a system that has been ... Sorry, just before  
8 we do that, on the adverse incident reporting, what  
9 steps did you take to ensure that your staff knew what  
10 they were required to do and in what circumstances they  
11 were required to do it?  
12 A. When that system was introduced, there was a series of  
13 training sessions which people -- which was  
14 a requirement to go to, as I recall. You had to sign up  
15 to go to it and you were chased if you didn't go. At  
16 that, there was a process of -- it was probably a half  
17 day or possibly a full day's session. It wasn't simply  
18 half an hour. You were taken through the new form and  
19 the process of reporting it and what was involved in it.  
20 Q. What was the system for monitoring and evaluating that  
21 that was all working as it ought to?  
22 A. This was led from the central trust department, and  
23 I think they would have had the information from the  
24 directorates about how that had gone, making sure that  
25 everyone had attended, and also producing reports on

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1 clinical incidents and the outcomes.  
2 Q. Just so that I see the line of reporting, this is  
3 a system that gets put in place, there's training  
4 sessions so that people know what an adverse incident is  
5 and in what circumstances they're to report it and how  
6 they are reporting it. So all that is done and that is  
7 its own little system. The oversight of that system,  
8 help me with how that is achieved.  
9 A. Again, that would be through the Trust clinical risk  
10 management committee -- I believe this is how it was by  
11 my memory -- led by the medical director, who would  
12 report to the Trust board.  
13 Q. I don't want to be asking you things that you think are  
14 not really within either your recollection or what you  
15 took to be your remit. Are these issues more for the  
16 medical director?  
17 A. He was in charge of the risk management, as it were,  
18 within the Trust, so all the directorates reported to  
19 him.  
20 Q. And then on risk management there's an accountability up  
21 to the board, is that?  
22 A. Well, presumably to the chief executive --  
23 Q. Yes.  
24 A. -- and to the board.  
25 Q. And ultimately, because you said it's department-led,

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1 the meeting.  
2 Q. And so who is invited to these meetings in relation to  
3 the cases that are going to be presented?  
4 A. Everyone on the paediatric directorate, all the  
5 consultants, the junior medical staff and the, so far as  
6 I know, the qualified -- the senior nursing staff are  
7 expected to attend, certainly the medical staff are all  
8 expected to attend. So the notice of the meeting goes  
9 out to all wards and departments, to all consultants and  
10 all junior doctors.  
11 Q. So you'll know there is going to be a mortality meeting,  
12 but how do you know whether it's going to involve one of  
13 the cases in which you were involved?  
14 A. Because you'll get a separate notice with the names of  
15 the cases. I think the names of all the cases, in fact,  
16 and who was involved, so as soon as you get that, if you  
17 notice that you are not available for that meeting,  
18 you'll let them know to put it off to a different  
19 meeting or, if you are available, you'll start gathering  
20 the information, the notes. For example, in our cases  
21 we often wanted to look at brain imaging, so we would  
22 like a radiologist present, and also make sure the  
23 pathology is going to be available, and quite often  
24 certainly I would have discussed any cases of mine with  
25 the relevant -- the radiologist, the pathologist, but it

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1 ultimately is this something that gets reported back to  
2 the department, how that system is working?  
3 A. I think there was an annual risk management report  
4 generated.  
5 Q. Thank you very much. Then if we go to the mortality  
6 meeting, that's a system that's been in existence for  
7 some time, before Lucy's death; would I be right in  
8 saying that?  
9 A. Yes.  
10 Q. Can you explain exactly, so far as you understood it as  
11 clinical director at that time, what that system  
12 involved?  
13 A. That involved a part of the monthly audit session, which  
14 was a half-day session, on a rolling calendar, in  
15 general being devoted to -- the first half of it usually  
16 was devoted to mortality presentations and the  
17 administration of this was managed through a secretary  
18 in PICU who kept the statistics, through the clerical  
19 department, on deaths and liaised with the audit  
20 coordinator, who was one of the clinicians in the  
21 directorate, about the presentation of cases, and that  
22 involved them having the notes, seeing who the  
23 clinicians were involved, listing the cases, seeing  
24 which ones had post-mortems and so on, listing the cases  
25 for presentation and then drawing up the timetable for

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1 was the audit coordinator's responsibility, and his  
2 secretary, to make sure that those people got a notice  
3 of the meeting and were invited to attend and had the  
4 relevant information.  
5 Q. Yes. Dr Taylor was the chairman of those meetings.  
6 A. He was, yes, for a while.  
7 Q. We asked him about that, its purpose. In his oral  
8 testimony, when he was giving evidence in relation to  
9 Claire, he says:  
10 "It's not an examination of the death; it's a review  
11 of the cause of death in the Children's Hospital so that  
12 the doctors may learn that the case has been concluded  
13 and this is the final outcome of the cause of death, and  
14 that helps to educate the doctors present that a child  
15 with, in this case diabetes or hyponatraemia, has died  
16 within the hospital."  
17 Is that what you understood was the purpose of the  
18 mortality meeting?  
19 A. The purpose -- yes. It's a teaching exercise and also  
20 information about children who have died.  
21 Q. You see, the way that Dr Taylor has cast that is on the  
22 basis that you already know what the cause of death is.  
23 So you know what the end point is, you know why the  
24 child has died. What you're trying to see is: how did  
25 that happen so that we can learn from that, make such

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1 changes to practices, or whatever it is that is  
2 necessary, with a view to reducing the chances of that  
3 happening again?  
4 A. That would be one of the --  
5 Q. So if, as in the case of Lucy, you get to that stage,  
6 which was at August of that year, and the consultant  
7 still doesn't know why she died, how do you move forward  
8 in a mortality meeting?  
9 A. Well, one of the ways of moving forward is for the case  
10 to be just presented in detail so that everyone can, as  
11 it were, apply their experience and knowledge to it.  
12 Q. Yes, but when I had asked Dr Taylor about that, he said  
13 a mortality meeting isn't actually the place where you  
14 could do that. Firstly, because you don't actually have  
15 the time to do that. In Lucy's case, there were five  
16 deaths scheduled to be presented that day. And he said  
17 that's not the place where you can start having  
18 a clinical debate about what the actual cause of death  
19 might be. That's the place where you start thinking:  
20 right, the child died like this, so perhaps we should  
21 change our systems in this way or that way. And that's  
22 why I've asked you the question. If you get to the  
23 stage where the mortality meeting has been scheduled and  
24 the presenter, the child's consultant has to say,  
25 "I still don't know why this child died", what do you do

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1 Q. It should do?  
2 A. Yes.  
3 Q. Is that in and of itself a thing to be reviewed as to  
4 how the death can have got to that stage without anybody  
5 knowing?  
6 A. Yes.  
7 Q. Or at least without the consultant knowing?  
8 A. Yes, I think so.  
9 Q. In those circumstances, would you expect to hear of  
10 a case like that?  
11 A. Yes.  
12 Q. And if you've heard about it, what do you do about it?  
13 A. If you have heard about a case like that where there are  
14 unanswered questions, there's something not right about  
15 it, then I think you have to trigger a -- undertake to  
16 trigger an investigation by yourself, probably in  
17 consultation with the medical director or the director  
18 of --  
19 Q. Which could be an ad hoc investigation really?  
20 A. Yes. It could be set up to investigate that particular  
21 case and have it reviewed.  
22 Q. Yes. Leaving aside that instance, I can pull up the  
23 attendance sheet, which is 319-023-003. The only person  
24 on that sheet who seems to have had anything to do with  
25 Lucy's care was Dr McKaigue, and he was the receiving

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1 about a case like that?  
2 A. Well, if that happens at the mortality meeting, then in  
3 a circumstance where you feel you should know why the  
4 child died, in other words not one of these complicated  
5 cases I have talked about where, after an enormous  
6 amount of investigation, you still don't understand the  
7 disease process, it's some odd thing, then that needs to  
8 be looked at further.  
9 Q. What would be the way in which that could happen?  
10 A. Well, that could be done by the pathologist or the lead  
11 clinician or the audit coordinator could undertake that  
12 or another clinician in the specialty perhaps.  
13 Q. Could that itself lead to a review into the child's  
14 case, the fact that you have got to that stage? By that  
15 time you would know that there's no coroner's inquest,  
16 the death certificate -- we've had a hospital  
17 post-mortem, we've got a death certificate. You would  
18 know that you're at the end point of those sorts of  
19 investigations or opportunities for investigation. Does  
20 that of itself trigger in some way a review into the  
21 case for how we could have got to this stage and the  
22 consultant who was in charge of her care doesn't  
23 actually, from his point of view, really know why she  
24 died?  
25 A. It should do.

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1 consultant paediatric anaesthetist. You can see his  
2 signature on the left-hand side about halfway down.  
3 There doesn't seem to be anybody else there who had  
4 anything to do with Lucy's case. And that's why  
5 there's -- and nobody, I have to say, can actually  
6 remember it being presented at a mortality meeting.  
7 So there's some concern that maybe there wasn't one.  
8 In your experience, you're there, I should say, but you  
9 didn't have anything to do with her case. In your  
10 experience, who presents at the mortality meeting?  
11 A. Either the lead consultant or their experienced junior,  
12 specialist registrar, can do it on occasion.  
13 Q. And if for some reason neither of those people can  
14 attend, what happens to the case then?  
15 A. It should be put off until a meeting where they can  
16 attend.  
17 Q. Would you be surprised about a mortality meeting going  
18 ahead in relation to a case where the senior clinicians  
19 who had been involved were not present?  
20 A. I would think it highly unlikely. I can't see how  
21 it would happen, really.  
22 Q. And if it was put off, who is in charge of making sure  
23 it comes back on again?  
24 A. It should go back on to the books in the -- audit  
25 coordinator and the secretary, so that they will

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1 reschedule it.

2 Q. However that happens, in your view this is a case that  
3 ought to have been presented at a mortality meeting?

4 A. Yes.

5 Q. And whenever it happens, if it did happen, in terms of  
6 the things to be discussed, given what you may now know  
7 of the case, would you even get into the adequacy of the  
8 notes that had come, that had been sent from the  
9 referring hospital? If there is concern about whether  
10 they're clear, coherent, would that be an issue that's  
11 likely to be discussed?

12 A. It's difficult to discuss things that happened elsewhere  
13 when those people aren't there to participate in the  
14 discussion, but it probably can happen to a certain  
15 degree, but it probably wouldn't --

16 Q. If it impacted on people's understanding or formulation  
17 of what had happened, is that something that could be  
18 discussed?

19 A. Yes.

20 Q. There is differing evidence on it, but some of the  
21 paediatric anaesthetists are of the view that they had  
22 a concern about the fluid regime at the Erne.  
23 Dr Hanrahan said he didn't because, in his view, her  
24 sodium didn't fall low enough for him to have a concern  
25 like that. But Dr Chisakuta, Dr Stewart, their view was

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1 or audit coordinator could agree to raise that with  
2 other teams. One of the circumstances I remember is we  
3 used to discuss some newborn babies who had surgical  
4 problems and it was very difficult to discuss those  
5 meaningfully because we never had the neonatal team or  
6 the obstetricians present and we spent some time trying  
7 to improve that so that we could agree how to do that  
8 because there would be -- I mean, perhaps relatively  
9 minor, but nevertheless important aspects of care and  
10 coordination of care that would come up or did come up.  
11 So that would be one example.

12 It turned out to be very difficult to do. I think  
13 a separate meeting had to be convened to do that. But  
14 you would need to agree -- I mean, the clinical director  
15 wasn't always -- couldn't always be at the audit  
16 meeting, so in a way it was the -- I would have thought  
17 it was the audit coordinator's responsibility to bring  
18 it to the clinical director if he or she wasn't already  
19 aware of it and they could agree how it could be taken  
20 forward.

21 Q. Dr Taylor had told us that he established a group called  
22 the Sick Child Liaison Group, which he would keep you  
23 in the loop about, and that was a group actually that  
24 was designed to take things from outside the hospital to  
25 the district hospitals.

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1 that that was current, that people were concerned about  
2 the fluid regime at the Erne.

3 If that was the view of those clinicians, is that  
4 something that you would expect would be raised at  
5 a mortality meeting?

6 A. Yes.

7 Q. And if when it was --

8 THE CHAIRMAN: Sorry. I don't think we need to go through  
9 all of the issues because I think in general terms the  
10 sorts of concerns and issues which have emerged over the  
11 last week and a half of evidence should be raised in  
12 some form or another at the mortality meeting, shouldn't  
13 they? What emphasis is given to them is different to  
14 some of the perhaps less serious ones, and that is a  
15 matter for conjecture, but the significant issues we've  
16 been discussing for a week and a half should be raised;  
17 would that be fair?

18 A. Yes.

19 THE CHAIRMAN: Thank you.

20 MS ANYADIKE-DANES: If I can ask you just a few things from  
21 your witness statement. As clinical director, how would  
22 you have expected learning from the audit and mortality  
23 meetings to be disseminated to the wider clinical teams?

24 A. You mean outside Children's? Well, if something had  
25 arisen that involved other teams, the clinical director

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1 A. Mm-hm.

2 Q. Was there any kind of liaison or relationship between  
3 any of the fora for reviewing cases or investigating  
4 cases in the Children's Hospital to get into the Sick  
5 Child Liaison Group and thereby find its way  
6 disseminated to the district hospitals?

7 A. Well, that could come up because Dr Taylor would report  
8 to the directorate group or sub-directorate group, so he  
9 would report issues to that group if they arose, and  
10 particularly from -- as would a number of other people  
11 about various things. We tried to make sure that  
12 we were represented so we could feed back and then  
13 determine how that could be taken forward.

14 Q. But was this something that you, as clinical director,  
15 were actually trying to use as a channel for getting  
16 learning from the Children's Hospital out to the  
17 district hospitals?

18 A. Yes. That would have been one of the ways to do that.

19 Q. Was it intended to have that role?

20 A. I think that was one of the roles, and also to improve,  
21 if you like, communication and combined working so that  
22 people outside and inside worked together, communicated  
23 regularly about problems, not simply when the acute  
24 event happened.

25 Q. And outside of a case-specific review, if I can put it

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1 that way, was there any kind of forum where, in  
2 a multidisciplinary way, with you involved, senior staff  
3 and managers within the children's services -- I'm  
4 thinking perhaps of clinical leads, senior nurses,  
5 directorate managers -- could actually meet and discuss  
6 issues? Was there a forum for that?  
7 A. We met every week.  
8 Q. That was the meetings you had every week?  
9 A. Yes, we had the sub-directorate meetings, and we  
10 sometimes had directorate workshops where we would take  
11 a day out. That tended to be for sort of larger  
12 development issues rather than day-to-day problems. Our  
13 weekly meeting covered a huge agenda of ongoing things  
14 to do with all aspects of the directorate.  
15 Q. And would those weekly meetings be minuted?  
16 A. They were, yes.  
17 Q. In your time they were minuted?  
18 A. Yes.  
19 Q. And what happened --  
20 A. They were note-type minutes.  
21 Q. I understand. What happened to that? When you or the  
22 group has discussed something and reached a view as to  
23 how something might be taken forward and improved, what  
24 happens to that?  
25 A. It would depend what it was. For example, as in the

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1 which I would send to the audit coordinator and also the  
2 head of the clerical end because there were various  
3 things in it.  
4 Q. What about something like staffing? One of the issues  
5 that we've heard about, certainly from Dr Hanrahan, is  
6 a concern about the staffing in the PICU and there was  
7 a lot of pressure on the anaesthetists there, and that  
8 might have had an effect on the amount of time that  
9 could be devoted to the sorts of things you would like  
10 to perhaps see, which is more consideration of notes,  
11 better recording, those sorts of issues that fall by the  
12 way if you're really desperately trying to treat  
13 patients because you have inadequate resources. Is that  
14 the sort of thing that could come to you?  
15 A. Well, it would. There was time set aside for this. The  
16 audit time was protected, that clinical work was  
17 suspended, non-urgent clinical work was suspended for  
18 a time every month so people couldn't say they didn't  
19 have time so, that people had time to do that, sit down  
20 and do the preparation and have the meeting. Staff were  
21 all under pressure, and there's no doubt the  
22 anaesthetists were under pressure and the nursing  
23 staff -- we had a constant ongoing project to get ICU  
24 beds staffed nursing-wise with the Eastern Health Board  
25 and the department and the Regional and Medical Services

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1 case of Dr Carson writing to all the consultants,  
2 I might do that about a particular issue. We might  
3 agree that I would write to all the consultants, send  
4 out a memo to all the consultants -- ultimately, some of  
5 it was done by email, but quite often -- and certainly  
6 initially -- it was done by a memo or an actual letter  
7 to everyone outlining what the issue was and what we  
8 wanted to be done.  
9 Q. And what level of detail could they go down to? Let's  
10 say that you had a concern about the standard of record  
11 keeping and you had seen a number of cases go through  
12 and you were a bit concerned about that. Is that  
13 something that the group could decide, yes, we do need  
14 to standardise a few forms here. Is that something you  
15 could take forward?  
16 A. That was done. Case note review was done as part of the  
17 audit time, and a report was generated. We all filled  
18 in a pro forma. Now most of the paediatricians used a  
19 BPA or Royal College pro forma, which covered  
20 inpatients, and certainly in our unit -- and I think  
21 they were similar -- the ward clerks randomly selected  
22 notes and we sat down and we completed them. We took  
23 a pile each, went through them, filled in the pro forma  
24 and then had a meeting where we went through it all to  
25 outline the problems. I would then generate a report

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1 Consortium. So there's no doubt that people were under  
2 pressure. But from the point of view -- there was  
3 protected time. What we didn't have in audit was any  
4 significant resource to help administer it, and this is  
5 why I think, unfortunately, things sometimes went by  
6 the wayside, like not bringing a case back when it  
7 should have been brought. That may have happened,  
8 I don't know that that happened.  
9 Q. You mean what you didn't have sufficient of was resource  
10 to manage the governance process?  
11 A. Yes. That's right.  
12 Q. I understand. And then just finally, in certain places  
13 in Lucy's notes and other documents associated with her,  
14 one sees references to hyponatraemia. There's  
15 a reference to hyponatraemia in the history on the EEG  
16 report. It just has as a list, it has "vomiting" and  
17 "hyponatraemia". The reference is 061-032-098. Then,  
18 of course, it's there on the autopsy request form.  
19 That is 061-022-073. There's a reference to it in the  
20 post-mortem report, 061-009-018. And there is also  
21 a reference to it in Dr McKaigue's PICU coding form,  
22 319-019-002. Lastly, it's referred to on the PICU  
23 database at 319-067e-003.  
24 And with those references to hyponatraemia, are you  
25 surprised that Lucy's case wasn't earlier associated

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1 with hyponatraemia?  
2 A. Yes. I think I have to be.  
3 MS ANYADIKE-DANES: Thank you.  
4 THE CHAIRMAN: Any questions from the floor? No?  
5 Mr McAlinden, no?  
6 Doctor, thank you very much. Unless there's  
7 anything you want to say -- and you don't have to say  
8 anything more -- you're free to leave.  
9 A. Thank you.  
10 (The witness withdrew)  
11 SISTER ETAIN TRAYNOR (called)  
12 Questions from MR WOLFE  
13 MR WOLFE: Good afternoon, is it Sister Traynor? Is that  
14 the appropriate address?  
15 A. I'm retired now. That'll do for the purposes of this.  
16 Q. If you prefer Mrs Traynor; is that appropriate?  
17 A. No, no, it's fine.  
18 Q. We begin, Sister Traynor, by asking you to confirm that  
19 you've made various statements and that you wish to  
20 adopt them as part of your evidence to this inquiry to  
21 supplement the oral evidence that you'll give this  
22 afternoon. Okay?  
23 A. Okay.  
24 Q. Let's do that now. You have provided to this inquiry  
25 two witness statements. The first, under reference

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1 A. Correct.  
2 Q. In terms of your employment, you were appointed as ward  
3 manager of the paediatric ward in the Erne Hospital, as  
4 it then was, in September 1991?  
5 A. Correct.  
6 Q. And you continued to work there until 2004?  
7 A. Mm-hm.  
8 Q. What is your current employment, sister?  
9 A. I have now retired.  
10 Q. You have officially retired?  
11 A. Yes.  
12 Q. The job that you took up after the Erne was in something  
13 called Developing Better Services?  
14 A. Yes. I was one of the nurses involved in the new  
15 project for the new South West Acute Hospital in  
16 Enniskillen.  
17 Q. So you were involved in the set-up, the preparatory work  
18 on the nursing side for that?  
19 A. Clinical adviser, I suppose, or assistant in relation to  
20 design.  
21 Q. Very well. I want to ask you some questions about your  
22 knowledge and experience of working with intravenous  
23 fluids, particularly in the paediatric setting, which  
24 would have been the bulk of your experience; isn't that  
25 right?

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1 WS310/1, was provided on 11 March 2013.  
2 A. Yes.  
3 Q. And then very recently -- in fact, I think at the start  
4 of this week -- you provided a short supplementary  
5 statement --  
6 A. Yes.  
7 Q. -- dated 3 June.  
8 A. That's correct.  
9 MR WOLFE: Sir, I trust that has been circulated. I see  
10 people nodding.  
11 You also provided a statement to the Police Service  
12 of Northern Ireland on 21 January 2005.  
13 A. That's correct.  
14 Q. And it is provided to the parties in a redacted form for  
15 various reasons. I want to ask you some questions about  
16 just your background, your qualifications and  
17 experience. Your curriculum vitae is before the inquiry  
18 at 315-006-001.  
19 To summarise, you qualified as a registered general  
20 nurse back in 1986.  
21 A. That's correct.  
22 Q. And subsequently, you undertook the sick children's  
23 nursing qualification --  
24 A. Correct.  
25 Q. -- in 1990?

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1 A. Yes.  
2 Q. Let's take the example of a child coming in with  
3 gastroenteritis. That must have been a very typical  
4 case in the paediatric unit.  
5 A. Mm-hm.  
6 Q. And would you, as a nurse, defer to the medical staff  
7 with regard to the design of a fluid regime for  
8 a particular patient or is that something you would have  
9 comfortably taken on board?  
10 A. No, I wouldn't; it was prescribed by the medical staff.  
11 Q. Right. So it would be for the medical staff to examine  
12 the child and formulate the appropriate fluid  
13 management?  
14 A. Yes.  
15 Q. And over the years, would you have become familiar with  
16 the different types of fluid regime that might be used?  
17 So for example, if a child was dehydrated, that would  
18 require a particular approach as compared with a child  
19 who isn't dehydrated and may simply need maintenance  
20 fluids?  
21 A. Yes.  
22 Q. So you would have been conscious of the difference  
23 between a maintenance regime and a replacement regime?  
24 A. It would have depended on the child's clinical  
25 presentation and any other associated diseases they may

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1 have, so yes. But I was not an expert in any way;  
2 you will have had a general understanding.  
3 Q. It's kind of you to say that. We have asked some  
4 witnesses who provided witness statements to the inquiry  
5 about your expertise because, as we will see as the  
6 questions develop this afternoon, you were asked to  
7 provide some input by Mr Fee as part of his review  
8 process.  
9 A. Yes.  
10 Q. Although whether or not you knew you were contributing  
11 to the review process is another question. But you  
12 contributed, at least so far as Mr Fee is concerned, to  
13 the review process in relation to the issue around  
14 fluids. You say you weren't an expert in fluids?  
15 A. Yes.  
16 Q. You candidly accept that. If I could just put to you  
17 what Dr Anderson has said. He describes you, factually  
18 correctly, as the ward sister and:  
19 "[You] would have had a general experience in fluid  
20 management, but no particular expertise."  
21 Is that fair?  
22 A. That's correct.  
23 Q. And Mr Fee describes you as a children's-trained nurse  
24 with many years of experience, but again I don't think  
25 he would suggest that you're an expert.

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1 receiving fluids which apparently were in excess of  
2 that?  
3 A. It might well have been that I mightn't have been  
4 involved with that child, but maybe on a ward round or  
5 something, or tending to patient care you notice a rate  
6 running and think -- maybe your instinct, you think,  
7 "I wonder what weight that child is?", or that rate is  
8 60 ml an hour for a child that is maybe a baby or  
9 something and think, "That doesn't seem right", and then  
10 I'd go and check it or go and ask, but I wouldn't be  
11 responsible for calculating or prescribing it.  
12 Q. The practice of that time -- and I want to say  
13 specifically the year 2000 -- in terms of maintenance  
14 fluids, the practice was in a lot of the hospitals in  
15 Northern Ireland -- and in particular, it seems, the  
16 Erne Hospital, because that's what we're dealing with --  
17 Solution No. 18 seems to have been the fluid of choice.  
18 A. Solution No. 18 was widely used most of the time until  
19 a U&E result was available and then in some cases they  
20 would have revised what fluid regime you were using,  
21 depending on the child's bloods, maybe. Say a diabetic,  
22 maybe -- depending on the child's condition as well, but  
23 it was always the first choice by paediatricians.  
24 Q. We have just talked about maintenance fluids, can I move  
25 on to something that might be described as a replacement

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1 A. No.  
2 Q. And you agree with that?  
3 A. Mm-hm.  
4 Q. In terms of fluid management, would you have been in  
5 a position to calculate maintenance fluids for a child?  
6 A. I would never have calculated it. I would have had an  
7 understanding of the application the medical staff used,  
8 we had it in a folder or on the treatment room door, one  
9 of the cupboard doors, the regime that the medical staff  
10 used. If I felt that maybe fluids was -- that maybe  
11 a rate was a bit high, I would have questioned it.  
12 Q. Let me put it to you by way of an example. One of the  
13 formulas that's commonly known as the Holliday-Segar  
14 formula, is that something that rings a bell?  
15 A. No.  
16 Q. Let me put it in numbers terms. Up to 10 kilograms in  
17 weight, a child might expect to receive, for maintenance  
18 purposes, 100 ml per kilogram. So over the course of  
19 a day, a 10-kilogram child might expect to receive  
20 1000 ml in maintenance fluid.  
21 A. Yes, that would have been the schedule that they would  
22 have used, yes.  
23 Q. I think what you're telling me is you would never have  
24 had to make that kind of calculation, straightforward  
25 though it is, but you would have noted if a child was

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1 regime? If you like, the textbooks say that when you're  
2 implementing a replacement regime, say in circumstances  
3 where the child is dehydrated, you would need to think  
4 about first of all the type of fluid that would be  
5 applied. And where, for example, you need to give  
6 a bolus, in other words getting the fluid in --  
7 A. Yes, a push-in.  
8 Q. -- fairly rapidly. Pushed in?  
9 A. Mm-hm.  
10 Q. You wouldn't use Solution No. 18 in those circumstances,  
11 you would use normal saline.  
12 A. Correct.  
13 Q. And you understood that?  
14 A. Yes.  
15 Q. In that kind of situation, after getting a bolus in  
16 perhaps, you would then, according to the textbooks of  
17 the time, consider using a more solute fluid, such as  
18 0.45, for replacement purposes; is that something you  
19 had experience of?  
20 A. 0.45 would have been used in maybe some recus cases, but  
21 it wasn't used widely.  
22 Q. Yes. It wouldn't be used for maintenance purposes --  
23 A. No.  
24 Q. -- but it could be used in a recus situation?  
25 A. Yes, but it wasn't something that we would have used on

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1 a regular basis.  
2 Q. Yes. Where you're in this replacement situation, you  
3 need to combine that with a fluid for maintenance  
4 purposes as well; isn't that right?  
5 A. Yes.  
6 Q. So all of those factors are something that you would, as  
7 an experienced nurse, have had some familiarity with?  
8 A. Yes.  
9 Q. Would you have been aware of the dangers of using an  
10 inappropriate fluid for a child or a fluid at too high  
11 a rate or too much of a volume?  
12 A. The type of fluid, say like the No. 18 Solution and the  
13 associated hyponatraemia, I didn't know about in 2000.  
14 But if you give a child too much fluid, certainly there  
15 was risks there.  
16 Q. If I can put it in these terms: it would have been known  
17 that Solution No. 18 didn't contain much salt, much  
18 sodium, it was low in sodium --  
19 A. Yes.  
20 Q. -- and if such a fluid was fed into a child at too fast  
21 a rate or too high a volume, you would be suspicious  
22 that that might cause problems for a child?  
23 A. Yes, if you knew all the details of the child, yes.  
24 Q. I want to turn to the specific case of Lucy Crawford and  
25 your involvement in that. I appreciate that your

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1 Q. I'll put some of the detail to you in a moment, but  
2 a nurse handed over to you and you discovered that this  
3 issue had occurred?  
4 A. Mm-hm.  
5 Q. Also at some time that morning, you got hold of the  
6 notes, certainly the nursing notes relating to Lucy?  
7 A. Yes.  
8 Q. And I want to ask you some questions about that in due  
9 course. Then, and correct me if I'm getting this  
10 chronology out of step, at some point on that morning  
11 you also got an opportunity to speak to  
12 Dr Jarlath O'Donohoe; isn't that right?  
13 A. Yes.  
14 Q. I want to park it there for a while. Is that chronology  
15 right, that nurses spoke to you as part of the  
16 handover --  
17 A. Yes.  
18 Q. -- you then got your hand on the notes, and then spoke  
19 to Dr O'Donohoe?  
20 A. In the nurse's presence, the report was given. Then at  
21 the end of the report the girls stated that Lucy had  
22 been transferred over to Belfast, and I had said, "What  
23 happened?", and, "Let me see the nursing notes", and  
24 when I looked at the nursing notes there was very little  
25 recorded and so I said, "You haven't very much recorded

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1 involvement, compared to some from whom the inquiry will  
2 hear, is in some sense peripheral, but not entirely so,  
3 so you clearly have had conversations with people --  
4 A. Yes.  
5 Q. -- at that time, which are of interest to the inquiry.  
6 Could I just sketch out, if I can, a rough chronology of  
7 what happened to the best of your recollection? Lucy  
8 was admitted in the mid-evening of 12 April 2000 --  
9 A. Mm-hm.  
10 Q. -- and was admitted overnight. You came on duty on  
11 13 April --  
12 A. Yes.  
13 Q. -- for the start of the morning shift?  
14 A. Mm-hm.  
15 Q. And I want to descend into the detail of what you heard  
16 on the morning of 13 April, but it's fair to say that  
17 you heard, shortly after you started your shift, about  
18 a problem overnight and that this poor child Lucy had  
19 been rushed up to the Royal; is that fair?  
20 A. That's correct.  
21 Q. It appears that Staff Nurse McManus was the person who  
22 handed over to you; do you remember that?  
23 A. I couldn't remember -- I know Nurse Swift was there, but  
24 I couldn't remember who the other nurse was. I thought  
25 Nurse Jones had handed over report.

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1 here, given that Lucy was as sick as she was".  
2 Q. I'm going to come to the detail of that.  
3 A. So I discussed that I felt that they hadn't completed  
4 either the nursing kardex or the fluid balance chart,  
5 and I asked them did they wish to consider what they  
6 needed -- to document what had occurred overnight.  
7 I said I will give you a minute or two to think about  
8 that.  
9 Q. When does Dr O'Donohoe come into play?  
10 A. Dr O'Donohoe arrived, I take it now, back from Belfast  
11 at some point mid-morning. I was in the treatment room  
12 doing IV antibiotics.  
13 Q. So he comes in at that stage?  
14 A. Yes.  
15 Q. And I'll want to ask you some questions about that  
16 meeting. The next morning, as I understand it, you got  
17 an opportunity to speak to your line manager,  
18 Mrs Millar, and you made a report to her?  
19 A. Yes, I tried to get her on the morning of the 13th, but  
20 I was unable to obtain her to discuss my concerns with  
21 her, so I arranged then for a morning appointment to  
22 speak to her first thing.  
23 Q. I think the purpose of your supplementary witness  
24 statement to this inquiry was to clarify that; isn't  
25 that right?

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1 A. Mm-hm yes.  
2 Q. In that in our opening to the inquiry, which you would  
3 have read, perhaps, we had suggested that it was as  
4 a result of speaking to Dr O'Donohoe on the 14th --  
5 that's the Friday morning -- that you made the report,  
6 but in fact you spoke to him on the 13th, tried to get  
7 hold of Mrs Millar on the 13th --  
8 A. Yes.  
9 Q. -- but wasn't able to do so for reasons that you've  
10 explained?  
11 A. Yes.  
12 Q. Let me go back then and start at the beginning of that  
13 sequence and ask you this: you can recall receiving  
14 a verbal report from members of nursing staff about  
15 a sick child having been transferred to the Royal; isn't  
16 that right?  
17 A. That's correct.  
18 Q. At that point, were any concerns being expressed to you  
19 by your nursing colleagues?  
20 A. No. There was very limited information given other than  
21 the child had been admitted with diarrhoea and vomiting,  
22 they had had difficulty getting IV access, they had put  
23 up IV fluids, and then she had subsequently had what  
24 I take it to be a seizure and had collapsed and was  
25 transferred out. There was a reluctance to discuss it

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1 a sealed envelope, as was standard practice. I remember  
2 it was Sally McManus who was handing over to me and  
3 Sally told me about Lucy and her transfer to  
4 Sick Children's."  
5 And then the police officer, who was DS Cross, asked  
6 you:  
7 "Do you remember any discussions about the fluid  
8 regime?"  
9 And you say you do not.  
10 A. Mm.  
11 Q. So the reference for that, sir, is 115-020-001.  
12 Were you able to establish the reasons for the  
13 reluctance to ventilate in relation to this issue?  
14 A. No.  
15 Q. You suggest perhaps tiredness.  
16 A. Well, I thought maybe you're tired, but I said you  
17 really need to consider this, and I didn't actively  
18 pursue it that day because I thought, well, there's  
19 something not right here. That was my instinct. But  
20 I thought, well, I'll speak to Mrs Millar and see how  
21 will we proceed with this.  
22 Q. Yes. When you say "there's something not right here",  
23 am I detecting that your sense of that is a combination  
24 of the body language of the nurses, the reluctance to  
25 ventilate, if you like --

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1 further by the staff involved, and I thought at the time  
2 maybe, you know, shock or tiredness, so I said I will  
3 leave you a wee while, and I looked at the card and  
4 said: you haven't got everything documented here, it  
5 doesn't tell me what happened overnight, do you want to  
6 record this, maybe you need to think about it.  
7 Q. And to the best of your knowledge, was anything added to  
8 the notes?  
9 A. No, they declined. I left them and came back. I said  
10 I'll go out and check that everybody else has started  
11 the morning work, to try and keep normal service  
12 carrying on, and I came back in and said, "Have you  
13 anything further to add?", and they say no.  
14 Q. If you can be specific, who were you speaking to at that  
15 point? You have mentioned Nurse Swift.  
16 A. I remember Nurse Swift. I don't remember Sally, to be  
17 honest. I remember Nurse Swift.  
18 Q. And you mentioned Nurse Jones.  
19 A. I thought Nurse Jones had given report.  
20 Q. And just perhaps, if it helps you, if I say that when  
21 you spoke to the Police Service of Northern Ireland in  
22 2005, you told them, if I could read it to you:  
23 "I was told that Lucy Crawford had been moved to the  
24 Royal and I was unaware of her condition. I remember  
25 saying to a nurse to put all records relating to Lucy in

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1 A. Yes.  
2 Q. -- and what you were picking up or not picking up from  
3 the notes?  
4 A. The fact that there was very little recorded and the  
5 fact that they weren't willing to document anything that  
6 had occurred.  
7 Q. Could I ask you this: you have said to us in your  
8 witness statement that, given the seriousness of  
9 Lucy Crawford's condition at the time, you were  
10 concerned about the lack of detail recorded --  
11 A. Yes.  
12 Q. -- as to what was prescribed and/or administered?  
13 A. Mm-hm.  
14 Q. What were you looking at in order to reach that view?  
15 A. The fluid balance chart wasn't completed, yet  
16 Nurse Swift was saying that she had been asked to erect  
17 the fluids at 100 ml an hour.  
18 Q. Could I perhaps put up on the screen -- the fluid  
19 balance chart you referred to, I hope, is 027-019-062.  
20 Is that --  
21 A. Yes.  
22 Q. There was another fluid balance chart associated with  
23 Lucy's time, short period of time, in the ICU at the  
24 Erne. This is the one --  
25 A. That would be the one I would have seen.

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1 Q. So this is the one that, if you like, contained the data  
2 which was relevant to the pre-collapse period,  
3 do you see that --  
4 A. Yes.  
5 Q. -- the collapse happening at about 3 am? So when you  
6 say an absence of detail, was the chart, if you like,  
7 just as we see it now?  
8 A. I feel that there wasn't enough detail. I can't state  
9 that that was definitely that. The totals aren't  
10 totalling, you see.  
11 THE CHAIRMAN: Can you answer it this way? If that is the  
12 chart as you saw it that Thursday morning, what is  
13 detail that's missing?  
14 A. That should be totalled at 400 ml to me rather than --  
15 if you look at the balance, what have I got already, you  
16 would be expecting about 400 ml, there's only "200",  
17 "200", "200". So what did she actually receive? That's  
18 what I was asking them to clearly tell me: what had she  
19 actually been given here?  
20 THE CHAIRMAN: It's completed, but it's not clearly  
21 completed --  
22 A. It's not accurate.  
23 THE CHAIRMAN: -- so you would have to guess by looking at  
24 the total amount of fluid?  
25 A. I didn't interrogate it in detail, but when you glance

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1 in the form that we see it on that morning?  
2 A. The first nursing kardex you put up, the kardex I saw,  
3 had very little written on it, so I don't know when that  
4 was completed, you know, "Admitted via GP with above  
5 history", and a few lines, but not the detail like that.  
6 I don't remember seeing that detail. I wouldn't have  
7 felt then that I had little information.  
8 Q. So the document we see on the left, which is  
9 chronologically --  
10 A. Recorded, yes.  
11 Q. -- the first page.  
12 A. Mm-hm.  
13 Q. And let me, just for the record, identify that again as  
14 027-017-058. You have a feeling that that information  
15 wasn't there in its entirety?  
16 A. No.  
17 Q. And what about the following page?  
18 A. That one, I didn't see that. But the nursing kardex  
19 that I looked at, which is your first one, it had only  
20 about four lines filled out. That is why I asked them  
21 did they wish to record anything further. I don't  
22 recall that.  
23 Q. Right. And plainly, at some point in time, something  
24 further has been recorded. In fact, substantial detail  
25 has been recorded.

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1 at it, you have "200, 200, 200, 100". Normally we  
2 recorded the amount transfused and your running total.  
3 So it was 100 ml/100, 100/200, 100/300, 100/400 is what  
4 I would have expected.  
5 MR WOLFE: Of course.  
6 A. When I asked them what did she actually receive, they  
7 couldn't answer. So that's what I mean: I'm not sure  
8 what she actually got and did she drink anything further  
9 after 9 and 10, you know.  
10 Q. And apart from the fluid balance chart, within the  
11 documents that we have are certain notes made by the  
12 nurses. Did you look at those?  
13 A. The nursing kardex? Yes.  
14 Q. Yes. Just so that I can understand -- let me guess that  
15 what I am going to put up on the screen is the nursing  
16 kardex and you can tell me if I am wrong, 027-017-058.  
17 If I could have that up on the left, followed by 057 on  
18 the right. Is that what you would refer to as the  
19 nursing kardex?  
20 A. Yes.  
21 Q. So that's the narrative, if you like, written out by the  
22 members of the nursing team in relation to what she had  
23 received.  
24 A. Yes.  
25 Q. Was that, to the best of your recollection, available

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1 A. As far as what's demonstrated there, but that to me is  
2 not what I seen.  
3 Q. I think what you have told us so far is this: that you,  
4 if you like, glanced at the notes, hardly studied them  
5 and realised that there was detail that should be there  
6 that wasn't there --  
7 A. Yes.  
8 Q. -- offered the nursing team an opportunity to fill in --  
9 A. Yes.  
10 Q. -- if you like --  
11 A. A chronological event.  
12 Q. -- a retrospective note.  
13 A. Yes.  
14 Q. A retrospective note in your view is entirely proper, is  
15 it --  
16 A. Yes.  
17 Q. -- as long as you make it clear that it is  
18 retrospective?  
19 A. Yes, that you date it "completed after event".  
20 Q. Of course. And was your impression that the relevant  
21 members of the nursing team declined that opportunity at  
22 that time?  
23 A. They both sat and looked at me blankly and so rather  
24 than pushing it further, I said, "I'll leave you to  
25 think about it and come back in", being I suppose

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1 diplomatic in one sense and giving them time to consider  
2 what they want to do.  
3 Q. Is that the time then that these notes were --  
4 A. I don't know.  
5 Q. Did you not go back and check what had --  
6 A. I went back to them and said, "What are you going to  
7 do?", and they said, "We're not adding anything  
8 further". But to me that's not what was there. To have  
9 that amount recorded in that, I would have thought that  
10 was reasonable. But to me, what I looked at had very  
11 little written on it.  
12 Q. And you can't help us then in terms of when these  
13 additional notes were added?  
14 A. No.  
15 Q. You talked, as I say, to -- when you talked to the  
16 police in 2005, you say that you remember directing  
17 a nurse to put all records into a sealed envelope.  
18 A. Yes, that if they were finished, to put it into an  
19 envelope -- it was just the nursing kardex and the  
20 fluid, whatever was there relating to Lucy, not medical  
21 notes -- but I didn't look at them again, they were  
22 sealed, that was it.  
23 Q. Where did they go?  
24 A. I don't know.  
25 Q. You didn't take command of them?

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1 A. No, didn't see any of them.  
2 THE CHAIRMAN: From what you said a moment ago, you would  
3 have expected them to go to Belfast with Lucy?  
4 A. Her medical notes, yes. That's what I believe they had  
5 went with her, but I wouldn't have seen them.  
6 MR WOLFE: I don't have the file out with me, but it's my  
7 recollection that the Royal also received, for example,  
8 the fluid balance chart, the one we've just studied.  
9 A. Yes.  
10 Q. Which, as you say, has problems in it. So plainly, they  
11 were still on your desk at that point in the morning.  
12 They were put into a sealed envelope, you think, and  
13 went off to the secretaries.  
14 A. Mm-hm.  
15 THE CHAIRMAN: Okay.  
16 MR WOLFE: Could I ask you this: apart from recognising, if  
17 you like, the holes in the notes, the notes weren't  
18 complete and allowing the nurses the opportunity to  
19 backfill that if they wished, did you reach any views or  
20 have any suspicions about the relevance of the fluid  
21 regime for Lucy's deterioration?  
22 A. I said to Mrs Millar that I felt that if she had 100 ml  
23 an hour for a number of hours, that may well have  
24 contributed to her collapse.  
25 Q. I'll come on to what you said to Mrs Millar in a moment,

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1 A. I didn't take them, no. I said, "Put all that into  
2 a sealed envelope, please".  
3 Q. Where would they go? Is there a filing cabinet or your  
4 desk --  
5 A. Usually they go to the secretaries, probably for filing,  
6 into the medical notes when the medical notes are  
7 returned.  
8 THE CHAIRMAN: When you were asking for them to be sealed,  
9 was that because you realised that something more might  
10 happen because of Lucy's deterioration and her transfer  
11 to the Royal, or was that a standard instruction on your  
12 part to seal the notes?  
13 A. The leg of those kardexes, if a child was transferred  
14 out and medical notes went with the child, I would  
15 always ask for those sort of notes to be together in an  
16 envelope with the child's name and hospital number on,  
17 so that at least when the medical notes came back, the  
18 nursing kardex and all could be added to the notes.  
19 THE CHAIRMAN: Okay.  
20 MR WOLFE: Just in terms of the medical notes, you didn't  
21 see them at all?  
22 A. No. Not that I recall, no.  
23 Q. And so if that's right, when I refer to medical notes,  
24 you wouldn't have seen the, for example, biochemistry  
25 tests, U&E results?

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1 but just pausing a moment, you saw a chart which  
2 appeared to show and, as the chairman suggests, with  
3 a little bit of guesswork or interrogation, appears to  
4 show 100 ml an hour from in or about 10.30/11.00. At  
5 3.00, then 500 ml of saline is written in.  
6 THE CHAIRMAN: I'm sorry, no, I don't think, to be fair, the  
7 witness hasn't -- I think your complaint is it's not  
8 clear to you from the chart what she received.  
9 A. No, it wasn't clear.  
10 THE CHAIRMAN: What you are then saying to Sister Millar  
11 is: if she received 100 ml an hour, that would be too  
12 much?  
13 A. That's right, thank you.  
14 THE CHAIRMAN: A point I just want to pick up on that is  
15 you have said a few minutes ago that you are generally  
16 alert to what the fluids should be, but you're no expert  
17 in calculating them. Do I take it from that that  
18 whether you're an expert or not, giving Lucy 100 ml  
19 an hour just looks like far too much to you?  
20 A. Yes.  
21 THE CHAIRMAN: Thank you.  
22 A. But I wasn't aware of how dehydrated Lucy was or what  
23 her bloods results were, but yes.  
24 MR WOLFE: Let me put it in these terms -- and we touched on  
25 this a little at the very start: at or around

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1 9 kilograms, coming into the hospital, just a little  
2 over, Lucy should have been on 900 ml per day. Dividing  
3 that up by 24 hours, that's roughly 30-odd per hour.  
4 Is that the kind of thinking you had in your head?  
5 THE CHAIRMAN: Subject to making up for the dehydration,  
6 which would increase beyond that.  
7 A. Yes.  
8 MR WOLFE: Well, there's a dehydration issue perhaps, but in  
9 terms of Solution No. 18, which you knew to be  
10 a maintenance fluid.  
11 A. Mm-hm. You would have expected, if it was just a normal  
12 maintenance and she had no dehydration, and not knowing  
13 what her dehydration was, you would have expected  
14 roughly around 30 ml an hour to be the calculated amount  
15 if it was a normal process.  
16 Q. And are you saying that you recognise that 100 ml of  
17 Solution No. 18 per hour just wouldn't be appropriate?  
18 A. No. It wouldn't have been, to me I felt that was a lot  
19 of -- per hour, that was a lot of fluid to infuse per  
20 hour. What I wasn't equipped with is what her blood  
21 results were and how dehydrated she was.  
22 Q. Did you put across to the nurses in front of you your  
23 concern that that seemed like an awful lot if she did  
24 get 100 per hour?  
25 A. One said 100, another said 80, and I said whatever she

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1 matters with Dr O'Donohoe. And can I ask you about  
2 something one of the witnesses from the Royal College of  
3 Paediatrics and Child Health has brought to our  
4 attention? Could I have up on the screen, please,  
5 WS298/3, page 12?  
6 This is a draft of a report which was compiled by  
7 Dr Boon of the Royal College and Dr Moira Stewart of the  
8 Royal College. Just to put it in context for you, back  
9 in 2002, they came to the Erne to investigate certain  
10 allegations with regards to the, if we put it in general  
11 terms, conduct of Dr O'Donohoe. And you contributed to  
12 that external review by speaking, I think by telephone,  
13 with one of the doctors and in person with the other.  
14 What they have recorded appears to concern your  
15 discussion with Dr O'Donohoe on the morning of  
16 13 April 2000. You can see there that they're saying  
17 that you weren't on duty when the child was admitted,  
18 you saw the nurses the next morning and, by implication,  
19 they didn't express any concern.  
20 Then you reported to the review a conversation with  
21 Dr O'Donohoe when he said to you:  
22 "What are you going to do with the IV fluids your  
23 staff got wrong?". In response, you are recorded as  
24 having said, "Who prescribed the IV fluids?". And then  
25 you have gone on to say to the review that there had

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1 got, who prescribed it and is it prescribed? And then  
2 when I turned the page over, it wasn't prescribed.  
3 Q. So you had also, just for completeness, an opportunity  
4 to look at the prescription?  
5 A. There was no prescription.  
6 Q. If you could take a look at the document at 027-019-063.  
7 A. Yes, but there's no rate.  
8 Q. Let me just unpack what you mean by "no prescription".  
9 This document was available to you on the nursing notes,  
10 was it?  
11 A. On the fluid balance chart, yes.  
12 Q. Yes. Is that the other side of the fluid --  
13 A. That's the other side of the fluid balance chart.  
14 Q. I understand. What you're saying is it's dated, the  
15 type of the fluid is included, it's an IV site, it's  
16 signed off by Dr Malik and Nurse Swift, but it doesn't  
17 become a prescription because it's not complete?  
18 A. It's not complete.  
19 Q. And for it to be complete, you would expect the period  
20 of time for administration, 24 hours, 12 hours or  
21 something like that --  
22 A. And the rate.  
23 Q. -- and the rate? I appreciate that, thank you.  
24 The next stage in the chronology, as we understand  
25 it, is that at some point that morning you discuss

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1 been a nursing error in totalling the fluids, what we've  
2 just looked at in the fluid balance chart presumably.  
3 And you have told the review that:  
4 "[You] felt Dr O'Donohoe was trying to instil  
5 a blame culture relating to the particular case."  
6 Does that record chime with your memory of 13 April  
7 and your conversation with Dr O'Donohoe?  
8 A. No. I didn't even remember having met with them, but  
9 obviously I had. But what I remember clearly from  
10 Dr O'Donohoe on the 13th morning was when he came back.  
11 He swung into the treatment room and asked me, "What the  
12 hell happened here last night?", and I said, "I don't  
13 know, Jarlath, you tell me". He may well have spoken to  
14 me the next day about that, but that day that was my  
15 only conversation with him because he was very -- his  
16 eyes, you know, seemed to be bulging in his head and  
17 he was irate, so I thought, "I'm not going to get into a  
18 conversation with you".  
19 Q. So just to put this into context, this is Dr O'Donohoe  
20 coming into the hospital having been up to the Royal  
21 presumably?  
22 A. Yes.  
23 Q. And you have had your meeting with the nurses, you have  
24 had the discussion about the notes, you're working  
25 in the nursing unit --

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1 A. Yes.  
2 Q. -- and he comes in and expresses himself quite  
3 agitatedly in those terms; is that fair?  
4 A. Yes.  
5 THE CHAIRMAN: Sorry, sister, the note that's on screen --  
6 I understand you saying that you didn't remember meeting  
7 this Dr Boon in 2002, and it's a long time ago,  
8 I understand that. But are you saying that -- Dr Boon  
9 seems to have made this as a note of your conversation  
10 with him. Are you saying that Dr Boon got that all  
11 wrong?  
12 A. No, I am not saying that he's getting that wrong.  
13 I don't recall this here, but I'm not saying that it  
14 didn't happen. What I clearly recall is that statement  
15 from Dr O'Donohoe on the morning of the 13th.  
16 Dr O'Donohoe may have approached me and asked me  
17 about the IV fluids on another day, when I stated that,  
18 but definitely on the morning of the 13th, that was my  
19 only -- that's the only recollection I have of talking  
20 to Jarlath: him swinging in and being irate.  
21 MR WOLFE: The difference of substance between what's  
22 recorded by the Royal College and by contrast what you  
23 tell us in your witness statement and what you have just  
24 said today orally is that while you tell the Royal  
25 College the issue raised by Dr O'Donohoe is about

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1 THE CHAIRMAN: Whether he spoke to you on the 13th along  
2 those lines or the 14th, he did speak to you along those  
3 lines?  
4 A. If I have said that, it must have happened, but I don't  
5 actually recall the detail.  
6 THE CHAIRMAN: Okay, thank you.  
7 MR WOLFE: Indeed -- self-evidently, perhaps -- your memory  
8 of those events would have been better in 2002 when you  
9 spoke to the Royal College than it perhaps is now,  
10 a further 12 years on.  
11 A. Yes, mm-hm.  
12 Q. Clearly, he was irate and you responded to him, perhaps  
13 in the terse terms that it comes across today,  
14 understandably perhaps. Was there an opportunity for  
15 a more developed understanding of his concerns?  
16 A. No, we didn't discuss it further in any great detail.  
17 I thought, when I reported my concerns to Mrs Millar,  
18 that we would have been able to have a full  
19 investigation around it. I reported to Mrs Millar the  
20 next day and then I thought that in due course we would  
21 have a full discussion about it.  
22 Q. But in terms of your opportunity to interact with him on  
23 this issue of what had gone wrong, it seems now, upon  
24 reflection, to have been just that morning; is that  
25 fair?

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1 fluids, it was a more general, "What the hell has  
2 happened here?", expression by the doctor.  
3 A. Yes, that was what I clearly remember: he was agitated,  
4 his eyes were bulging, he had swing in the door, I was  
5 in the process of drawing up an IV, and this is what he  
6 said. I thought: I am not going to engage in  
7 a conversation with you now because you're too irate,  
8 I'll just say, "I don't know, Jarlath, you tell me".  
9 THE CHAIRMAN: In the version that's on screen, I would look  
10 at that and think that Dr O'Donohoe's coming back and he  
11 immediately knew that the IV fluids were wrong. And  
12 when he started to blame the nurses, your response was  
13 to say, in effect, "You prescribed them".  
14 A. Yes, nurses don't prescribe fluids.  
15 THE CHAIRMAN: I know. That's how it reads to me. So in  
16 particular, he's coming in from Belfast, he's tired and  
17 upset about what happened to Lucy and he might be irate  
18 about what happened, so if I can summarise it like this:  
19 he's blaming the nurses and you turn round and say,  
20 "Sure, you prescribed them"; is that a fair  
21 interpretation?  
22 A. Yes, that's a fair interpretation.  
23 THE CHAIRMAN: And that's the gist of what Dr Boon recorded?  
24 A. It is, but that might be the next day that Dr O'Donohoe  
25 spoke to me about that.

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1 A. That's all I really recall. I didn't discuss it in  
2 great detail with him, as far as I can recall. I don't  
3 recall ever sitting and talking to him about it.  
4 Q. Would it be fair to say then that the correct impression  
5 to draw from your evidence is that quite quickly after  
6 his return to the hospital, he was speaking to you about  
7 a problem with the fluids and he was seeking to  
8 understand how that had happened?  
9 A. Yes.  
10 THE CHAIRMAN: He was doing more than that: he was blaming  
11 the nurses and Sister Traynor blamed him.  
12 MR WOLFE: Yes.  
13 Arising out of that conversation, allied to the  
14 concerns that had already been raised for you with your  
15 conversation with the nurses, you sought out Mrs Millar;  
16 is that correct?  
17 A. I tried to speak to Mrs Millar even before I spoke --  
18 before Jarlath came back. So it was as soon as maybe  
19 about 8.30 in the morning when I thought she might be  
20 in, I tried to get her on both her mobile and her  
21 landline, and finally got her secretary some time later  
22 on in the morning, who told me she wasn't available.  
23 Q. If we could have up on screen, please, a short extract  
24 from your witness statement, 310/1, pages 3 and 4,  
25 please. The excerpt starting at the bottom of page 3

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1 recounts your interaction with Mrs Millar. She was your  
2 line manager?  
3 A. She was my line manager.  
4 Q. And in going to her, were you activating, if you like,  
5 a formal procedure?  
6 A. Usually, if you had a concern about something as serious  
7 as this, you would go to your line manager who would  
8 then activate the procedure.  
9 Q. So we understand there's a procedure called a critical  
10 incident?  
11 A. Mm-hm.  
12 Q. That's what you were viewing this Lucy incident as?  
13 A. Yes.  
14 Q. What were the factors in your head, if you like, that  
15 equated this or defined this as a critical incident?  
16 A. Well, any child who collapses and unfortunately passes  
17 away for -- you want to identify what actually has  
18 happened and can we prevent it happening again and what  
19 factors within that could have been avoided and what  
20 remedial actions do we need to take. That's usually  
21 what you would expect out of your clinical incident.  
22 Q. Is it fair to say also that arising out of what you'd  
23 discovered at that point -- and one realises that you  
24 weren't carrying out an investigation -- but you were  
25 suspicious that there was at least a possibility that

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1 going to make a formal report of this?  
2 A. No, I didn't tell him that.  
3 Q. Is there any reason why you didn't tell him that?  
4 A. I didn't see him. My duty was to report my concerns to  
5 Mrs Millar. We don't normally. Normally you have  
6 a meeting then to discuss it. It wouldn't be the norm  
7 to explain, say to anybody, "By the way, I'm doing  
8 this".  
9 Q. Was it your understanding that upon reporting it to  
10 Mrs Millar on the morning of 14 April that this was the  
11 first formal report of it or do you not know?  
12 A. I suppose I was expressing my concerns to her and then,  
13 at that time, the culture was that they then led with  
14 the investigation.  
15 Q. Could I maybe ask the question slightly differently: had  
16 Mrs Millar known before you rapped on her door that  
17 morning that there was an issue here?  
18 A. When I tried to get her the day before and spoke to her  
19 secretary I said that if Mrs Millar phones during the  
20 day, would you tell her that I need to speak to her  
21 urgently, that a child has been transferred out and that  
22 I have concerns about her care.  
23 Q. Right.  
24 A. Whether her secretary told her that or not, I don't  
25 know, but that I needed to see her urgently.

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1 her treatment had impacted upon Lucy in a negative way?  
2 A. Mm-hm.  
3 Q. If we read on here, you recount the history and then  
4 at the top of the page, you say -- and this is what  
5 you're apparently saying to Mrs Millar:  
6 "I stated that I had concerns that the IV fluids  
7 administered, although not recorded or prescribed, may  
8 have contributed to the child's deterioration."  
9 A. That's correct. But I didn't have the full -- I would  
10 have probably said to her, "I don't have all the details  
11 about Lucy, I don't know how dehydrated she was", and  
12 things like that, "but to have fluids at 100 ml an hour  
13 was abnormal".  
14 Q. It appears then, if we can leave that document there,  
15 you did tell her about your conversation with  
16 Dr O'Donohoe.  
17 A. Yes.  
18 Q. We see that at (vi). And what of that conversation  
19 do you think you told her?  
20 A. I explained to her that the fluids hadn't been  
21 prescribed and that Nurse Swift had reported that  
22 that is what Dr O'Donohoe had prescribed, even though  
23 they weren't recorded, and that anyway I was concerned  
24 about that and that he then was irate about the matter.  
25 Q. Can I ask you this: did Dr O'Donohoe know that you were

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1 THE CHAIRMAN: When you went to see her the following  
2 morning, she didn't say, "I've heard a lot about this  
3 already", or anything like that?  
4 A. No, she didn't tell me she knew anything about it until  
5 I made my statement to her and then, sometime later  
6 in the conversation, she then stated that she was  
7 related to them.  
8 THE CHAIRMAN: To the Crawfords?  
9 A. Mm-hm.  
10 MR WOLFE: Apart from your dealings with the nurses that  
11 you've told us about, your brief interaction with  
12 Dr O'Donohoe, which you've told us about, did you have  
13 any conversation with any of the other significant  
14 players, and by that I mean Dr Malik, who had been in  
15 attendance at the child's --  
16 A. No.  
17 Q. Dr Auterson?  
18 A. No. I didn't even know what anaesthetists had been  
19 there, so no.  
20 Q. Could I have up on the screen then just a note of what  
21 has been recorded arising out of your discussion with  
22 Mrs Millar? 036A-045-096 and could we have alongside  
23 that 097, please? This is the form that was completed.  
24 I take it none of that page is in your hand, sister.  
25 A. No.

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1 Q. Did you know that a form was being completed?  
2 A. Well, normally you would fill out a form, or Mrs Millar  
3 would have filled out a form, but normally you would get  
4 a look at it then to say that's in the correct context  
5 or otherwise, but I didn't.  
6 Q. So you were familiar with the process which involved the  
7 clerical exercise of completing a form?  
8 A. Yes.  
9 Q. The usual approach would be to allow you a copy of it to  
10 verify the accuracy of what's been recorded?  
11 A. Correct.  
12 Q. And you have no recollection of that happening?  
13 A. No.  
14 Q. Is that because the form wasn't completed in your  
15 presence? By that I mean --  
16 A. Did she scribe it as I was --  
17 Q. Yes.  
18 A. I don't believe she scribed it, but I know she made  
19 notes on a jotter sort of thing.  
20 Q. And what has been recorded is that, starting at the  
21 bottom left:  
22 "Information provided verbally to E Millar by ward  
23 sister [that's yourself] on 14 April. Child admitted  
24 before day staff went off duty on 12 April. IV fluids  
25 not able to be sited by SHO. Sited by Dr O'Donohoe.

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1 ventilation."  
2 What was your understanding of what would happen  
3 after a report such as you were making?  
4 A. I would have thought there would be, I suppose,  
5 a thorough investigation around the matter.  
6 Q. Were you subsequently informed that Mr Fee and  
7 Dr Anderson were carrying out an investigation?  
8 A. I don't remember much about Dr Anderson, but I remember  
9 being told that Mr Fee was leading on the investigation  
10 because Mrs Millar was related to them, the Crawford  
11 family.  
12 Q. And presumably your intention in going to Mrs Millar was  
13 to put this issue on this kind of formal footing --  
14 A. Yes.  
15 Q. -- so that it would be investigated?  
16 A. Yes. And I also did ask her if there was anybody else  
17 we needed to notify as well verbally. I asked her that,  
18 was there anybody else we needed to notify.  
19 Q. And what were you implying by that question?  
20 A. I was wondering did we need to -- I was asking was there  
21 anybody else I needed to notify, possibly, so she said,  
22 "No, we'll deal with it".  
23 Q. You were to be interviewed by Mr Fee. That interview  
24 took place on 27 April. Were you face-to-face with  
25 Mr Fee for the purposes of that interview?

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1 Later. Child collapsed 03:00 on 13 April 2000, bagged,  
2 resuscitated, transferred ..."  
3 I can't make that out.  
4 A. "To HDU."  
5 Q. Thank you:  
6 "To paediatric ICU Belfast. Concern expressed about  
7 fluids prescribed/administered."  
8 And that's your concern, is it?  
9 A. Yes.  
10 Q. Is that an accurate reflection of --  
11 A. I suppose that's the summary of what we discussed.  
12 Q. Thank you. Is there anything significant or otherwise  
13 that you would have said that hasn't been recorded to  
14 the best of your recollection?  
15 A. Well, I would have said about the fluids not being  
16 prescribed and that there were errors on the fluid  
17 balance chart, and I would have also referred to the  
18 nursing kardex.  
19 Q. And then over the page, it says:  
20 "Child collapsed unexpectedly. Cause unknown.  
21 Consultant paediatrician, consultant anaesthetist  
22 called. Child intubated, transferred to HDU."  
23 And then it says:  
24 "Report from Belfast (verbal to Dr O'Donohoe), that  
25 the child was clinically dead, but still on mechanical

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1 A. Yes.  
2 Q. Did you understand that you were being interviewed as  
3 part of the review process?  
4 A. I can't honestly -- he said we were here to meet, to  
5 generally discuss the issues raised, but Nurse Swift was  
6 with me, so I felt it was quite general rather than  
7 formal.  
8 Q. You told the Police Service of Northern Ireland in your  
9 statement, 115-020-003, that you weren't interviewed for  
10 the review, but you say you recall Mr Fee phoning you to  
11 ask if it was common for 100 ml per hour to be  
12 prescribed, and you remember saying yes, but you were  
13 not specifically thinking about Lucy.  
14 A. Yes.  
15 Q. I just want to get this straight. You can remember  
16 a face-to-face meeting at which Nurse Swift attended?  
17 A. Yes, I remember meeting with Mr Fee and Nurse Swift was  
18 with me, and we were in a very small room because  
19 we were actually sitting quite close together. At the  
20 time I was interviewed by the PSNI, I was quite sick at  
21 that time, so there are some things that maybe I would  
22 have been unclear about.  
23 Q. So just to separate this out: you told the police there  
24 was a telephone conversation with Mr Fee; are you  
25 telling us today that in fact you think there was one

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1 conversation, and it was face-to-face in a room?  
2 A. I believe that I actually met him in the room, but  
3 at the time I maybe thought I'd had a call, he might  
4 have called me again, I don't know.  
5 Q. Okay. Could we have up on the screen, please, the note  
6 that was recorded, presumably by Mr Fee, arising out of  
7 the interview? It's at 033-102-295. As you say,  
8 yourself and Nurse Swift were apparently interviewed  
9 together, which would tend to suggest that it was in  
10 a room as opposed to over the phone.  
11 A. Mm-hm.  
12 Q. And I will read it out so we can orientate ourselves:  
13 "Mr Fee spoke with Sister Traynor, who commented  
14 that the fluid replacement volume was not unusual in  
15 a child of this age, given her condition. She also  
16 stated that there did not appear to be evidence of  
17 overload of fluids. We reviewed the notes again.  
18 Sister confirmed that the rate to be administered would  
19 normally be recorded on the fluid balance chart along  
20 with the type of fluids. Mr Fee spoke to Staff  
21 Nurse Swift ..."  
22 We don't need to necessarily concern ourselves with  
23 that just yet. But in terms of what he's recorded  
24 there, you said in your witness statement to the inquiry  
25 that upon the inquiry asking you questions and referring

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1 A. Pardon?  
2 THE CHAIRMAN: It might have been Nurse Swift who was partly  
3 at fault.  
4 A. In relation to the fluids?  
5 THE CHAIRMAN: Yes. I'm not saying she was at fault, let me  
6 make it clear. If there was a mix-up or confusion on  
7 that Wednesday night, Thursday morning, about how much  
8 fluids Lucy got, Nurse Swift was part of that group --  
9 A. Yes.  
10 THE CHAIRMAN: -- and you were the person who had raised the  
11 issue --  
12 A. Yes.  
13 THE CHAIRMAN: -- but you were being interviewed at the same  
14 time as Nurse Swift.  
15 A. Correct.  
16 THE CHAIRMAN: Does that strike you as inappropriate?  
17 A. It wasn't appropriate and I didn't feel very comfortable  
18 about it. And the conversation that Mr Fee had with us  
19 was actually very limited, so I believed then that there  
20 would be a thorough investigation afterwards. I thought  
21 this was just gathering facts to a certain extent.  
22 MR WOLFE: It is the case that, subsequently, Staff  
23 Nurse Swift provided a written account. You weren't  
24 asked to provide a written account?  
25 A. Not that I recall.

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1 you to this document, that was the first time you had  
2 set eyes on it?  
3 A. Yes. That was the first time that I recall seeing that,  
4 yes.  
5 Q. So you didn't provide a written statement to Mr Fee?  
6 A. Not that I recall, no.  
7 Q. You weren't asked to verify the note that he had  
8 recorded of what you were saying?  
9 A. I don't remember that.  
10 Q. Right. In terms of what he has recorded, is it  
11 accurate?  
12 A. No. In my witness statement I've stated that it's not  
13 accurate. I believe that he asked me, "Was it unusual  
14 to have 100 ml an hour prescribed for a child in  
15 children's ward?", and my response was it may not be  
16 unusual because we admitted children up to 16 years of  
17 age. I couldn't make a comment in relation to Lucy  
18 because I hadn't seen her, I didn't know her percentage  
19 of dehydration and how she was clinically.  
20 THE CHAIRMAN: Do you understand why you were questioned or  
21 interviewed or spoken to, however we describe it, at the  
22 same time as Nurse Swift?  
23 A. I don't.  
24 THE CHAIRMAN: Because on one interpretation of events, it  
25 might have been Nurse Swift who was partly at fault?

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1 Q. Just taking it line by line then. In the first line,  
2 Mr Fee spoke with you, who commented that the fluid  
3 replacement volume was not unusual in a child of this  
4 age, given her condition. So that, you would agree with  
5 me, is a specific reference to the circumstances of  
6 a child of Lucy's age --  
7 A. Yes.  
8 Q. -- who had her condition, which was gastroenteritis. It  
9 doesn't say anything about dehydration.  
10 A. Yes.  
11 Q. Can you recall being asked to specifically address the  
12 factors that were relevant for fluid purposes to Lucy's  
13 case?  
14 A. No. With Mr Fee, this is?  
15 Q. With Mr Fee.  
16 A. No.  
17 THE CHAIRMAN: I think your basic point is you didn't know  
18 exactly what Lucy's condition was or the extent of it.  
19 A. No, and I hadn't seen her blood results or anything  
20 about her.  
21 THE CHAIRMAN: So for you to say the fluid replacement  
22 volume wasn't unusual given her condition is something  
23 which you say to me now would have been beyond you  
24 because you didn't know what her condition was?  
25 A. No.

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1 THE CHAIRMAN: Right.  
2 MR WOLFE: The next sentence is that you also stated that  
3 there did not appear to be evidence of overload of  
4 fluids. Lucy had had quite a high volume of  
5 Solution No. 18.  
6 A. Mm-hm.  
7 Q. And an extremely high volume and, at least according to  
8 the expert report of Dr MacFaul, the inquiry's expert,  
9 an extremely high volume of normal saline --  
10 A. Yes.  
11 Q. -- which had the potential to cause fluid overload.  
12 Again, were you in possession of facts such as she got  
13 400 ml of Solution No. 18?  
14 A. My feeling was that she had got that, but going back to  
15 the fluid balance chart, that it wasn't totally  
16 completed, my comment would have been that there was no  
17 evidence of fluid overload, but if I did make that  
18 comment it's because the fluid balance chart wasn't  
19 accurate. I couldn't have made any comment about Lucy  
20 otherwise, nor did we discuss that. My recollection was  
21 it was the records and the record keeping that was  
22 discussed and whether it was normal for someone to get  
23 100 ml an hour in children's ward, which was possible,  
24 depending on the age.  
25 Q. I'm conscious that you have said it clearly in your

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1 A. No. From what I can recall, he didn't specifically  
2 discuss Lucy. It was quite general.  
3 Q. But in introducing an example of a question, as you  
4 suggest, with 100 ml per hour as its premise, was that  
5 not a clear steer towards asking you to comment on the  
6 appropriateness of such a rate for a child in the  
7 circumstances of Lucy Crawford?  
8 A. No, I didn't read that question that way. I thought  
9 he was asking, "Was it so unusual to have 100 ml running  
10 that it should have rung alarm bells?"  
11 Q. How would you respond now to the suggestion that a child  
12 of her age and her condition should get 100 ml per hour?  
13 A. I would have said it was unusual. That's why I reported  
14 it to Mrs Millar, because I was concerned.  
15 Q. The concern, sister, is that having raised an expression  
16 of worry with Mrs Millar, the note of your meeting with  
17 Mr Fee seems to provide a degree of reassurance to the  
18 review which the Trust was carrying out, which may, on  
19 one view, have been misleading.  
20 A. That would never be have been my intention in any way  
21 and I wouldn't have read it in that way.  
22 Q. During the meeting did you say anything at all about  
23 your worry or concern for Lucy's treatment, the worry or  
24 concern that had prompted you to approach Mrs Millar in  
25 the first place?

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1 witness statement, but you say that the issue that was  
2 posed to you by Mr Fee was a question about whether it  
3 was usual for a patient to have 100 ml per hour. Asked  
4 in that way, that seems a rather loose question to ask.  
5 A. Yes.  
6 Q. In that a patient's case is necessarily influenced by  
7 individual factors; is that fair?  
8 A. Yes, it would be fair.  
9 Q. So in what specific context or in what specific way were  
10 you giving an answer which said 100 ml per hour wouldn't  
11 be unusual?  
12 A. I felt that he was asking that to have 100 ml per hour  
13 running, was it so unusual that it shouldn't have  
14 happened? Whereas if we had some large sturdy boys  
15 maybe up with fluids up running post-op and it might  
16 have been possible, so I got the impression he was  
17 asking me was it so unusual that it should have rung  
18 alarm bells and I was saying, no, it is possible for  
19 children to have that, but it depends on each child's  
20 condition.  
21 Q. Presumably it couldn't have escaped your understanding  
22 that Mr Fee was interested in Lucy Crawford's case.  
23 A. Yes.  
24 Q. Was there none of that in the context to his questions  
25 of you?

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1 A. Like I said earlier, I thought it was just a general  
2 discussion, so he had said you know why you're here,  
3 I think, and then generally led into the business about  
4 the fluid balance chart.  
5 Q. The rest of the note seems to deal with what Nurse Swift  
6 was asked, and she is recorded as stating that they were  
7 advised to administer 100 ml per hour until Lucy had  
8 produced urine; do you see that?  
9 A. Yes, I do.  
10 Q. So the specific facts of Lucy's case, as understood by  
11 Nurse Swift, were laid out on the table; can you  
12 remember that?  
13 A. No.  
14 Q. Could I ask you then about a final conversation or  
15 a final meeting that you would have had?  
16 MR Counsell: Mr Chairman, I wonder if, before we move away  
17 from the document on the screen, the witness could just  
18 be asked these two things? First of all, given the  
19 relative brevity of the note, whether she can recall how  
20 long the meeting lasted, and, secondly, whether she  
21 recalls whether Mr Fee took a note during the meeting.  
22 THE CHAIRMAN: Thank you very much.  
23 MR SIMPSON: Could I add something into that?  
24 THE CHAIRMAN: Could you hold yours?  
25 MR SIMPSON: Absolutely, no difficulty whatsoever.

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1 THE CHAIRMAN: Doing the best you can, can you estimate how  
2 long the meeting lasted?  
3 A. It was very brief.  
4 THE CHAIRMAN: If I said less than half an hour?  
5 A. Definitely.  
6 THE CHAIRMAN: Do you want to bring it down further than  
7 that?  
8 A. Well, his notes obviously are very brief, but my feeling  
9 was -- because I have said a couple of times now that  
10 I felt this was only just a general conversation, it was  
11 that short. From what I can remember, we were no sooner  
12 in until we were out again.  
13 THE CHAIRMAN: Okay. And do you have any recollection about  
14 whether Mr Fee was taking notes?  
15 A. He had a jotter, yes, so he probably wrote some things  
16 down, but he didn't share that with us, that I recall.  
17 THE CHAIRMAN: Mr Simpson?  
18 MR SIMPSON: It's in relation to the second sentence of the  
19 note:  
20 "She also stated that there did not appear to be  
21 evidence of overload of fluids."  
22 I would like my learned friend to tease out exactly  
23 what she recalls, whether that's accurate, and what she  
24 actually said.  
25 THE CHAIRMAN: Yes.

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1 A. That might have been the -- that was the nursing notes  
2 and the fluid balance chart.  
3 THE CHAIRMAN: Okay. The impression I get from that -- and  
4 please tell me if this is right -- is that after  
5 a couple of introductory remarks, you look at the fluid  
6 balance chart and:  
7 "[You] confirmed that the rate to be administered  
8 would normally be recorded on the fluid balance chart  
9 along with the type."  
10 You were making the point earlier on that the rate  
11 to be administered isn't on the chart.  
12 A. It isn't on the fluid balance chart.  
13 THE CHAIRMAN: So Mr Fee has picked that up from you?  
14 A. Yes.  
15 THE CHAIRMAN: And that's specifically by reference to Lucy?  
16 A. Yes.  
17 THE CHAIRMAN: Part of this discussion is definitely about  
18 Lucy?  
19 A. Yes.  
20 THE CHAIRMAN: You look at the fluid balance chart and you  
21 emphasise your point that the rate of fluid isn't  
22 recorded as it should be?  
23 A. Mm-hm.  
24 THE CHAIRMAN: Let's go back to the second sentence when you  
25 are recorded as saying there didn't appear to be

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1 MR WOLFE: Okay.  
2 Sister, you see the second line there?  
3 A. Yes.  
4 Q. The issue of overload of fluids, according to Mr Fee's  
5 note, was something that you were either asked to  
6 comment on or did comment on.  
7 A. Yes.  
8 Q. Can you help us with that? Did you make a comment of  
9 that nature?  
10 A. The comment of that nature related to the fact that the  
11 fluid balance chart wasn't recorded.  
12 Q. Sorry? Say that again.  
13 A. The comment related to the fact that the fluid balance  
14 chart wasn't fully recorded, wasn't totalled. You  
15 weren't sure what she actually had received.  
16 THE CHAIRMAN: That, sister, if I may say so, looks to be  
17 the fourth sentence, where he says -- the note  
18 continues:  
19 "We reviewed the notes again. Sister confirmed that  
20 the rate to be administered would normally be recorded  
21 on the fluid balance chart along with the type of  
22 fluids."  
23 So I might interpret that as meaning that, looking  
24 at the notes again, which -- does that mean the notes  
25 were in front of you, for a start?

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1 evidence of overload of fluids.  
2 First of all, do you remember saying that, and,  
3 secondly, if you did say it, do you know how you got to  
4 that position?  
5 A. My comment related to the fact that the fluid balance  
6 chart was not completed accurately. That is what I was  
7 talking about, not that Lucy didn't receive an overload  
8 of fluids, because if they were running at 100 ml  
9 an hour, she would have.  
10 THE CHAIRMAN: Does that mean then that you couldn't say  
11 whether there was an overload of fluids rather than  
12 there was no overload of fluids?  
13 A. I couldn't say that there was an overload of fluids. At  
14 that time what I recall is we were discussing the fluid  
15 balance chart and that it wasn't accurately recorded.  
16 THE CHAIRMAN: If it's not accurately recorded -- and  
17 you have made the point that it should be 100/100,  
18 100/200, 100/300, and so on -- and it's not recorded  
19 like that, it's not clear to you how much she received.  
20 A. Yes.  
21 THE CHAIRMAN: And your initial complaint to Mrs Millar was,  
22 if she received 100 ml an hour, that's too much, but  
23 you're not sure that she was receiving that because the  
24 record isn't clear?  
25 A. It's not accurate and was that her degree of

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1 dehydration. I wasn't aware of what percentage of  
2 dehydration Lucy had.  
3 THE CHAIRMAN: Okay, Mr Simpson?  
4 MR SIMPSON: Yes.  
5 MR WOLFE: Sir, I know the stenographers have asked me for  
6 a short break. I have about ten minutes to do.  
7 THE CHAIRMAN: Would you mind taking a break for about  
8 ten minutes? We are going to get you finished within  
9 quarter of an hour of coming back and then we will get  
10 back on to the other issues I have to raise.  
11 Thank you very much. We'll resume at 4.10.  
12 (4.00 pm)  
13 (A short break)  
14 (4.12 pm)  
15 MR WOLFE: Sister, just one point before moving on to  
16 discuss your meeting with Dr Kelly, which occurred on  
17 23 June 2000. As it appears on all of the documents  
18 before the inquiry, there was a prescribing error  
19 in Lucy's case in that Staff Nurse Swift would claim to  
20 have heard that she should infuse 100 ml per hour until  
21 the child urinated --  
22 A. Yes.  
23 Q. -- whereas Dr O'Donohoe believed that he had said  
24 a bolus of 100 ml followed by 30 ml per hour of  
25 Solution No. 18. Was that issue, that clear error or

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1 two other purposes of the report: one was to look at  
2 Dr Asghar's letter, which had come in at or about that  
3 time, expressing concerns about Dr O'Donohoe; is that  
4 right?  
5 A. I was aware that Dr Asghar was unhappy with  
6 Dr O'Donohoe.  
7 Q. And the third purpose of the meeting was to discuss your  
8 view of Dr O'Donohoe's professional competence. Could  
9 we have up on the screen, please, the note of that  
10 meeting? It's at 036A-007-013. It's a note which is  
11 substantially redacted because it concerns issues of  
12 competence, et cetera, which are not relevant to this  
13 inquiry.  
14 But the bit that's relevant, about a third of the  
15 way down the page, is this: Dr Kelly took you through  
16 the Lucy Crawford case and outlined the report from  
17 Dr Murray Quinn, consultant paediatrician, Altnagelvin.  
18 If I could pause there. Do you have an independent  
19 memory of this meeting?  
20 A. No.  
21 Q. Do you recall how long it might have lasted?  
22 A. No.  
23 Q. It records there the report of Murray Quinn was outlined  
24 to you. Can you recall ever seeing that report?  
25 A. Never seen the report.

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1 that miscommunication, brought to your attention?  
2 A. Yes, I was aware that Jarlath O'Donohoe had felt he had  
3 stated that and Bridget(?) stating the other, but when  
4 it was raised, I don't know.  
5 THE CHAIRMAN: Is that something that you picked up as these  
6 events went on, or was it something which was discussed  
7 with you at any time during your input into the  
8 investigation?  
9 A. I had an awareness, but I can't recall that we discussed  
10 it --  
11 THE CHAIRMAN: Or where it came from?  
12 A. Yes.  
13 THE CHAIRMAN: Okay.  
14 MR WOLFE: I'm wondering when it emerged during your meeting  
15 with Dr Kelly. Dr Kelly has said to us in his witness  
16 statement that, on 23 June, he met with you to discuss  
17 Dr Quinn's opinion in relation to Lucy Crawford.  
18 Let me ask you this: did you know that  
19 a Dr Murray Quinn had been retained to carry out, if you  
20 like, a paper review or desktop review of Lucy's  
21 management?  
22 A. Yes, I was aware of that, but we hadn't met with  
23 Dr Quinn.  
24 Q. As I say, one purpose of the meeting was to discuss  
25 Dr Quinn's report, according to Dr Kelly. There were

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1 Q. Well, can you help us at all, when it describes the  
2 report as having been outlined to you, what format that  
3 might have taken?  
4 A. Well, looking at this here, it would appear, even though  
5 I don't remember this, that he obviously has discussed  
6 it briefly with me.  
7 Q. Yes, you can see the third sentence where it attributes  
8 to you the fact that you're noting that:  
9 "... Dr Quinn felt it unlikely that the fluid regime  
10 prescribed or the initial management of the child  
11 contributed to the death."  
12 Does that help you at all? Does that suggest you  
13 might have been reading the report and noting that fact?  
14 A. No, I don't remember seeing the report. I was not  
15 actively involved in any of that investigation.  
16 Q. Do you know why you were being spoken to in relation to  
17 this report?  
18 A. Dr Asghar was not happy with Dr O'Donohoe, there were  
19 issues between the two, and I had spoken to Dr Asghar  
20 and said, "If you have concerns, you need to raise  
21 them". And I felt that I probably was asked to be --  
22 I suppose was spoken to because of that, on the back of  
23 that.  
24 Q. Again, I realise I'm probably pushing your memory too  
25 far, but if I can ask you this: where you're apparently

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1 noting that the fluid regime prescribed, according to  
2 Dr Quinn, did not contribute to the death, can you help  
3 us at all on whether you're commenting on that or  
4 whether you're expressing support for that view or  
5 whether you even understood the view?  
6 A. I wouldn't have understood the view because I didn't see  
7 the notes, so it was obviously a conversation, but ...  
8 (Pause). I couldn't make any comment on that because  
9 I didn't have all the details relating to Lucy.  
10 Q. I can see you're still trying to digest this.  
11 A. Yes.  
12 Q. Take your time by all means. (Pause). If I can  
13 reassure you, the redacted portion of the document is  
14 unrelated to Lucy, and that is why it has been covered  
15 up.  
16 A. Okay:  
17 "Sister Traynor did not feel that there was any  
18 significant time period when unobserved anoxic events  
19 may have occurred."  
20 That wouldn't be something I would have been making  
21 any comment on.  
22 Q. An anoxic event is a deprivation of oxygen for  
23 a significant period of time.  
24 A. Yes. I would take it to be that. It's not terminology  
25 I would use.

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1 A. Yes.  
2 Q. -- problem for the child?  
3 A. Mm-hm.  
4 Q. Did the outcome that you were apparently being told  
5 about at this meeting come as a surprise to you?  
6 A. They're -- and I'm speaking "they" in brackets -- the  
7 medical staff are more better qualified to make that  
8 assumption, but I would have thought that if she got  
9 100 ml an hour for a number of hours, I did have that  
10 concern that it contributed to her collapse.  
11 THE CHAIRMAN: She doesn't remember the meeting, she can  
12 hardly remember whether she was surprised or not.  
13 A. Yes, thank you.  
14 MR WOLFE: In fairness, what I'm putting to you is,  
15 I suppose, in another way the conclusion of the report.  
16 Leaving aside this meeting, did it emerge for you and  
17 the staff in some other form that the fluid management  
18 of the child was regarded as not beings culpable?  
19 A. We were never formally notified to that effect either.  
20 MR WOLFE: Right, very well. I have no further questions.  
21 THE CHAIRMAN: Thank you, Mr Wolfe.  
22 Any questions from the floor for the sister? No?  
23 Sister, thank you very much for coming along, you're  
24 free to leave, thank you.  
25 (The witness withdrew)

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1 Q. So again, in terms of this note, I can see that in the  
2 last sentence Dr Kelly is indicating that:  
3 "It was important to reassure staff as much as  
4 possible at this stage."  
5 We'll obviously hear from Dr Kelly in relation to  
6 this, but can you help us at all on whether you think  
7 you might have been shown the report simply to reassure  
8 you that in terms of the management of the child, the  
9 Trust, through its investigation, had reached this view  
10 that there was nothing to reproach staff about?  
11 A. I can't comment on that because I don't recall ever  
12 seeing a report from Murray Quinn. I would have got  
13 a verbal report, possibly, you know. I would feel that  
14 certainly is what I might have got, but it wouldn't have  
15 been formally discussed.  
16 THE CHAIRMAN: I think to be fair to Dr Kelly, he doesn't  
17 say in that note that you got a report; he says he took  
18 you through the case and outlined the report, which  
19 suggests to me -- and we'll hear from Dr Kelly -- that  
20 there's some sort of summary given.  
21 A. He might have made a general comment or a general run of  
22 sentences on it.  
23 MR WOLFE: I know we've touched on this already, but had  
24 there been an assumption on your part up to this point  
25 that the fluids might have caused some --

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1 Okay, ladies and gentlemen, let me turn now to the  
2 issue which I said I would raise before we finished  
3 today. It's about the request on behalf of Dr Taylor,  
4 through his legal team, that Professor Kirkham should be  
5 called to give evidence in Raychel's case and also she  
6 should be asked to review the other deaths which are the  
7 subject of the inquiry.  
8 I need to give you some background before I open up  
9 the discussion. You'll remember that professors Kirkham  
10 and Rating gave evidence here together on 14 January.  
11 At some point after their evidence was complete, I was  
12 advised that Professor Rating had written to the inquiry  
13 again and had sent in a further note of his comments on  
14 his own evidence, points that he didn't think he had  
15 made clearly and yet more papers to refer to. I can  
16 only describe it in those general terms because I have  
17 not seen what Professor Rating sent in and I have  
18 deliberately not seen it for three reasons.  
19 The first reason is that I have said publicly before  
20 and have required the parties to abide by this that  
21 I will not accept volunteered statements from witnesses  
22 without my prior approval. That step was taken towards  
23 the end of Claire's case in order to stop last-minute  
24 and uninvited statements by witnesses. And I thought  
25 that that should extend to an inquiry expert witness as

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1 well as to witnesses from any of the trusts or  
2 elsewhere.

3 My second reason is that the issues around what  
4 happened to Adam have been considered at very great  
5 length by the inquiry, initially through  
6 Professor Kirkham's report, then through two very long  
7 meetings in Newcastle-upon-Tyne, which everyone got the  
8 minutes of, and then through the engagement of  
9 Professor Rating, who after he provided a report  
10 independently, was provided with Professor Kirkham's  
11 report. She was provided with his. They each responded  
12 to each other and finally gave a full day's evidence on  
13 14 January.

14 My third reason for not looking at this statement  
15 from Professor Rating is that I'm concerned that if  
16 I accept further evidence from him, when would it ever  
17 stop? If I receive further evidence from him, do I have  
18 to refer that back to Professor Kirkham? Does she then  
19 get a chance to reply to it? Do we have to call both of  
20 them back again? At what point do we call an end to  
21 this? To put it gently, we have already devoted a huge  
22 amount of time, money and resources in this inquiry to  
23 the issue which Professor Kirkham raised, and I can't  
24 let this debate go on forever between her and  
25 Professor Rating.

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1 earlier history, her family history, and she says this  
2 will require modification when she's able to view  
3 Raychel's earlier history, her family history from the  
4 general practice notes and have access to three further  
5 reports.

6 The inquiry responded to that and the easiest way to  
7 pick this up is by an annotated note which starts at  
8 221-004-001. You will see at paragraph 2 that we note  
9 that:

10 "Your report is preliminary in nature and should be  
11 considered as a work in progress. We note that you  
12 consider you require the following further materials and  
13 information."

14 Which we go through. And then at the bottom of that  
15 page in italics you will see the points that we have  
16 made, but then Professor Kirkham has responded to this  
17 note by inserting, in italics, a number of points. She  
18 says:

19 "It would have been helpful to have the GP and  
20 neonatal notes to know whether Raychel had any  
21 significant past medical history or whether there was  
22 a family history which might not have been elicited  
23 during an emergency admission."

24 So she's asking for further information, and you'll  
25 have seen as that report goes on that it turns out that,

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1 So I wanted to draw that to your attention for two  
2 reasons. One is in case anybody says that  
3 Professor Rating's report or additional information  
4 should be circulated and how that might be taken  
5 forward, if it's to be done at all. The second reason  
6 is in case that bears on anybody's comments or what they  
7 want to say to me about extending the remit of  
8 Professor Kirkham beyond the stage where it is at at the  
9 moment.

10 Turning now to Raychel's case. As you will have  
11 seen, from the papers which are circulated,  
12 Professor Kirkham's brief in Raychel's case when she was  
13 originally engaged by the inquiry was as set out at  
14 221-001-026 at paragraph 132. You'll see from the  
15 screen and from what you have read before is what  
16 Professor Kirkham was asked for is her assistance on the  
17 following discrete neurological issues:

18 "1. At what point in time did Raychel suffer  
19 irreversible damage? 2. If she was unable to identify  
20 a specific time, then give a range of times."

21 In her response at 221-002-008, she has answered  
22 that question at paragraph 26, where she says that the  
23 damage became irreversible between 4 and 4.45 am and she  
24 gives her reasons for that. But having done that, she  
25 then goes on to raise additional issues about Raychel's

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1 of the three additional reports that she asked for, one  
2 had already been provided, and she comments on that.

3 Then if I could take you on to page 221-004-003, at  
4 paragraph 15. She was asked to explain:

5 "It would greatly assist the inquiry if you could  
6 fully explain why you believe that the input of an  
7 expert in fluid balance is now indicated."

8 She says:

9 "Although it is possible that Raychel's severe  
10 cerebral oedema demonstrated on CT and at autopsy was  
11 secondary to dilutional hyponatraemia from the use of  
12 large volumes of Solution No. 18, this diagnosis is  
13 currently more controversial than it was at the time of  
14 the inquest."

15 I pause there to indicate that my note of and the  
16 transcript of Professor Kirkham's evidence when she came  
17 on 14 January was that dilutional hyponatraemia on its  
18 own and without more will not cause severe cerebral  
19 oedema. She says, however, in this note:

20 "It is possible that Raychel's severe cerebral  
21 oedema was secondary to dilutional hyponatraemia, but  
22 this is currently more controversial."

23 That's in essence the gist of her debate with  
24 Professor Rating. Professor Rating says this is  
25 consistent and Professor Kirkham is saying, no, there

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1 must be more going wrong than dilutional hyponatraemia  
2 leading to cerebral oedema.

3 In any event, that's setting the background. So the  
4 position, just for confirmation, is that we do not have  
5 a final report from Professor Kirkham in Raychel's case.

6 In terms of whether we should seek a further report  
7 from her, a final report, and whether we should engage  
8 the additional two experts and whether we should engage  
9 her in the other cases, I want to set out my preliminary  
10 thoughts, which are subject to anything which anybody is  
11 about to say.

12 I will get clarification from Mr Uberoi in a few  
13 moments about which other cases he suggests  
14 Professor Kirkham might be involved in. But my  
15 preliminary position is that we already have  
16 a paediatric neurologist in Claire's case. That was  
17 Professor Brian Neville. He has reported and I will be  
18 hard to persuade that we should engage Professor Kirkham  
19 to add her thoughts on her theory about these matters in  
20 Claire's case, which has already been explored in this  
21 area.

22 In Lucy's case -- and, I think, Mr Counsell has  
23 something to say about Dr Murray Quinn -- my concern  
24 there is that we have a very limited remit. We're not  
25 investigating the clinical circumstances of Lucy's

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1 clearly what the expert advisers have done and what the  
2 peer reviewers have done. But the views which they've  
3 expressed and the steers they have given are not  
4 evidence and they are only that, they are only steers.  
5 Okay?

6 And one final point. Whatever view I ultimately  
7 take, I will of course acknowledge in my report that  
8 there is more than one expert view on the relationship  
9 between hyponatraemia and cerebral oedema, and the  
10 report will necessarily include a section or a reference  
11 to the debate between Professor Kirkham and  
12 Professor Rating, although, I think, in fact, in  
13 reality, it extends beyond them because it extends to  
14 Professor Neville as well.

15 So Mr Uberoi, having made those introductory  
16 remarks, can I ask you: do you have anything more that  
17 you want to say to me beyond what is contained in your  
18 letter and, apart from that, do you have anything  
19 immediately that you want to respond to on the points  
20 I have made about Professor Rating's yet further  
21 representation?

22 Submissions by MR UBEROI

23 MR UBEROI: On that preliminary point, I certainly agree  
24 that, in my submission, it wouldn't have been  
25 appropriate for you to read it or take it into account,

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1 death. I understand the point which has been made that  
2 Dr Quinn may be vulnerable to criticism in my report and  
3 when he comes to give oral evidence. But whether that  
4 is a sufficient basis for extending Professor Kirkham  
5 into Lucy's case, I think, is open to question and as  
6 DLS have pointed out in a letter today, or perhaps  
7 yesterday, the consent of the Crawford family might be  
8 required for that.

9 The gist of the DLS letter is they see a logic to  
10 involving Professor Kirkham in Raychel's case, but if  
11 she was to be extended into Lucy's case, the consent of  
12 the Crawford family would be required. And in Conor's  
13 case, my concern there is that what we're looking at in  
14 Conor's case is unhappily limited to the implementation  
15 of the hyponatraemia guidelines; it's not an exploration  
16 for the cause of Conor's death because we've already  
17 been clearly advised that Conor did not die from  
18 hyponatraemia.

19 One other point before I open the floor -- and  
20 I will start with Mr Uberoi when I come to it -- is that  
21 you have raised a query about the status of the notes  
22 from Dr Marcovitch and Dr Bohn. The conclusions which  
23 I reach in my final report will be based on the evidence  
24 which is presented to the inquiry. The role of the  
25 advisers is to give the inquiry a steer, and that's

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1 and there's no disagreement from me with the approach  
2 you have taken on the question of the extra information  
3 that he's provided.

4 Perhaps if I may take this opportunity to put some  
5 flesh on the bones of our letter on 3 May? Dealing  
6 again in a preliminary fashion with one or two of the  
7 points you have made -- and I'm grateful for them --  
8 I do understand your point about the specific questions  
9 which were asked of Professor Kirkham. Within the  
10 context you have described, she was briefed very fully  
11 with a brief of some 28 pages, I believe, and in terms  
12 of asking for the extra documentation, she was invited  
13 in that brief to point out to the inquiry or to suggest  
14 to the inquiry further relevant documentation that she  
15 needed in order to give her expert views. So she's  
16 simply done that, in my submission, in her first  
17 response. Therefore what you are left with at the  
18 moment is the first report and her supplementary  
19 comments.

20 Dealing first with the question of whether she  
21 should be called to give evidence on that, it is -- and  
22 remains -- my submission that she should be. If I might  
23 expand on why, my principal submissions would be these.

24 Even given the fact of a circumscribed brief, she is  
25 a hugely eminent neurologist and, in my submission,

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1 we have seen her give evidence once and she was  
2 measured, considered and persuasive. But more  
3 importantly than that, even if an argument exists to  
4 suggest that her comments go beyond the specifics of her  
5 brief, nonetheless she has been very clear and very  
6 specific, applying that knowledge and using that  
7 eminence in the information and the evidence which she  
8 has set out in those two reports. And in my submission,  
9 it would be entirely unsatisfactory for that to just be  
10 left hanging in the air.

11 What she has said is, on the balance of  
12 probabilities, Raychel's intracerebral problem may have  
13 been exacerbated, but was not necessarily caused by the  
14 administration of hypotonic fluids. And specifically,  
15 at 221-004-003 -- that's her second report, sir -- what  
16 she said is:

17 "I have seen cases of hyponatraemia presenting in a  
18 very similar way and I think that an alternative is more  
19 likely than dilutional hyponatraemia for the cause of  
20 Raychel's acute cerebral oedema, cerebral herniation and  
21 brain death."

22 And that is evidence which, if it's right -- and  
23 I entirely accept that's a secondary supplemental point  
24 the "if it's right", and it is one which ultimately you  
25 will use your judgment to decide upon.

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1 Professor Kirkham.  
2 So in my submission, that is his view as well, and  
3 we therefore have the views expressed by  
4 Professor Kirkham, irrespective really of whether they  
5 are in any way beyond of scope of her brief, allied with  
6 what appear to be the views of Dr Marcovitch. If those  
7 views are to be set to one side for whatever reason,  
8 then certainly in Raychel's case, firstly, you would be  
9 left with no expert evidence before you from  
10 a neurologist, and also what that brings into view then  
11 is potentially simply the rebuttal document or the short  
12 document which you have received from Dr Bohn.

13 THE CHAIRMAN: That's not a rebuttal document in my eyes.

14 I can't emphasise enough the advisers are just doing  
15 that; they're not giving evidence.

16 MR UBEROI: I'm very grateful for that because it does  
17 appear to make one or two points about  
18 Professor Kirkham's evidence and perhaps I will  
19 short-circuit my submission on that because, in essence,  
20 what I was going to point out is it's clear he hasn't  
21 read the oral evidence of Professor Kirkham and  
22 incorporated it into his note.

23 THE CHAIRMAN: Nor, I think, had Dr Marcovitch because his  
24 note pre-dates them giving evidence.

25 MR UBEROI: That must be right.

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1 If it is right, it goes right to the heart of your  
2 terms of reference and the subject matter of this  
3 inquiry. If matters are left as they stand, in my  
4 submission, it's very difficult to know how it could  
5 properly be judged whether or not that is right.

6 Surely, in my submission, Professor Kirkham's  
7 clinical experience of cases presenting in a very  
8 similar way to Raychel, which is a term she's used, is  
9 relevant to your terms of reference.

10 Adding to her views, in my submission, they can't  
11 just be viewed exclusively in isolation and it's also of  
12 note that the inquiry's adviser, Dr Marcovitch,  
13 certainly appears, to my eye, to have expressed  
14 a measure of support for the views Professor Kirkham as  
15 expressed, both in her Adam Strain reports, but also in  
16 her Raychel Ferguson reports, and that's in his memo of  
17 11 January.

18 What he's saying, on my interpretation, in his memo  
19 is effectively that Professor Kirkham is entitled to  
20 express caveats about the cause of death in Raychel's  
21 case necessarily being dilutional hyponatraemia, and as  
22 a result what he says, in terms, is he believes it  
23 reasonable for the inquiry to consider what he terms the  
24 concept of idiosyncrasy, by which he means some of the  
25 potential alternative explanations put forward by

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1 But therefore, as the Dr Bohn note suffers from that  
2 deficiency, and also Dr Bohn appears to effectively be  
3 an intensivist, so he is using his experience --  
4 extensive although I'm sure it is -- in order to take  
5 some issue with Professor Kirkham's views, and she's of  
6 a different discipline, in my submission, it must be  
7 right that the Bohn note doesn't take you further in  
8 resolving the question of whether or not  
9 Professor Kirkham's evidence and expertise can assist  
10 you any further in the inquiry.

11 THE CHAIRMAN: I have to say to you in that regard, that by  
12 the same token, Dr Marcovitch is treated in the same  
13 light. So you can't rely on Dr Marcovitch if you're  
14 going to set aside Dr Bohn. Okay?

15 MR UBEROI: I do agree, sir, but that, in my submission, is  
16 moving to the --

17 THE CHAIRMAN: Cutting to it, I'm taking them as advice  
18 rather than evidence. Okay?

19 MR UBEROI: In my submission, that must be right, sir,  
20 because it does bring me full circle to the point  
21 I started with, which is that it is Professor Kirkham  
22 who you've heard from, so it wouldn't be right and  
23 cannot be that very brief notes, particularly if full  
24 evidence hasn't been read from advisers, can knock aside  
25 the two or three days of evidence which you've already

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1 had the benefit of from Professor Kirkham.  
2 THE CHAIRMAN: Okay.  
3 MR UBEROI: The reason, in my submission, why this is,  
4 of course, of significance -- and I'm fully aware that  
5 you know it is of significance, sir, and view it as such  
6 -- is because of the specific question of fairness.  
7 You have said on numerous occasions -- for example,  
8 in your correspondence with Mr Justice Weir of the  
9 coroner's service and also pursued through your inquiry  
10 counsel over the last couple of weeks -- that you must  
11 explore the question of whether or not, if  
12 Lucy Crawford's hyponatraemia had been properly  
13 identified, whether in that scenario the subsequent  
14 death of Raychel Ferguson might have been averted, and  
15 indeed that is the very substance of your amendment to  
16 your terms of reference on the question of how the  
17 Lucy Crawford aftermath section of evidence is relevant  
18 to those terms of reference.  
19 As that is a possible criticism that you are  
20 considering, it would not be fair, in my submission, for  
21 it to be made if the true role of Solution No. 18 in  
22 dilutional hyponatraemia in Raychel's death was not  
23 considered with an open and inquisitorial mind and that  
24 open and inquisitorial approach must, in my submission,  
25 extend to Professor Kirkham being allowed to expand on

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1 not be persuaded.  
2 THE CHAIRMAN: Does that involve then bringing  
3 Professor Rating back in?  
4 MR UBEROI: No, sir, not in my submission.  
5 THE CHAIRMAN: Why have him in Adam's case and not in  
6 Raychel's?  
7 MR UBEROI: Well, the approach that was adopted in Adam's  
8 case, in my submission, was adopted because of the fact  
9 that PRES as a potential cause of death came on to the  
10 scene at a rather late moment in the form of  
11 Professor Kirkham's report and the two of those  
12 witnesses were tested together and, in my submission,  
13 that was an enlightening way to approach their evidence  
14 and the reason I say Professor Rating does not need to  
15 be called back is consistent with my submissions on the  
16 Adam Strain part of the case, which is that it was  
17 Professor Kirkham who plainly provided the more  
18 satisfactory expert evidence for your report.  
19 THE CHAIRMAN: That involves me taking the view now that  
20 I prefer Professor Kirkham to Professor Rating,  
21 therefore, for the purposes of any further investigation  
22 into Raychel's death, I'll now decide the debate between  
23 them in Adam's case in favour of the Kirkham line and  
24 pursue only the Kirkham line in Raychel's case. That  
25 seems a bit premature, doesn't it, if I'm going to go

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1 the clear views which I began these submissions with as  
2 to the potential role of hyponatraemia and the  
3 potential relevance of her experience of seeing other  
4 children presenting in the same way.  
5 Stretching even further back, the same goes for the  
6 case of Adam Strain. If there is to be a pursuing of  
7 the line of enquiry whereby one is to suggest if  
8 a different response had accompanied that case, then  
9 maybe Solution No. 18's role in Adam's death would have  
10 been raised as a red flag and subsequent events could  
11 have altered. Well, for anyone on the receiving end of  
12 that type of criticism, it would be unfair, in my  
13 submission, for Professor Kirkham's evidence as to cause  
14 of death to have not been heard and fully considered.  
15 So in my submission, sir, despite your observations  
16 about her potentially straying beyond your initial  
17 instructions to her, nonetheless that evidence is there  
18 and it is clear. She is an eminent expert and, in my  
19 submission, it remains appropriate for her to be heard.  
20 The contrary position is tantamount to that view  
21 being pre-emptively dismissed without giving her the  
22 opportunity to persuade you of it and explain it to you.  
23 In my submission, surely the correct approach is to  
24 allow her the opportunity to persuade you first and then  
25 for you to hear submissions on why you should or should

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1 down that line?  
2 MR UBEROI: Not to my eyes, sir, for two reasons. One, to  
3 repeat the same submission, which is that you have had  
4 the evidence of hearing them for two or three days and  
5 it would therefore be foolhardy for some sort of  
6 preliminary view not to be potentially reached if you  
7 were persuaded more of one than the other.  
8 But secondly, of course, that is where you are  
9 already because Professor Kirkham has already been  
10 briefed as the neurologist in Raychel's case and  
11 Professor Rating hasn't and, in my submission, the  
12 Adam Strain circumstances were quite specific to the way  
13 PRES came on the scene at a later date in that case.  
14 It's also of note on that point, in my submission,  
15 that it would not be the same debate being rehashed  
16 because, in her reports on Raychel Ferguson,  
17 Professor Kirkham is no longer pointing to PRES; she's  
18 pointing to a different cause of death. So the starting  
19 point of having one expert from each discipline would  
20 potentially be just as sensible in Raychel Ferguson as  
21 it has been in all the other parts of the case, save for  
22 with Professor Rating.  
23 THE CHAIRMAN: Okay.  
24 MR UBEROI: Sir, there are two distinct decisions to be  
25 made, and the first submission from our letter of 3 May

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1 was, in light of her reports and the views expressed in  
2 it, Professor Kirkham really should be offered the  
3 opportunity to give oral evidence.

4 You have alluded to the second point. I do agree,  
5 it is in the letter of course. A number of my  
6 submissions just made, in my submission, potentially  
7 overlap to the question of whether or not  
8 Professor Kirkham be invited to give her view on other  
9 deaths. But as with so much in this inquiry, they're so  
10 fact-specific, I will go through them as you've invited  
11 me to do.

12 Put very simply, I had anticipated and agreed with  
13 your point about the Claire Roberts section of the  
14 hearing. Professor Kirkham, of course, didn't give  
15 evidence until after the Claire Roberts stage, but  
16 nonetheless you do have an opinion from  
17 Professor Neville in that stage and it flows back in  
18 with the point I was making earlier whereby you would  
19 not, in my submission -- or should not in my  
20 submission -- leave yourself without some neurological  
21 opinion on Raychel Ferguson. So I agree entirely about  
22 Claire Roberts.

23 The Lucy Crawford aspect of the case, in my  
24 submission, while I entirely appreciate that one must at  
25 all times be alive to the fact that Lucy Crawford

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1 relevance of Conor's death to the inquiry is to see how  
2 the department's guidelines were being implemented after  
3 his death because it appeared from some of the  
4 information that we had analysed that the guidelines  
5 were not followed, and it gets us into the governance  
6 area. Like a employer, it's all very well and good to  
7 have an equal opportunities policy, but if nobody is  
8 implementing it, it is not worth the paper it is written  
9 on. And if you have hyponatraemia guidelines, which are  
10 not properly disseminated and followed in hospitals,  
11 that's not a acceptable situation.

12 MR UBEROI: I understand that and I see the sense in it.

13 That leaves the question of the Lucy Crawford potential  
14 report out of the additional deaths.

15 Sir, unless I can assist you with specific  
16 questions, those are my submissions.

17 THE CHAIRMAN: I'll come back to you if I need to.

18 Thank you very much.

19 Submissions by MR COUNSELL

20 MR COUNSELL: The submissions I make relate only to the  
21 circumstances surrounding Lucy Crawford's death.

22 My submission on behalf of Dr Quinn is that you  
23 really should obtain neurological evidence in relation  
24 to those circumstances.

25 Can I make this clear? I leave it entirely to the

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1 clinical is not a matter before you, nonetheless in  
2 dealing with that situation you, of course, consulted  
3 and amended and reissued your terms of reference. And  
4 what those terms of reference do, in my submission, is  
5 bring in the need for you to understand whether, and the  
6 quote is:

7 "There was a failure to understand the correct cause  
8 of death."

9 Therefore, as that cause of death still remains in  
10 your terms of reference as it applies to Lucy Crawford,  
11 it does appear to me, as a matter of logic, that it is  
12 something that Professor Kirkham could be invited to  
13 comment upon in as discrete a fashion as possible.

14 That just leaves Conor Mitchell, sir, which we're  
15 entirely in your hands on. I'm not sure we've received  
16 too many papers in that case yet. I formed a view from  
17 my preliminary reading, as you alluded to, that  
18 hyponatraemia is not the likely cause of death here, but  
19 it's something that's prospective and for the future and  
20 I'm not in a position to address you on substantively  
21 now.

22 THE CHAIRMAN: I know this disappointed Conor's mother --  
23 and I'm afraid that's something that I have to accept  
24 that she is disappointed by -- but on the advice that we  
25 received that he didn't die from hyponatraemia, the

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1 inquiry to decide from whom that neurological evidence  
2 should come. This submission is coincidentally made at  
3 the same time as you're hearing submissions about  
4 Professor Kirkham, but it is necessary, in fairness, in  
5 order for this inquiry to make decisions as to the cause  
6 of Lucy Crawford's death, for the inquiry to obtain that  
7 evidence.

8 I'm conscious, as you've already said, that  
9 of course the inquiry is not dealing, directly at any  
10 rate, with the clinical issues surrounding her death,  
11 but one of the things the inquiry is being asked to  
12 consider is significant criticism of the role of  
13 Dr Murray Quinn. You will recall that Dr Quinn, who was  
14 provided just simply with the case notes to review,  
15 expressed surprise in his report that those volumes of  
16 fluid could have produced gross cerebral oedema, causing  
17 coning. And as you will have seen from the statements  
18 which he has provided which explain that, what he meant  
19 by that was that, in his view, from the little  
20 documentation and information he had, he didn't consider  
21 and still does not consider that the volumes of fluid  
22 which Lucy had been given could have produced sufficient  
23 gross cerebral oedema to cause coning. He also went on  
24 to make any conclusions as to the cause of the cerebral  
25 oedema.

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1 Sir, as you know, Dr Quinn maintains that position  
2 in the statements that he has provided to this inquiry.  
3 And he is not alone in maintaining that position because  
4 the inquiry has already heard from other witnesses the  
5 day before yesterday, I think. I wasn't here, but the  
6 day before yesterday, from Dr Hanrahan, to similar  
7 effect.

8 That position is the subject of trenchant criticism  
9 from Dr MacFaul, the inquiry's paediatric expert, who  
10 describes the conclusions, if that's what they are --  
11 although they're really no more than an expression of  
12 surprise -- as misleading and essentially wrong. The  
13 reference is 250-003-057. Those criticisms are echoed  
14 in the inquiry's opening at, in particular,  
15 paragraph 580.

16 The criticism is now being taken up during the  
17 course of the evidence. Just one example: during the  
18 course of Dr Auterson's evidence, he was asked by  
19 Mr Wolfe at day 101, pages 172 and 174, what he thought  
20 about those conclusions and he said he thought that they  
21 were wrong.

22 We've heard from other witnesses, Dr Hanrahan, who  
23 does not come to that view. Indeed, Dr Hanrahan's view,  
24 when questioned, was that he didn't consider the level  
25 of fluid was likely to have been the cause in the

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1 Ironically, he has used exactly the same word  
2 in relation, yes, to Raychel Ferguson's circumstances,  
3 but the same word "surprised" as Dr Quinn does in that  
4 report:

5 "... surprised that the volumes could have caused  
6 cerebral oedema sufficient to cause coning."

7 If it's a steer, with respect what does that mean?  
8 It means, doesn't it, that it should steer you in the  
9 direction of obtaining the evidence which can confirm it  
10 either way? Whether or not the evidence comes from  
11 Professor Kirkham or from somebody else -- in my  
12 submission, it really should come from somebody. And if  
13 this inquiry is to act fairly and completely to  
14 investigate the circumstances of Lucy Crawford's tragic  
15 death, then it really must, in my submission, obtain  
16 that neurological evidence.

17 I just remind you of this finally. Of course, there  
18 has to be a point at which expert evidence has to stop,  
19 and, of course, you have to have in mind the narrowness  
20 of the remit. But as you know, and as was mentioned  
21 in the opening, Dr Quinn, who was a paediatrician of  
22 impeccable record, asked to come in and prepare a short  
23 report, still faces proceedings from his regulatory body  
24 which are awaiting the outcome of these proceedings.  
25 And that is an important matter and one I ask you to

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1 absence of a much greater drop in sodium.

2 The reality is that the witnesses from whom you've  
3 heard and will hear disagree on this important issue,  
4 and that has two, in my respectful submission,  
5 fundamental consequences. One is that, in the absence  
6 of expert evidence from somebody who really can assist  
7 the inquiry, namely a neurologist, the inquiry is not  
8 able to come to a conclusion about that and not able to  
9 come to a conclusion about two things. First of all,  
10 what in reality was the cause of Lucy Crawford's death.  
11 And to echo the point made by Mr Uberoi just now,  
12 although the remit of this inquiry is narrow, it does  
13 refer to the failure to identify the correct cause of  
14 death. So it's central to that issue, even though we're  
15 not specifically considering clinical issues here,  
16 clinical failings and so forth.

17 Secondly, of course, in relation to Dr Quinn, who  
18 I represent, it's of the most fundamental importance  
19 because it forms a central tenet to the trenchant  
20 criticisms made of him by Dr MacFaul, the only expert  
21 witness who deals with the conduct of Dr Quinn.

22 I appreciate, as you've said, sir, that the steer  
23 that you've got from others, from the advisers, is only  
24 a steer, but you will have in mind what  
25 Professor Marcovitch has said in his report.

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1 take into account.

2 So for all of those reasons, inconvenient though it  
3 may be, you should obtain some neurological evidence to  
4 assist you.

5 THE CHAIRMAN: Thank you very much, Mr Counsell. I'll come  
6 to the family representatives last. Before I come to  
7 the Trust, there's nobody here to make submissions,  
8 Mr Lavery, for the Belfast Trust.

9 Mr Counsell, sorry, are you involved with anybody  
10 for Adam's case?

11 MR COUNSELL: No.

12 MR LAVERY: I wonder if I could address you on behalf of the  
13 Western Trust in Raychel's case in relation to this  
14 issue?

15 THE CHAIRMAN: Right.

16 Mr Simpson, between you, my initial question is  
17 about the position I have taken about Professor Rating's  
18 volunteered statement or submission or whatever it is  
19 that I haven't looked at.

20 Submissions from MR SIMPSON

21 MR SIMPSON: I think that was an appropriate approach at  
22 this stage.

23 THE CHAIRMAN: My view is that although an inquiry is a bit  
24 different from a court, both Professor Rating and  
25 Professor Kirkham have had endless opportunities in

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1 advance of coming to give evidence to say what they  
2 wanted to say and I really am very reluctant for them to  
3 start extending debates after the event to take us even  
4 further because literally we would never end doing that.  
5 MR SIMPSON: I think that's right. I can deal very shortly  
6 with the Lucy Crawford aspect of the matter. We have  
7 set that out in our letter. I have no further  
8 submissions to make, sir.  
9 THE CHAIRMAN: But you take the view that it could only be  
10 done with the consent of the Crawfords?  
11 MR SIMPSON: Yes, absolutely. I appreciate the family have  
12 been reluctant to answer correspondence, but I do  
13 think --  
14 THE CHAIRMAN: I think in this case I'd need more than  
15 a silence from them. I would need an explicit consent.  
16 MR SIMPSON: We've made that clear in our letter and that is  
17 our position, sir.  
18 THE CHAIRMAN: Okay, thank you. Mr Lavery?  
19 Submissions by MR LAVERY  
20 MR LAVERY: Mr Chairman, first of all, in relation to the  
21 point about Professor Rating's reports, which you've  
22 indicated that you have not yet even yourself had an  
23 opportunity to read, I can see the logic in that and  
24 I know your views, Mr Chairman, in relation to witnesses  
25 producing a running commentary on the evidence.

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1 Professor Kirkham was saying that dilutional  
2 hyponatraemia couldn't account for the cerebral oedema  
3 without more.  
4 MR LAVERY: She did, and you questioned her on that quite  
5 closely. Yes, I accept that, Mr Chairman. She wouldn't  
6 accept that hyponatraemia had anything to do with Adam's  
7 death.  
8 THE CHAIRMAN: She said you can get hyponatraemia, but  
9 hyponatraemia doesn't lead on to cerebral oedema.  
10 MR LAVERY: Yes, she did say that. But in Raychel's case  
11 she's saying it's possible. The point I'm making is if  
12 one had Professor Kirkham and if one did recall  
13 Professor Rating and had them both giving evidence on  
14 this point, it may be that their differences on the  
15 issue would narrow.  
16 THE CHAIRMAN: So on this suggestion --  
17 MR LAVERY: You indicated previously, Mr Chairman, I think  
18 in response to Mr Uberoi's submissions, that if you were  
19 going to call Professor Kirkham, would you also then  
20 have to call Professor Rating?  
21 THE CHAIRMAN: That's the query.  
22 MR LAVERY: I disagree with Mr Uberoi on that point and I  
23 think one would have to call him and it would be useful  
24 for the inquiry to have evidence from both,  
25 Professor Kirkham and Professor Rating.

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1 Although having said that, this is obviously  
2 a rapidly-developing area of medicine. Views are  
3 changing on a regular basis.  
4 THE CHAIRMAN: Isn't that exactly the reason why I have to  
5 cut it off at some point?  
6 MR LAVERY: On the one hand, is that not more of another  
7 reason to have a look at the evidence?  
8 We endorse, on behalf of the Western Trust,  
9 Mr Uberoi's comments insofar as it relates to the recall  
10 of Professor Kirkham. In our respectful submission, it  
11 goes to the crux of the inquiry. When one looks up at  
12 the board, this is an inquiry into hyponatraemia-related  
13 deaths. Professor Kirkham, as I understand it, isn't  
14 denying that hyponatraemia wasn't in any way related to  
15 these deaths, but her view may, on one view, be  
16 developing because in the final report that she has put  
17 up, she's conceded that it is possible that the cerebral  
18 oedema in Raychel's case was caused by dilutional  
19 hyponatraemia. She's used the word "possible".  
20 Professor Rating has said in his evidence he's satisfied  
21 that it is consistent with dilutional hyponatraemia.  
22 THE CHAIRMAN: In Adam's case?  
23 MR LAVERY: In Adam's case.  
24 THE CHAIRMAN: I'm sure you'll correct me if I'm wrong, but  
25 the distinction between them in Adam's case was

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1 THE CHAIRMAN: Right. Thank you very much. Is there  
2 something more?  
3 MR LAVERY: No.  
4 Further submissions by MR COUNSELL  
5 MR COUNSELL: I wonder if I could come back? I have not  
6 seen the letter which raises the question of consent.  
7 Perhaps, in due course, I could be provided with it --  
8 THE CHAIRMAN: Yes, of course.  
9 MR COUNSELL: -- and we can consider it.  
10 The alternative, in my submission, if that is the  
11 case that Lucy Crawford's parents need to give their  
12 consent -- and I don't quite follow why it should be  
13 that Dr MacFaul has been able to give evidence on the  
14 same circumstances and yet another expert should not --  
15 this inquiry should not consider any further criticism  
16 of Dr Quinn on this issue because it would be unfair to  
17 do so in the absence of the inquiry being able to  
18 explore whether that criticism was merited.  
19 THE CHAIRMAN: Thank you.  
20 Further submissions by MR LAVERY  
21 MR LAVERY: Can I make one final point? You have indicated  
22 that Professor Kirkham's evidence is not yet complete  
23 and that you're expecting further evidence from her.  
24 THE CHAIRMAN: We stopped at a point because what you have  
25 are the exchanges that we had and the last exchange that

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1 we've provided is asking her to explain her call for  
2 three more expert reports plus extended family records.  
3 As it turned out, when she responded to that, she  
4 acknowledged that she had in fact seen one of the expert  
5 reports. On the response that she made, she was still  
6 calling for two further expert reports for Raychel's  
7 records and for the family's records.  
8 MR LAVERY: Do we take it from that that the inquiry is not  
9 going to pursue a further statement from her?  
10 THE CHAIRMAN: That's the point of this afternoon's  
11 discussion. Whether, for instance, the inquiry engages  
12 yet further experts in order to brief Professor Kirkham  
13 to her satisfaction to finally produce a report and to  
14 ask the Ferguson family for their consent for further  
15 records from the family to be sent to Professor Kirkham.  
16 That's one option. Another is simply to say to  
17 Professor Kirkham, we have to draw a line somewhere,  
18 we will call you to give evidence on the basis of the  
19 information we have.  
20 Mr Sharp, you're neutral?  
21 MR SHARP: Neutral, yes, chairman.  
22 THE CHAIRMAN: Mr Hunter, do you have anything to say?  
23 I think the specific point for Adam's mother is whether  
24 I should look at Professor Rating's additional  
25 representations.

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1 THE CHAIRMAN: Well, I should say I'm reluctant to go down  
2 that line that Mr Uberoi suggested, which is in effect  
3 to make a decision at this stage that I prefer  
4 Professor Kirkham to Professor Rating and therefore if  
5 we're to pursue any more paediatric neurological issues,  
6 I'll go with her alone, particularly when she is --  
7 whether she's right or wrong, virtually every other  
8 expert has disagreed significantly with various points  
9 that she has made.  
10 MR HUNTER: That's correct, sir. At the end of the day,  
11 it's a matter for you as to what weight you attribute to  
12 each of the experts and to the evidence.  
13 The final point I'll make on that is, of course,  
14 throughout the debate Professor Kirkham had raised three  
15 views as to possible alternative causes for Adam's  
16 death. As the matters were explored, she basically  
17 abandoned two of those. Her words in relation to those  
18 were -- and I'm talking about the cerebral venous  
19 thrombosis and the developmental delay -- her final  
20 words on that were that in Adam's case both those were  
21 "possible, but not probable". Those are her words, not  
22 mine. And at the end, she was left then dealing with  
23 PRES and her final position on that was that it was her  
24 view that PRES was possibly the cause of Adam's death on  
25 the balance of possibilities.

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Submissions from MR HUNTER

1  
2 MR HUNTER: That's correct, sir, but I would echo what you  
3 said earlier: that at some point a line has to be drawn  
4 under the evidence. I have to be very conscious of the  
5 effect this process is having on my client. This  
6 process is an ordeal for her.  
7 THE CHAIRMAN: Yes.  
8 MR HUNTER: She, I'm sure, is as anxious as you are to have  
9 the matter come to a conclusion.  
10 In relation to Professor Kirkham's evidence and  
11 Professor Rating's evidence, we have heard extensively  
12 on the subject. In my view, it has been canvassed --  
13 and rightly so -- because, of course,  
14 Professor Kirkham's views were diametrically opposed to  
15 all the other experts', and that is a point in itself,  
16 sir. This inquiry does not come down to  
17 Professor Kirkham versus Professor Rating. It  
18 encompasses a huge amount of evidence from other expert  
19 witnesses, which are all relevant. That's that point.  
20 In relation to using Professor Kirkham for any of  
21 the other deaths in the inquiry, sir, that might seem to  
22 give the impression that Professor Kirkham's views are  
23 being preferred over Professor Rating's. From that  
24 point of view, I would certainly be reluctant to see  
25 that happen.

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1 THE CHAIRMAN: That was on the basis that it couldn't be  
2 ruled out.  
3 MR HUNTER: Yes, correct. I suggest to you that the other  
4 experts -- and by that I mean, of course, Dr Coulthard,  
5 Dr Haynes, Professor Gross, the other pathologists --  
6 they put it much, much further than that. They don't  
7 have any doubts.  
8 THE CHAIRMAN: Yes.  
9 MR HUNTER: So, sir, at the end of the day, it's a matter  
10 for you.  
11 THE CHAIRMAN: Okay. Just before I turn on to Mr Quinn.  
12 Mr Uberoi, if I went down the line that you're  
13 suggesting and you were encouraging me to take the view  
14 that Professor Kirkham is clearly better than  
15 Professor Rating, so if I'm going to continue with  
16 a neurologist, it should be Professor Kirkham, what if  
17 I took the other view? What if I took that I prefer,  
18 in the round, Professor Rating's evidence taken together  
19 with the other experts', so not pursue Professor  
20 Kirkham?  
21 MR UBEROI: My submission is contingent upon you allowing  
22 yourself to form some preliminary view in favour of  
23 Professor Kirkham over Professor Rating. You have my  
24 written submissions on the point. I don't wish to  
25 engage with Mr Hunter on an interpretation of her

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1 evidence, save I would particularly point out that in  
2 distinguishing between the possible and the probable,  
3 those extracts from her evidence were only in the  
4 context of her being very clear and, in my submission,  
5 very persuasive as to her view on cause of death.

6 THE CHAIRMAN: Thank you.

7 Mr Coyle, you can speak on behalf -- I think in  
8 terms of Mr and Mrs Roberts, I don't think any issue has  
9 been raised this afternoon.

10 MR COYLE: I don't act for them, sir, and I can't assist  
11 you.

12 THE CHAIRMAN: I don't think there is any suggestion that so  
13 far that, if Professor Kirkham's remit is to continue or  
14 to be extended, it should extend into Claire's case.

15 I will leave that as it stands and, if on behalf of the  
16 Roberts family, anybody wants to say anything about that  
17 at the start of next week, I'll take it, but I don't  
18 think that anyone is suggesting that. Turning to  
19 Raychel?

20 Submissions from MR COYLE

21 MR COYLE: As regards Raychel, sir, we endorse your view  
22 that the debate has to come to an end. Plainly this is  
23 a sensitive time, coming up to the time of Raychel's  
24 death, so this is a vexing matter for the family.

25 If it were the case that you were to allow

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1 Professor Kirkham to persist her enquiry or strand of  
2 thinking, it is somewhat off the pace from the broad  
3 sweep of the experts the inquiry has heard. It does  
4 lead, sir, to the implication that she wishes to have  
5 the family records, and that would raise Article 8  
6 issues, and while undoubtedly the family would comply  
7 with all lawful orders, it would seem that it would  
8 disclose potentially personal matters that are utterly  
9 extraneous to your investigation.

10 THE CHAIRMAN: Let me make two points about that. First of  
11 all, the family records would be -- first of all, the  
12 first issue is would the family consent to the records  
13 being made available to Professor Kirkham, and the  
14 second issue is, in considering the first one, they  
15 would have to understand that any extraneous material  
16 would be deleted from them.

17 So let's suppose for the sake of argument  
18 Mrs Ferguson's medical notes are like that (indicating),  
19 it wouldn't mean just giving over the file. It would be  
20 the same as what would apply in the High Court, the  
21 notes would be stripped of anything that is not in any  
22 way relevant to the issue.

23 Mr and Mrs Ferguson, I don't know if they have  
24 a position about consent today. I would like to know  
25 what their position is about consent early next week.

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1 MR COYLE: Yes.

2 THE CHAIRMAN: They should understand that it is not being  
3 suggested that their entire family medical history be  
4 handed over without editing of all material which is not  
5 relevant to any issue that Professor Kirkham could  
6 reasonably investigate.

7 MR COYLE: Yes. I'm sure some comfort will be drawn from  
8 that, sir, but we would wish to reflect, given the  
9 particular time that we're at.

10 THE CHAIRMAN: I understand. Monday is the anniversary,  
11 isn't it?

12 MR COYLE: Indeed so, and the inquiry isn't sitting for that  
13 very reason. So for the opportunity to reflect on your  
14 comments, which are helpful and may assuage some of the  
15 anxieties --

16 THE CHAIRMAN: That is one issue about Professor Kirkham and  
17 her access to the family's records beyond Raychel's.  
18 Beyond that, there's the issue about whether we secure  
19 the two additional expert reports that she's asked for  
20 and, beyond that, is the issue about whether we then  
21 engage Professor Rating as well as Professor Kirkham if  
22 we're going to go down this route.

23 MR COYLE: As regards the extent of the investigation on  
24 this occasion, that is really for you and your team,  
25 sir.

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1 THE CHAIRMAN: What about leaving it only to  
2 Professor Kirkham?

3 MR COYLE: We wouldn't be supportive of that perspective,  
4 sir. She is, in our estimation, quite off the pace, in  
5 spite of her eminence, in terms of her explanation, and  
6 sits at a remove of the broad sweep of experts, as we  
7 see it. Therefore, to prefer her view or give any  
8 nuance that would invite the conclusion that her view  
9 was preferred wouldn't be something that the Ferguson  
10 family would support or agree with, sir.

11 THE CHAIRMAN: Thank you very much.

12 Ms Ramsey for Miss Mitchell?

13 Submissions from MS RAMSEY

14 MS RAMSEY: Mr Chairman, our position would be that we would  
15 agree with the preliminary views that you, Mr Chairman,  
16 have set out. We endorse the other families' views  
17 in relation to Professor Kirkham providing an additional  
18 report.

19 Insofar as Conor's case is concerned, our clients  
20 are very aware of the narrow limitations of the  
21 investigation of this inquiry into Conor's death. We  
22 therefore feel there's absolutely no requirement for  
23 Professor Kirkham to have any input into Conor's case.

24 And then, finally, I just want to make a more  
25 general point, which would be that the family would be

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1 very keen to progress to a timetabling of Conor's case  
2 as soon as possible, Mr Chairman.

3 THE CHAIRMAN: There's an overarching issue, Ms Ramsey,  
4 which I have referred to, which I have to bear in mind.  
5 In court now it's regarded as the overriding objective  
6 and I'm not subject to the same rule, but I can't  
7 disregard a number of factors: the length of the inquiry  
8 to date, which is rather too long, the continuing  
9 expense of the inquiry, the extent of the  
10 investigations, the number of reports and the length of  
11 the evidence which has already been heard and what  
12 effect going down any of these lines would have on the  
13 continuation of the inquiry in the coming months.

14 Those are not determining factors, but they're  
15 factors which I have to take account of when I am  
16 considering what route to take on the various  
17 submissions I've heard this afternoon.

18 Mr Coyle, I'm sorry to press you over this weekend  
19 because I know this isn't -- of all the anniversaries of  
20 Raychel's death, I'm sure this year's one is  
21 particularly stark given what Mr and Mrs Ferguson have  
22 been listening to over the last number of months. But  
23 could I press you, if you could possibly have an answer  
24 on the issue of their consent at some point before the  
25 end of next week --

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1 terms of that exercise.

2 THE CHAIRMAN: Yes.

3 MS RAMSEY: On behalf of Conor's Mitchell's family, we could  
4 also apprise the inquiry in relation to any issues  
5 requiring consent.

6 THE CHAIRMAN: Ms Anyadike-Danes?

7 Submissions from MS ANYADIKE-DANES

8 MS ANYADIKE-DANES: If I might make a few comments. The  
9 first point is Professor Kirkham did go beyond the  
10 narrow questions that were asked of her in relation to  
11 Raychel, but then, in fairness, there was a precedent  
12 for that because she did exactly the same thing in  
13 relation to her report for Adam.

14 If we stick to those points that she was asked to  
15 address, during the course of the evidence from the  
16 experts, that very point as to when it was thought that  
17 Raychel had passed the point of no return or passed  
18 retrieval, if I can put it that way, that very issue was  
19 asked of Dr Haynes when he was in the witness box, and  
20 he proceeded to answer it and explain it.

21 That was a point that had been specifically asked of  
22 Professor Kirkham to address and, so far as I'm aware,  
23 she hasn't been provided with his analysis of when  
24 Raychel was likely to have suffered irretrievable brain  
25 damage and been essentially brainstem dead, even before

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1 MR COYLE: Yes, sir.

2 THE CHAIRMAN: -- because I have to make a decision on this  
3 sooner rather than later.

4 MR COYLE: One point we may wish to give practical thought  
5 to is who would do the redaction of the records if there  
6 was consent and agreement? In other words, it is  
7 unlikely the general practitioner might be prepared to  
8 do that and then there would be a measure of complete  
9 disclosure of those records.

10 THE CHAIRMAN: Is not the position that if this was a High  
11 Court action, would the records not be redacted by the  
12 representative of the plaintiff, as they would normally  
13 be?

14 MR COYLE: Yes.

15 THE CHAIRMAN: Therefore, the redaction, if they were made  
16 available, the redaction of any family records would be  
17 conducted by your solicitor and yourself --

18 MR COYLE: Yes.

19 THE CHAIRMAN: -- with Mr Quinn, subject only to some  
20 clarification of what exactly it might be that  
21 Professor Kirkham might be interested in.

22 MR COYLE: Yes, it would be for her to articulate the  
23 specific matters that might attract your attention and  
24 then that exercise might be carried out, but again, sir,  
25 so we could draw some comfort from what you have said in

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1 the formal tests were taken.

2 So although it was a matter that was specifically  
3 asked of her, we don't have her view on whether he was  
4 correct on that. Now, him being correct on that point  
5 turned out, as you know, Mr Chairman, to be quite  
6 significant for the treating clinicians at the time  
7 because there were issues about whether or not anybody  
8 could have, if they had acted slightly differently,  
9 assisted matters, and that turned out to be significant  
10 to know when that end point was likely to have been  
11 reached. So it probably is important for, for example,  
12 Dr McCord, who, it was suggested, might have been able  
13 to give some guidance to have perhaps affected matters.

14 THE CHAIRMAN: Sorry, be careful. Dr Haynes has already  
15 resiled from that. When he gave his evidence, he had  
16 said he had made that -- his criticisms or prospective  
17 criticisms were very hesitant.

18 MS ANYADIKE-DANES: Sorry, I wasn't talking about his  
19 criticisms, he was asked the self-same question. I'm  
20 not -- why it might be significant. He was asked the  
21 same question as to when he thought that point was  
22 reached that we had carved out as an issue within  
23 Professor Kirkham's expertise an answer for that. And  
24 the only point I was making is if you were thinking  
25 about whether there was anything further to be heard

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1 from Professor Kirkham, she has not had an opportunity  
2 to see his analysis of the end point as to whether she  
3 agrees with it, either as the end point or the analysis  
4 of how he got there. So that was that point.

5 The other point is that in terms of those others who  
6 have felt that the fall in serum sodium levels or the  
7 administration of those sorts of volumes of low sodium  
8 solute isn't the whole story. You'll be aware, sir --  
9 I'm not entirely sure that the others in the chamber who  
10 may not have got to that evidence yet will be aware that  
11 that has been a point for others. We know from the  
12 Raychel case that that was a point for Dr McCord. His  
13 evidence was that the same fluids were used for children  
14 up and down the country and he felt there had to be an  
15 innate sensitivity in Raychel's case for her to have  
16 responded in that way.

17 Dr Jenkins, when he gave his UTV interview  
18 in June 2004, said the same thing or similar. With  
19 regard to Raychel's death, she had vomiting:

20 "There's no doubt severe vomiting followed her  
21 operation, but in fact many children have vomiting of  
22 that severity and don't come to the same problems that  
23 she came to. And as far as I could determine, the fluid  
24 regime that had been used in her care was the standard  
25 that many other units were using."

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1 extent of cerebral damage. Simon Ellis disagreed with  
2 him on that point, although I think in general he liked  
3 his paper. He says:

4 "You're incorrect to say that neither the magnitude  
5 nor the rate of fall in serum sodium concentration is  
6 important in the genesis of brain damage."

7 So that's what he went back to Allen Arieff on.

8 Allen Arieff responded to that and he said:

9 "On the contrary, that is the case. It is not well  
10 correlated. There is absolutely no evidence in support  
11 of that correlation."

12 And he referred to various research that was carried  
13 out.

14 That, therefore, is a very important point that  
15 perhaps you might think it's relevant to hear somebody  
16 on because that turned out to be a highly important  
17 difference, not just between Professor Rating and  
18 Professor Kirkham, but between some of the other experts  
19 and Professor Kirkham. I think in particular of  
20 Professor Coulthard, whose very firm view was that the  
21 rate of fall was significant.

22 I think, therefore, in light of that -- and I'm not  
23 advocating one way or another who you go to, but there  
24 seem to be areas in relation to the role of  
25 hyponatraemia that are perhaps not entirely settled, and

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1 And of course, Mr Chairman, you will know that that  
2 was one of the things that the CMO herself -- and we'll  
3 come to her evidence in due course in the investigation,  
4 said in her interview that she thought something else  
5 had happened.

6 There is a report, an undated document prepared by  
7 Altnagelvin, a fatal case of hyponatraemia in  
8 Altnagelvin Hospital, and that refers to -- this was  
9 caused by a very rare idiosyncratic reaction to the  
10 surgery.

11 So that whole issue is a live one, not just in  
12 Raychel's case, but perhaps in some of the other cases.  
13 And allied to that -- and I'm leaving aside  
14 Dr Hanrahan's evidence because you have already heard  
15 that. His view was that rate of fall was insufficient,  
16 but you will know the context of that. But Dr Crean put  
17 in another witness statement in Lucy's case and he  
18 appended to that an exchange between Simon Ellis and  
19 Allen Arieff, and that is published in the BMJ  
20 in September 1993. What Simon Ellis from Radcliffe  
21 Infirmary was doing is that he was picking up on  
22 a statement by Allen Arieff et al, because they were his  
23 colleagues at that time, in 1992, in his 1992 article,  
24 which referred to whether or not the rate of fall or the  
25 degree of hyponatraemia was well correlated to the

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1 it may be that these cases are different and that might  
2 also bear some consideration as to whether, if one looks  
3 at them, however many you think, if any, it's  
4 appropriate that is done as a sequence, looks to see  
5 whether the differences tell you anything about the role  
6 of hyponatraemia, it may go to support a general  
7 underlying point on it or it may not, but there might be  
8 some benefit because they are so different. Adam is  
9 a very different case from Lucy. She in turn is  
10 different from Raychel and they're all different from  
11 Claire, and there might be some learning, given what the  
12 inquiry is charged to do in relation to the  
13 hyponatraemia inquiry.

14 So Mr Chairman, you may wish to think of it in those  
15 terms also. I only do that to point out what is still  
16 out there and yet to be resolved. At the moment,  
17 I think it's difficult to say that we have a concluded  
18 view in Raychel's case from Professor Kirkham.

19 THE CHAIRMAN: Well, we don't.

20 MS ANYADIKE-DANES: Exactly.

21 THE CHAIRMAN: Thank you.

22 So I'll make a ruling on this as soon as I can. I'd  
23 like to confirm -- I know Mr and Mrs Roberts are here.  
24 I'd like to confirm their view. If Mr Quinn, Mr McCrea  
25 and the Fergusons' solicitors could be asked to look at

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1 this transcript and I will pick up with them next week  
2 whether they have anything to add and maybe you'll come  
3 back to me next week as well, Mr Coyle.  
4 10 o'clock on Tuesday morning. Thank you.  
5 (5.30 pm)  
6 (The hearing adjourned until 10.00 am on Tuesday 11 June)  
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