Friday, 7 June 2013

(10.00 am)

(Delay in proceedings)

(10.13 am)

THE CHAIRMAN: Good morning.

Mr Quinn, do I understand correctly that the issues which you referred to yesterday afternoon about Claire's death, you want those to be put back until next week?

MR QUINN: Yes, that would be suitable, Mr Chairman. Tuesday morning would be suitable for that.

THE CHAIRMAN: Okay, we'll do that.

Then so far, Mr Uberoi, as the issues about Professor Kirkham are concerned, I will deal with them later on today, but I have two witnesses who have come to give evidence and I want to get through their evidence and facilitate them before we get into that debate. Okay?

MR UBEROI: Thank you, sir.

THE CHAIRMAN: Thank you very much.

Ms Anyadike-Danes?

MS ANYADIKE-DANES: Could I please call Dr Hicks?

DR ELAINE HICKS (called)

Questions from MS ANYADIKE-DANES

MS ANYADIKE-DANES: Good morning. Do you have there your CV?

A. I do.

Q. Thank you. I'm going to ask you if you adopt your witness statements that you have previously made in this matter, subject to anything that you say now in evidence.

You have made two previous witness statements in relation to Adam's case and Claire's case.

A. Yes.

Q. You gave evidence in relation to those at an earlier time. Some of that might become relevant now, but in any event you have already spoken to those. The one you made for Lucy's case, the series for that is 338, and it's dated 13 May 2013. Do you adopt that, subject to anything that you might say today?

A. I do.

Q. Have you discussed Lucy's case or even revisited Adam's or Claire's case with anyone prior to today, other than legal representatives?

A. No.

Q. Thank you. Then if we go to your CV, it's 311-013-001. If we can pull up alongside it 002. We can see from that that you qualified as a doctor in 1972.

A. Correct.

Q. In 1979, I think, begins your time in neurology and you were a registrar in neurology at the Royal.

A. Yes, I had a senior registrar post in paediatrics, which was a five-year training post, and I was seconded for a year to the neurology departments in the Royal Victoria and also Claremont Street Hospital which also part of the neurology service at that time.

Q. Yes. And then you had a position as a clinical fellow in neurology for about two years in the Children's Hospital in Boston; is that right?

A. Well, I had a one-year fellowship -- one year paid from here on a salary from the Northern Ireland Postgraduate Council and then the second year was funded in Boston.

Q. And that was 1980 to 1982?

A. Correct.

Q. Then in 1983 you became a consultant in paediatrics with an interest in neurology, and that was at the Children's Hospital.

A. Yes.

Q. So although you weren't a consultant neurologist, certainly you have got that interest, and that makes you a consultant for about 17 years by the time of Lucy's admission in 2000?

A. Yes.

Q. And you became a consultant paediatric neurologist in 1993 at the Children's Hospital.

A. Yes. The title of the post changed. As the hospital

became a Trust, the job descriptions were slightly amended to take account of changes that had occurred.

Q. Does that mean in 1993 you focused more on paediatric neurology than you might have done in your time from 1983?

A. I focused less on general paediatrics, so there was more time for paediatric neurology.

Q. More time for the neurology aspect of your work?

A. Yes.

Q. Thank you. You also are a member of a number of professional bodies. In terms of those that you were a member of before Lucy's admission in 2000, you were a fellow of the Royal College of Physicians from 1994, and also a founder fellow of the Royal College of Paediatrics and Child Health from 1997.

A. Yes.

Q. And in addition, you're a member of the British Paediatric Association from 1997 until --

A. 1977.

Q. I beg your pardon. Yes, 1977, until the foundation of the RCPCH, and when did you become a member of the British Paediatric Neurology Association?

A. 1983.

Q. Also before Lucy's admission?

A. Yes.

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

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

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

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

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

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

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

A. Two aspects to that. One is I was aware that there was a group set up to look at transport services for adults, children and neonates, which are separate to that. Regarding the transfer of children in -- do you mean to intensive care or generally?

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

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

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

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

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

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

A. PICU was in the paediatrics directorate.

Q. So that would be you?

A. Yes.

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

A. Yes.

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

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

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

Q. At the PICU end?

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

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

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

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

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

THE CHAIRMAN: Thank you.

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

A. Yes.

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

A. Mm-hm.

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

A. Mm-hm.

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

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

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

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

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

way into some sort of guidelines or guidance, ahead of that, was it your expectation that these children would come either with the relevant part of their notes or copies of that would be sent on, maybe by being faxed?

A. Yes. I think -- it didn't always happen and we would have to seek it afterwards, but that should have been part of it, and I cannot remember now whether it was clearly written down as part of their documentation.

Q. But in any event, you're fairly clear that there was a checklist like that which was a system in operation?

A. I do remember a checklist from earlier on.

Q. Thank you. And then if we go to 320-052-006, this is part of a minute dated 29 September 1998. You can see there at item 14 that the issue there is "Clinical quality and clinical governance", and the paper is actually tabled. I am not sure that you actually attended this one, but you can see that the CMO is explaining that new structures were being formulated to drive the quality agenda. She's informing members that:

"Clinical governance will focus on the overall service performance rather than just on individual performance standards."

Were you aware of that?

A. I must have been. I would have received the minutes of it. Well, sometimes the minutes didn't appear until

quite a bit later, so if I was at the meeting I would have heard the discussion.

Q. But even if they didn't come until quite a bit later, ultimately you got them?

A. Yes.

Q. What would that have involved doing? If the CMO is explaining that is what she wants to see, how does that translate into anything at the Children's Hospital?

A. Um ... I suppose, from the point of view of overall service performance, it's looking at the service, not simply from the point of view of the activity and the information that had become customary for the commissioning or purchasing process; it'd be looking at the services from the point of view of the quality indicators.

Q. When you've attended a meeting like this and any of these issues that I have just been taking you through are being discussed, what do you do about that when you get back to the Children's Hospital?

A. I would have normally taken time to report back to the team in the Children's Hospital, on occasion the medical director or the Trust team as well.

Q. That would be Dr Carson?

A. Mm-hm, particularly if there were particular issues. During my time as clinical director or at the

directorate meeting -- we had weekly meetings -- and there was usually at least one person who was a member of this committee on it. It was me for a while, but I then came off, and we would normally expect that prior to the meeting we would discuss any issues that we thought were going to be relevant to be discussed at the department, the SAC meeting, and that then we would feed back any issues that had come up.

If there were -- one of the frustrations, I don't want to sound as if I'm explaining, but one of the real frustrations at the coalface, as it were, was putting a lot of time and effort into projects that never got anywhere. So we always wanted to make sure, particularly, that if we were going to do something, that it was going to fit in with the regional -- not imperative, but a regional project so as to be sure it fitted in with regional plans. I don't know whether I'm explaining that well.

Q. No, no. If you take this one, the issue of clinical governance, which was an important question --

A. Mm.

Q. -- and part of a gradual move towards developing better governance structures. A paper that has been tabled in relation to it, the CMO has made her intentions clear. When you go back to the Children's Hospital, how

is that going to be translated into anything in relation to clinical governance for the Children's Hospital?

A. Well, it will have to fit in with the overall Trust, but we would look at it from the point of view of what each service might need to do.

Q. And the mechanism for doing that will be what?

A. It would be done through the Trust audit department, I guess. I'm not sure -- I'm not answering this right.

The first mechanism, I guess, would be to promulgate it, to make people aware of what we were going to need to be doing and what we'd need to be looking at in specific for each service. One of the other things that complicates this is that, particularly the specialty services, they all had systems within their own UK specialty organisation as well, so they would dovetail into that, and the clinical quality and clinical governance came into that eventually. It wouldn't have had earlier on.

So we would be -- so some services might have been -- I'm not sure that I can think of a precise example -- further on with this through their specialty organisation.

Q. I see. But in any event, this initiative, am I right in saying this initiative is something that you'd have taken back and reported to the medical director?

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

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

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

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

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

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

A. It could have been.

Q. Yes.

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

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

A. I believe so.

Q. Sorry?

A. I believe so.

Q. And how would he know that?

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

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

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

Q. Thank you. Was it an effective forum?

A. The specialist --

Q. Yes.

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

Q. And why was that?

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

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

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

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

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

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

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

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

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

a colleague, Dr Webb, who had been appointed, and I think he took over the editing and preparation of the neurology section rather than myself.

Q. Sorry, we can see it at 319-067A-006. There we are.

A. Yes.

Q. So it's a:

"Handbook of guidelines for the management of many common paediatric medical conditions."

It's compiled with the assistance of staff. We can see some of those who have previously given evidence in relation to other cases. There's Dr Bartholome, then there's yourself, Dr Hicks. We see Dr O'Connor, Dr Savage, Dr Steen, Dr Webb. And they've all been previously involved in Claire and Adam's cases.

Who actually was this targeted at?

A. It was targeted at the paediatric staff in training mainly.

Q. Does that mean everybody below consultant level?

A. More or less, yes.

Q. How did the clinicians get access to it? Did it form part of an induction? Was it there available on the wards? How did they know about it and get access to it?

A. It was available on the wards. It should have been available on every ward. I can't recall if every new member of staff was given a copy, but they would have

been made aware of it at induction. Certainly all the consultants were provided with a copy.

Q. All the consultants were?

A. Yes.

Q. The reason I ask you is Dr Hanrahan seemed to know nothing about it.

A. It may have gone out of print by the time he was appointed. I'm not sure about that.

Q. Given that it is dated 1999, to what extent did this reflect anything that might have been learnt in relation to Adam and Claire's cases? I don't necessarily mean just about hyponatraemia. There were issues in both those cases about record keeping. There were issues, for example, in Claire's case about hospital post-mortems. To what extent, given that it came a number of years after those deaths, was it intended to incorporate any learning? Not just from those two deaths, but just generally learning.

A. It was intended to incorporate --

Q. It was?

A. It was intended to incorporate learning, I believe.

Q. So it would have been a good vehicle for disseminating any learning from that? You see, I can't actually find anything in there about record keeping and its importance.

A. No.

Q. And it does have a section on autopsy. We can go to that at 319-067A-030. We can pull up the next page because that goes on to deal with the coroner, 031. This is something else that Dr Hanrahan had no real knowledge about. If one sees it, firstly there's nothing in there about, so far as I could tell, help with how you fill in a death certificate. It's really quite brief as to the information being provided.

If you look at the hospital autopsy part, there was quite a bit of evidence as to the information that should be provided to the pathologist and the discussions that it would be helpful to have by way of clinicopathological correlation and so forth when the clinicians involved in that were giving their evidence. It doesn't seem to reflect any of that.

I will give you a comparator. This is the Altnagelvin's doctors' handbook. If one pulls up, in substitution for page 26, 316-004A-025. We'll come back to that.

Just so that you know why I'm going to it, their handbook is dated August 2001, so just after Raychel's death, which was in June. But no law, if I can put it that way, had changed in relation to reporting to the coroner a death, so still under the same

legislation. But the information there as to what to do, how to do it, is much more detailed.

Dr Hanrahan, when he was giving his evidence about reporting to the coroner, seemed to be quite unclear, apart from in very basic terms, as to what he should be doing and what might be the result of it.

Were you aware of how doctors should be assisted with their statutory and professional duties in relation to the reporting of deaths to coroners?

A. Well, I was aware that they needed to know the duties of a doctor, the General Medical Council guidance. It would have been part of their, I suppose, appointment and initial orientation to ensure that they were aware of that. And subsequently, also, during appraisal, annual appraisal.

Q. When you say orientation, you mean that's part of an induction that they would get that?

A. They should do, yes.

Q. They should do?

A. Yes.

Q. Did you know that that actually happened?

A. Well, the Trust -- I have to say, for new consultants, the Trust held -- took charge of the induction, and I can't -- I'm afraid I can't remember exactly the details of that. I personally, as clinical director,

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

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

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

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

A. Yes.

Q. And to be clear on?

A. Yes.

Q. Equally, the provision of a death certificate?

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Raychel's death, was that another reason he was told for the change of use was because there had been a number of deaths associated with low sodium. He didn't say when those deaths were, I'm not sure that he knows whether he was told that, but in any event he associated the use of low sodium with risk, if I can use it in that way. So he's very, very clear about that, and yet Dr Chisakuta and -- as the chairman's just told you -- all the other witnesses simply don't recall that at all.

So far as you're concerned, in the Children's Hospital, were there clinicians who were beginning to associate the use of low-sodium fluids with some kind of risk for certain children? Maybe not all, but certain children. Were you aware of that?

A. No, I don't think so.

Q. Well, did you associate it with risk if used inappropriately?

A. As a neurologist, I did, yes.

Q. Sorry?

A. As a neurologist, yes.

Q. You did?

A. Yes.

Q. And do you think you were alone in that or could your colleagues also, your fellow neurologists, also have formed that view by 2000?

A. I would have thought neurologists would have been aware of the risks, particularly in neurological practice.

Q. Yes. And what is the risk that you were aware of by 2000?

A. That rapid lowering of serum sodium can be associated with adverse events. Seizures is the number one I can think of.

Q. How would you achieve a rapid lowering?

A. Well, it can be achieved as part of disease process --

Q. Yes.

A. -- or it can be achieved by excessive dilute fluid.

Q. Yes. It's correct, isn't it, that trainees -- and by that I mean everybody short of a consultant -- administer IV fluids to children in the Children's Hospital?

A. Yes.

Q. Yes. So they could do that inadvertently, reduce a child's serum sodium level too quickly?

A. Yes.

Q. That could happen?

A. Yes.

Q. Why is that not in the guidebook as a warning? When you've got that section dealing with the administration of IV fluids, why isn't there a warning, if the neurologists appreciated that, that one has to be

careful about that?

A. I don't know. I can't account for it.

Q. Would that not be an appropriate thing to put in there?

A. Yes.

Q. Yes. And do you think that, apart from the neurologists, other disciplines were as well aware or as attuned to that risk? Other paediatricians, might they be?

A. I certainly thought the specialists were, yes.

Q. The specialists were?

A. Yes.

Q. But those who weren't specialists might not be?

A. They might not be. They seemed not to be.

THE CHAIRMAN: The trainees wouldn't be?

A. Um ... Well, the trainees -- it depends at what stage of their training. It would be part of their training to teach them about --

THE CHAIRMAN: Weren't these guidelines to help the trainees?

A. Yes.

THE CHAIRMAN: So if you don't put it in the guidelines, then the trainees are going to have to go somewhere else for the assistance they need?

A. They do also get training during their induction on fluid.

THE CHAIRMAN: But if you leave it at that, then you wouldn't bother writing the guidelines. If you are going to say they are going to get their training somewhere else, they're going to get their training in induction or they're going to get their training day-to-day on the ward with consultants, then you wouldn't bother writing guidelines. So when you are writing guidelines, you must be trying to bring together any issues which seem to bear repetition or emphasis; right?

A. Yes.

THE CHAIRMAN: So if low sodium can cause seizures as a result of either excessive dilute fluid or as a natural consequence of other diseases, that's something that the trainees need to know.

MS ANYADIKE-DANES: And would you have said that, within the Children's Hospital, you had there those who were most likely to know about the developments in that area as to electrolyte imbalances and the effect of the use of low-sodium fluids, SIADH and so forth? Would you think that you had a better chance of knowing the developments in that than your colleagues in the district hospitals?

A. Yes, to some extent certainly.

Q. Were you aware of the two Arieff papers, for example?

A. I don't remember them.

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

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

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

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

sure that the anaesthetists did know about the lessons from Adam's case; are you aware of what that mechanism would be?

A. Well, it would need to be a mechanism that reported, reviewed the case, and reported the problems and generated some recommendations for management, I would think, and that would need to be agreed by the anaesthetists and shared in the hospital; is that what you mean?

Q. Not exactly, although that would have been a start. You were the clinical director of paediatrics from 1996 to 2002.

A. Mm-hm.

Q. 1996 was the year of Adam's inquest. That's when the statement was made. The statement was provided to the coroner as part of Dr Taylor's evidence. So you, so far as I can tell from your CV, were actually clinical lead at the time that statement was being provided to the coroner.

A. Right. I don't know. I took over on 1 October.

Q. You took over on 1 October, his inquest was in the summer. So just after then you would have been clinical lead. And you were never even made aware of that case? If some system was going to be established to disseminate, to at least the anaesthetists, all the

lessons, as the clinical lead, would you have been involved in whatever was established to achieve that?

A. Yes.

Q. So for that to happen, you would have to know about it?

A. Yes.

Q. And you never knew about it?

A. No, never.

Q. How do you or did you, when you were clinical lead, ensure that the consultants in paediatrics were keeping up-to-date with current practices, particularly in relation to the management of fluid balance? How did you do that?

A. Initially, when I took over, I don't think there was a system for doing that. The process of appraisal, when it began, included a review of continuous professional development.

Q. When did that start?

A. About 2000, 1999 or 2000. 2000 or 2001, I think, was the first formal year that we did it in the Royal.

Q. How would that process have assessed whether any given clinician was keeping up-to-date with current practices?

A. The process -- you would examine or review evidence that the consultant would bring of what courses and study days and so on that they had attended because you would go to a course and you would be issued with

a certificate and so on.

Q. I see.

A. I would personally engage -- I had a number of different types of consultant in the directorate who were signed on for CPD with different colleges, surgeons, psychiatrists, paediatricians and so on. So it was, to be honest, quite difficult to really scrutinise their development programme and it was an evolving process so that it became, I think, more meaningful in the discussion one had about identifying people's needs vis-a-vis various aspects of their practice.

Q. How did that work across directorates? Because some of those who are in PICU, which is within your directorate, are also in ATICS, those are the anaesthetists. So how did that work? Because presumably at that level you don't have -- I don't want to say control over them -- but they're not within your remit, or are they?

A. No. It didn't work very well, to be honest. It was a problem between directorates and it was a problem between hospitals as well.

Q. Have you seen Dr MacFaul's report? He's the inquiry's expert.

A. I haven't seen his most recent one. I read part of the report for Claire Roberts.

Q. Have you seen his report for Lucy?

A. No. I haven't been able to access anything online for personal reasons for the last few weeks.

Q. Did you know he provided a report for Lucy?

A. I'm not sure whether I was aware of that. I knew he had done one for Claire.

Q. Yes. Right. In the course of that report, he makes a number of criticisms of some of the clinicians, not singling them out in any way, but reviewing what happened and then indicating what he thought might have been problematic. In relation to Dr Hanrahan, it really starts, I think, at 250-003-007.

This should help you. Under (xiii) -- in fact it starts really above that, but you can see that, in terms of the clinical shortcomings, he says of Dr Hanrahan at (xiii):

"He did not review the case records and the fluid regime and did not appreciate the volume overload with hypotonic fluid. He was aware of the low blood sodium, but concluded this as insufficient in severity to cause the cerebral oedema. This point is reasonable given the knowledge of the time as a cause of cerebral oedema. He did not consider that this level of hyponatraemia could also be a sign of the fluid overload nor take account of the weight gain [which he thought was another sign], nor that the severity of hyponatraemia at the time of Lucy's

collapse could have been greater than was measured after the high volume of normal saline had been given."

And so on. So he makes a number of discrete points in relation to Dr Hanrahan's involvement in Lucy's care at the hospital and the aftermath of her death. Are those the sort of things that you would have wanted to know about?

A. About a consultant?

Q. Yes.

A. I think so.

Q. And if you were going to hear about them as the clinical director, how would that information come to you?

A. Well, they might volunteer it.

Q. And if they don't, how does it come to you?

A. Another member of staff might bring it to my attention, although, frankly, that's pretty unusual.

Q. Yes.

A. It certainly was then.

Q. So what then is the system that you have, other than somebody just knocking on your door and saying, "Look, I think, in retrospect, I could have done things better"? Other than something like that, what's the system for being able to identify and pull up deficiencies?

A. I think the systems at that time -- and I'm not sure

what's in place now -- were not good for doing that. For example, there was no system -- it's one of the things I've come to realise in my part in this inquiry, that there was no system for the clinical director to really be informed of all deaths, and certainly to be informed about deaths that were referred to the coroner. It simply didn't exist. And I have to admit that I didn't think about that. I hadn't thought of that at that time as being an issue.

THE CHAIRMAN: Is that, doctor, because you assumed that if there was a clinical death in paediatrics, that you might be told about it?

A. Sorry?

THE CHAIRMAN: You said there was no system in place for telling you about clinical deaths.

A. About deaths. What I mean is there wasn't a system for notifying you -- for notification on an individual basis. We did see statistics, of course.

THE CHAIRMAN: But if you're the paediatric lead and therefore, for so long as you hold that position, you have some additional responsibility in this area. So you were not necessarily made aware of the deaths of children, even if they went to the coroner?

A. No.

THE CHAIRMAN: So that if anything came out of the coroner's

system, you wouldn't necessarily be aware of that either, and I think as you just said a moment ago, your phrase was, I think: in terms of doctors reporting concerns to you, you said another member of staff might bring it to your attention, although frankly that's pretty unusual.

A. Yes.

THE CHAIRMAN: So in effect, there was no system of any sort for monitoring the standard of care provided?

A. Well, there wasn't at that time.

THE CHAIRMAN: And when we say "at that time", we're not talking about some ancient history; we're talking about 2000?

A. Mm.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: You said you just didn't think of it, but you are part of Specialty Advisory Committee that's established by the CMO, which in 1998 is saying, "I want a big push for clinical quality and clinical governance". So it was coming down the track what the CMO wanted. So how could you, in 2000, not have realised at the very least, "I must put in a system whereby I know all the child deaths"? Because if you don't know them, you can't even begin to see in a systematic way what might have gone wrong.

A. Well, we did know the deaths through the mortality reporting system, through the mortality meetings ...

THE CHAIRMAN: Sorry, with all due respect, that's pretty meaningless, isn't it, because the deaths that you learn of through the mortality system might be an unavoidable, inevitable death on the one hand, or it might be a death which results from inadequate treatment in the Royal or in the Erne, or in Altnagelvin or wherever; right?

A. Yes.

THE CHAIRMAN: How do you distinguish between the two?

A. It's very difficult looking at them in bulk, as it were.

THE CHAIRMAN: Is the mortality meeting not supposed to be the meeting at which all these issues are brought out and there's intense debate and it's not minuted because, I am told, that would discourage debate. So if debate is encouraged by the fact that there's no minutes, are you telling me that in fact the debate never really took place?

A. No, debate did take place.

THE CHAIRMAN: And the outcome? Or no outcome?

A. Well, you've asked me to think of that and I'll try.

THE CHAIRMAN: Yes.

MR UBEROI: Sir, for clarification, can I remind you of a couple of pieces of evidence? I entirely understand why you're scrutinising whether a mortality meeting took

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

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

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

THE CHAIRMAN: Thank you.

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

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

A. I didn't.

Q. Why not?

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

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

A. Mm.

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

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

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

A. Yes.

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

A. There seems to have been, yes.

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

A. Yes.

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

A. I do remember that.

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

A. Yes.

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

A. Yes.

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

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

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

seem simple. Children in PICU generally, most of them, require respiratory support, and that requires them to have a consultant anaesthetist who is responsible for that care in whatever way the consultant anaesthetist organises their responsibilities. But most, if not all, other children will have respiratory problems because of an illness that would be appropriately looked after by a different -- another consultant, and this issue would arise. So there would always be a consultant's name, and I think it was always the same name, from the administrative point of view --

Q. Dr Crean has said that.

A. -- that tended to go on. I didn't understand why it always had to be Dr Crean's name, and this was discussed at our meetings before my time as clinical director and it was an ongoing administrative issue.

Q. When you came to your position as clinical director, that system was still in place?

A. That system was in place.

Q. If you didn't understand it, what were you able to do about changing it?

A. I'm not sure I managed to change whatever was the IT issue behind putting the name on. But what we certainly did was insist that there must be a consultant anaesthetist and it should be the relevant consultant

anaesthetist and another consultant who should be notified immediately.

THE CHAIRMAN: The relevant consultant anaesthetist presumably is the person who's on -- if it's Dr Crean on Monday and then, say, Dr Taylor on Tuesday and the child is still in intensive care on Tuesday, it's not Dr Crean on Tuesday because he's not there, it becomes Dr Taylor? In effect, the identity of the relevant consultant anaesthetist changes as the shift changes; is that right?

A. It has to, apparently, yes, because they change.

THE CHAIRMAN: Yes. And that's how the system worked, that there was one at a time who was dedicated to PICU, so whoever was dedicated to PICU on a particular day was the identified consultant anaesthetist responsible for the care of the child on that day.

A. Yes.

THE CHAIRMAN: And that then depends on effective communication between the outgoing anaesthetist and the incoming anaesthetist as to what the problem is, how the child's progressing --

A. And the other consultant or consultants, depending on how many of those there are.

MS ANYADIKE-DANES: And if you're going to have a system like that, which even for the chairman just to describe

it like that, you can see that continuity of care would require a reasonable degree of communication between all of those; would you accept that?

A. Yes.

Q. That might mean it would be more than usually helpful to have clear notes or clear record keeping.

A. Yes.

Q. And how, in the notes or the record keeping, do you identify at any given time who the consultants are who have the overall responsibility for the child's care?

A. Well, the anaesthetist will make notes each day according to whoever's on.

Q. Yes. Let me help you with why I put it in that way. Because although there is an anaesthetist on duty, it may be that another anaesthetist perform a procedure to help out. In this case, actually, Dr McKaigue would have been the anaesthetist as she came in, handing over to Dr Crean, but he was called away for an emergency, and so Dr Chisakuta, who was not going to be on duty on that day in relation to Lucy, stepped in to perform a procedure. So you would see his note in her records.

A. Mm.

Q. But that doesn't necessarily mean that he is going to be her consultant for that day in relation to anaesthesia. So that's why I'm asking you. If you're going to work

a system like that, how do you record who the relevant consultants are?

A. Well, for each day there should be a note made, a record made of who was on that day. They would normally do the ward round in the morning.

Q. And is that kept in the child's notes so if, after the event, you want to try and see who we should be talking to in relation to a child, is that rota or that note kept anywhere in the children's notes?

A. It should be within the body of the notes.

Q. Yes. And when I was asking Dr Hanrahan about that, because Dr Hanrahan had acknowledged that -- I think his expression was a degree of vagueness over the consultant with overall responsibility. And that vagueness had left him in the position of not really knowing whether he was the one who should have been, for example, writing the discharge letter, whether that was his role or it was the role of Dr Crean. His description of events was:

"As far as I was concerned, I was brought in to give a specialist neurological report. I did a few other things as well to help out, but that was primarily what I was brought in to do."

He did not regard himself as taking on jointly, in a formal way, the overall care or responsibility for

Lucy's care.

When I pressed him a little bit on that, he acknowledged that there was a bit of vagueness about who would be or should be having overall responsibility and said that things have been tightened up now.

If I go back to you, were you aware that there were occasions when it wasn't entirely clear who the consultant or consultants were who had overall responsibility?

A. I might have been aware that it occurred from time to time. I wouldn't have been aware that it was a regular problem. As far as I'm concerned, it was unacceptable for there to be uncertainty.

Q. So if Dr Hanrahan, on reflection, had thought that there probably was a bit of vagueness and that was unfortunate because it meant that effectively certain jobs fell between two stools, is that something that you would expect to know about so that you could monitor that sort of thing?

A. I'm not sure that there would have been a system for telling me that at that time. But if there was concern, if someone had noticed that or felt it was a concern, then they would let me know. I'm trying to think if I can think of another example of that, but I can't. But from time to time -- certainly from time to time

there were issues about who was in charge of a child, and it would come to the clinical director.

THE CHAIRMAN: I'm not so sure, doctor, how concerned I am, because I can see how in any situation a bit of uncertainty might develop. For instance, if you have, as in this case, paediatric anaesthetists, a number of them, who are looking after Lucy and then they call in Dr Hanrahan -- so the extent to which he becomes involved influences a decision about whether he becomes the consultant in charge or not. And it might be difficult sometimes to identify the point at which his involvement is significant enough for him to be in charge or whether he is assisting the anaesthetists, and then, even if he does become the responsible consultant, the anaesthetists stay involved obviously because Lucy stays in PICU. So I can see how the grey area emerges and I'm sure, when you say that this was an issue when you were in Boston, that there's nothing novel about this.

A. No.

THE CHAIRMAN: I think the problem comes primarily afterwards when, after Lucy dies, there's an issue about the death certificate. There's an issue about who speaks to the parents, what the parents are told, and there's an issue about what the parents are told and,

Lucy's case, perhaps, highlights the confusion that can arise when there are difficulties about what has to be explained to the parents, who reports to the coroner and what is reported to the coroner; would that seem fair?

A. I think that's fair enough and I think when there's another hospital involved, it's even more complicated.

MS ANYADIKE-DANES: I can give you a concrete example of that, which is to do with a discharge letter. It turns out that a discharge letter was not sent to either Lucy's GP or the Erne Hospital, and certainly Dr Hanrahan thinks that that should have happened.

I don't think there was any disagreement amongst the clinicians who have given evidence that certainly a discharge letter to the GP ought to have happened, and, more to the point, they said that the practice was that the GP would receive a phone call because sometimes it took time for the discharge letter to be produced. So just so that the GP was alerted to what had happened and had information that he could assist the family with if the family came and saw the GP.

Dr MacFaul, the inquiry's expert, at 250-003-117 at paragraph 600, says that failure to send the discharge letter to either Lucy's GP or the Erne Hospital -- he says that that was a significant deficiency not to do that, and in his view that was a task for Dr Hanrahan

because of the level of his involvement in the latter stages of Lucy's care. One of the reasons he says it's so significant is, he said, because writing a letter like that offers an opportunity for the treating team to review the management of a particular case. So that's an opportunity to again see what happened, what went wrong, and for learning points to emerge.

I will ask you the question in a minute, but just so that you have the information. Professor Scally, who is also an expert for the inquiry, he says that the Children's Hospital ought to have informed Sperrin Lakeland in a formal manner, so over and above the communication with the GP, hospital to hospital, Trust to Trust, they ought to have informed them that Lucy had died and that there were concerns among some of the clinicians as to the quality of the treatment that she had received in the Erne. Okay? So that's what the inquiry's experts are saying.

How this comes about is, when we asked Dr Hanrahan about it, he said, "Well, I didn't think that I had to do that because I hadn't assumed formal responsibility, so it wasn't my task". We don't need to pull it up, but he goes into that in the transcript of 5 June at page 23. Dr Crean, on the other hand, was of the view that the responsibility for Lucy's care had indeed

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

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

A. I suppose one or other of those people, the consultants involved, might have brought it to me, or more likely somebody in the clerical line who's -- the chart's not meant to be filed until all the documentation is complete. One of the problems here is that the child went for a post-mortem and the notes go to the pathology department. There had been a historical problem of notes not coming back in a timely manner, which was a difficulty for writing timely letters and summaries. But it was standard practice that the notes after an admission should not be filed, and that was standard practice in all the wards and departments, as far as I'm aware, until there was a discharge letter and summary, and there was a pro forma that had to be completed.

Q. We have seen that, yes.

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

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

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

A. Yes.

Q. Just make sure we're talking about the same thing. 061-004-011; is that what you're talking about?

A. Well, that's a handwritten version.

Q. Is there another type?

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

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

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

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

A. Well ...

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

A. Correct.

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

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

Q. Essential, did you think?

A. Yes, essential.

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

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

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

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

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

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

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

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

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

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

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

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

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

least three doctors who say they believed it was. Okay? But let's assume for the moment that it is the case.

A. So that if it's believed that treatment was inappropriate or inadequate, then --

THE CHAIRMAN: Or even let's suppose that Lucy didn't die because of the defective treatment, but that there was defective treatment. So whether she died or not, if there is a solid view that there was defective, negligent treatment in the Erne, do you agree with Professor Scally that the Royal was under a duty to formally report that to Sperrin Lakeland Trust in 2000?

A. I wouldn't have been aware of that duty.

MS ANYADIKE-DANES: Well, would you have sought to do it in such circumstances?

A. If that circumstance was definitely present, then --

Q. Sorry, let me try and give you a scenario.

THE CHAIRMAN: It's okay. If that circumstance was definitely present?

A. Then I think, as clinical director I would have probably had to seek the advice of the medical director in doing so, but that would have been my track to do that, to say, "Something has gone seriously wrong here, we need to communicate this formally".

MS ANYADIKE-DANES: Would you have formed the view that even if you didn't think necessarily perhaps you had you had

the authority to do it, would you have formed the view that you would want to let other trusts know that?

A. Yes, I think so.

Q. Having formed that view then, are you saying you would take that to your medical director as to how that is to be achieved or --

A. Yes.

Q. -- whether he accepts that?

A. Yes.

Q. Then if a death is reported to the coroner and there is going to be an inquest or there's a decision about that, but the treatment actually originated in the referring hospital -- so, like Lucy, the child arrives in a moribund state, in due course brainstem death is certified, the case is notified to the coroner and a decision is made, do you think it appropriate that the referring hospital is told that the case has been referred to the coroner and also advised as to whatever is the decision that's made?

A. Yes.

Q. Routinely?

A. Yes, I think so, yes.

Q. And who has the duty to do that?

A. Um ... Well, I would normally expect that the consultants involved who had communicated with the

referring hospital would do that.

Q. And do they know that that is what is expected of them by you?

A. I don't know.

Q. Well, how would they know that?

A. Well ... I mean, I ... We always would have -- I'm sorry, I just need to think about this. We always would have expected consultants to communicate back to referring hospitals whatever happened. So I think -- and that regularly happened. I don't know that it ever --

Q. But how does any given consultant know that is expected of them, whatever he or she does in their own hospital, about that death, over and above that that they're expected to communicate with the referring hospital? How does any consultant know that?

A. I don't know that they -- that we had a way of expecting them to do that.

Q. But you're saying that is what you would have expected them to do.

A. Yes, I'm saying that as part of the communication that I would have expected them to have with the referring hospital.

THE CHAIRMAN: I know in this case that there were discussions between different consultants in the Royal

and the Erne. There was some toing and froing between them by phone, but what is not clear is that the Erne was told that Lucy's death had been referred to the coroner or what the outcome of that was. I think there's some suggestion that it did happen, though the circumstances around it are a bit vague, maybe because it's so long ago, but you would have expected that to have happened in any event?

A. Yes.

MS ANYADIKE-DANES: Mr Chairman, I think a break is required.

THE CHAIRMAN: Doctor, we'll stop until 12.15. Thank you.

(12.03 pm)

(A short break)

(12.20 pm)

MS ANYADIKE-DANES: Dr Hicks, what I'm really trying to do is to see the extent to which the treatment of Lucy gave rise to any concerns, now that you have the information in front of you, as I realise that you didn't have that information at the time. Because what I'm trying to explore with you is whether there are things that came out of her treatment and care that should have come to you through some system or other, if they are concerns. All right? So we've been going through a number of them.

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

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

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

A. That they're not reading the notes?

Q. Yes.

A. Yes.

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

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

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

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

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

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

Q. Yes.

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

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

A. Right.

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

A. From what I know, yes.

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

A. Yes.

Q. Before you do that?

A. Yes.

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

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

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

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

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

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

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

Q. Yes.

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

Q. Yes.

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

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

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

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

A. Yes.

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

A. Yes.

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

seen that, as to what was being reported?

A. No.

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

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

A. That it was reasonable, yes.

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

if Dr Hanrahan is given no further information to help him formulate a cause of death to put on a death certificate? What do you think should have happened?

THE CHAIRMAN: I'm not sure that question will be clear to Dr Hicks --

MS ANYADIKE-DANES: Sorry.

THE CHAIRMAN: -- who hasn't necessarily been following what's been going on here for the last week and a half.

MS ANYADIKE-DANES: I beg your pardon.

THE CHAIRMAN: Sorry, let me try to put it in context: as a result of whatever discussion took place, it was decided that there would be no coroner's inquest and it was then decided that there would be a hospital post-mortem instead. Then there was a delay for some time and the family's undertaker contacted the hospital from Fermanagh to say that they needed a death certificate. And at that point, a death certificate was issued by Dr Hanrahan. It is suggested to me that it was issued on Dr Hanrahan's instructions, but filled out by Dr Dara O'Donoghue.

MS ANYADIKE-DANES: So the issue that I'm wondering if you can help us with is that Dr Hanrahan is clearly of the view that he doesn't really know why Lucy has died. So he reports that case to the coroner because, in his view, he can't write a death certificate at that stage.

Okay? He reports the case, the upshot is that there is a discussion which neither person can recall what the content of that discussion is, but the result of it is there is to be no inquest, there's to be a hospital post-mortem if the parents agree, and ultimately a death certificate is written. But where I'm taking you to is, during that conversation that he has with somebody at the coroner's office, if he receives no further information to help clarify what the cause of death should be, what do you think he should have done as clinical lead? What would you expect him to have done?

A. Go back to the coroner.

Q. Sorry?

A. Ring the coroner again and possibly get some senior advice in the hospital. But I think he needs to ring the coroner. If he'd asked me that day, that's what I would have told him.

Q. If he had come back to you that day and said, "I have had a conversation at the coroner's office, I'm still none the wiser as to why this child died, what do you think I should do?", what would your advice have been?

A. He should ring the coroner.

Q. And why do you say that?

A. Well, if you don't know why the person has died, if you're uncertain why someone has died, if you can't --

I mean, you can't sign a death certificate if you don't know what the cause of death was.

Q. Yes. In any event, that's not what happens. Without knowing what the content of the discussion is, what happens is that it becomes clear that there isn't going to be an inquest, nor is there going to be a coroner's post-mortem. And because Dr Hanrahan still is of the view that he can't write a death certificate, he seeks a hospital post-mortem in the hope that that can give him sufficient information. Is that an appropriate use of the hospital post-mortem?

A. Well, I mean, yes, I don't -- I think in the fullness of the situation, that might be questionable, but that's why post-mortems have always been done: to ascertain or confirm the cause of death and to seek further information.

Q. When I put that point to Dr Crean, he was very clear on it, and he said that is not the purpose of a hospital post-mortem. In his view, you have to be able to write a death certificate. If you can't write a death certificate, then it's a report to the coroner. What the hospital post-mortem can do is for learning purposes, it can give you more information, clarify matters, but you need to be able to know the cause of death. Would you accept that?

A. Yes.

Q. So if Dr Hanrahan did not know the cause of death coming out of that conversation with the coroner's office, he should not have been agreeing to a hospital post-mortem in the hope that that will clarify matters for him?

A. Yes.

Q. Sorry?

A. Yes.

Q. He shouldn't have been?

A. He shouldn't have been.

Q. How will he know that? Where does he get the information that explains these things to him?

A. Well, that's part of undergraduate medical training and postgraduate medical teaching and experience as you go along. It's been my own personal experience and I realise things are different now. I had cause as a pre-registration house officer to call the coroner and be involved in these discussions and less often now perhaps than then.

THE CHAIRMAN: I don't think we need to linger very long on this because, I'm afraid, what happened was clearly inadequate. But would it surprise you that Dr Hanrahan said he hadn't received any undergraduate or postgraduate training on his responsibilities in reporting a case to the coroner?

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

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

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

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

would you expect the reason for that to be recorded as well if the clinician had thought that that's what should happen?

A. Yes.

Q. Just one final point on the report to the coroner. Dr Carson said in his witness statement -- and we don't need to pull it up, but the reference is 306/1, page 3 -- and it's in answer to question 1(e), he says it was his expectation that:

"If the coroner was notified about a death, Dr Murnaghan or Mr Walby would be informed by the responsible consultant."

Did you know that?

A. No.

Q. He didn't tell you that?

A. I don't remember any guidance as regards that.

Q. If that was the medical director's expectation, where would you expect to find that?

A. Somewhere in some guidance or instructions.

Q. That's what I'm trying to ask. When the medical director says he has his expectations, this is what he would like to have done, how does that get communicated to you as the clinical lead, if that's the relevant clinical lead, and then on to the clinicians so that they know they are meeting the expectations of the

medical director? How does that happen?

A. The way that that kind of thing, which was really a directive, was communicated was to send a written letter, signed written letter, to every member of staff, relevant member of staff, to all the consultants, and probably to all the junior doctors.

Q. And did that happen in your experience?

A. I don't recall that happening.

Q. Do you ever recall the medical director having some expectation or some requirement that something happen and that being reflected in writing? Do you have any experience of that?

A. I don't have any memory of that, no.

Q. Well, how did he generally tell you what he wanted to happen?

A. He would write.

Q. And that's what I was asking you. You've got no recollection of him ever having written?

A. I have no recollection of him having written and I have no recollection of him writing to me as a consultant or to me as a clinical director.

Q. I don't mean about this point. I mean about anything.

A. We'd get letters saying, "I require you to do this or this is a duty you need to do", and he would give the reference. If it was based on DHSS policy or something

like that. Sorry, is that ...

THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: So that would happen, but you just don't remember it in relation to this --

A. I don't remember it.

Q. If I just ask you about the hospital post-mortem, the autopsy request form, because I think you were starting to embark on that before. When there's going to be a hospital post-mortem, there has to be obviously an autopsy request form. Who, in your view, should be filling in the autopsy request form?

A. Either the consultant or a senior member of the team, junior -- you know, a senior junior doctor in training, specialist registrar.

Q. For example his registrar?

A. Yes.

Q. So in this case it could be Dr Stewart?

A. Yes.

Q. Would she be sufficiently senior in your view?

A. I think she would have been at that time, yes.

Q. If that task is going to be done, what do you expect is the process of getting the information that is relevant for the pathologist?

A. It's a process review of all the information available: the chart, all the --

Q. If the registrar is doing it, do you expect the registrar to discuss that with the consultant?

A. Quite often he would. That would not be uncommon. There would usually be a discussion about it, about who was going to do it. If the consultant was asking the registrar to do it and the registrar had any questions about it, they would ask.

Q. Was there any training or guidance provided as to how to do that?

A. Well, I have trouble remembering exactly whether there was anything, but I -- we did have sessions with the neuropathologists and possibly even the pathologists, speaking to us. I have a feeling there was a document about that, but I cannot -- I just cannot remember the details. Certainly in the neurology teams we had a weekly meeting and, once a month, there was a neuropathology review session, and from time to time they would cover other topics and one of them would be, you know, revising information or reminding people. Quite often, these topics were reviewed once a year when there was a new intake of trainee staff.

Q. The accuracy of the summary, the clinical summary that gets sent, is something that you'll recall was an issue in Claire's case.

A. Yes.

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

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

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

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

the coroner about the decision over the issue of the death certificate. In his witness statement 277/1, page 7, he says:

"The decision about the issue of the death certificate was made by Dr Hanrahan."

What you have just described is: if you have reported it to the coroner, in your view it's the coroner who makes the decision, not the clinician.

A. Yes. And that's normally -- my experience, which is some time ago, would be the last words would be, "Doctor, you can write the death certificate".

Q. So if that doesn't happen and Dr Hanrahan takes it upon himself to issue the death certificate or, rather, the medical certificate of cause of death, would that concern you that he thought it was possible for him to do that, assuming that to be an accurate statement of the law?

A. What concerns me is there's still not clarity of the accurate cause of death, yes. That would really --

THE CHAIRMAN: That's a bigger issue. It's not whether the coroner has given the say-so because on the information which seems to have been in the air in April 2000, the coroner was not taking the case for a coroner's inquest. If Dr Hanrahan understood that to be the case, then he may have thought he could go ahead

and issue the death certificate without --

A. Despite not knowing the --

THE CHAIRMAN: Well, no, he could issue the death certificate without the coroner's approval if the coroner had said he wasn't going to conduct an inquest. But even if that was the case, then he still had to know what the cause of death was to put into the certificate. So isn't that the more important point, what the cause of death was?

A. Yes.

THE CHAIRMAN: Because that's fundamental to completing a death certificate.

MS ANYADIKE-DANES: I was just going to come to ask you that.

THE CHAIRMAN: Let's get to that point.

MS ANYADIKE-DANES: What Dr Hanrahan says is effectively he never, prior to this death certificate being issued, actually was clear about the cause of death. So does that concern you, that in those circumstances he nonetheless guided Dr Dara in having this death certificate issued?

A. One of the things, if I may say, is that as a cause of death, cerebral oedema is quite acceptable, and actually that is what was her ultimate cause of death. The problem is the process or the course to that, that it is

not completely explicit.

Q. There are two things I wanted to ask you about that. One is, if Dr Hanrahan's view is, "I don't really know why Lucy died, I don't really know what her cause of death is". That's the first point I want to put to you. If he is in that state, would it concern you that he nonetheless directed and guided Dr Dara, his SHO/acting registrar, to issue the death certificate; would that concern you?

A. Yes.

Q. So that concerns you. If we come to what is actually on the death certificate. You said that you have no difficulty with the cerebral oedema because that is actually why she died. But then you have:

"... due to or as a consequence of dehydration due to or as a consequence of gastroenteritis."

What if anything concerns you there?

A. Well, dehydration often causes -- gastroenteritis commonly causes dehydration, but that does not commonly in and of itself -- and many children die worldwide from gastroenteritis and dehydration still, but they haven't had abnormal fluids. So they die of dehydration, not cerebral oedema. So there's something missing.

Q. Yes, something missing. The dehydration didn't naturally and in and of itself lead to the cerebral

oedema?

A. No.

Q. No.

A. And I can't think of any way that it would really.

Q. In fact, that particular cause of death sequence has been described by the inquiry's experts as being simply illogical.

A. Yes.

Q. Are you concerned that a consultant directed his acting registrar to issue a death certificate with that cause of death?

A. Yes.

Q. And if that had come to your attention, what would you be wanting to do about that?

A. I think we would have had to investigate how it had happened and the case.

Q. What I had been putting to both Dr Stewart and Dr Dara is, if you put the intervening step that would link the dehydration to the cerebral oedema, which most of them seem to think is an inappropriate rehydration therapy regime, in other words something to do with the fluids, that then becomes an iatrogenic act, and that's the problem about issuing a death certificate without going back to the coroner.

A. Yes.

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

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

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

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

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

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

Having said he finds it increasingly bizarre, he says -- can we have the two pages side by side? Thank you. You see he talks about it being bizarre. Then he says:

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

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

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

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

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

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

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

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

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

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

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

A. I can, yes.

Q. That hadn't struck you before?

A. No.

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

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

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

Then he talks about the swabs taken from the lungs

were unsuccessful and didn't grow:

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

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

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

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

A. Not really.

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

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

Q. What should have happened once a post-mortem report comes back like this that you can't understand? You have seen the CT scans. In your view they're clear, they show that she had cerebral oedema and coned and so, for that matter, does the -- there's a description of the fixation of the brain. That also refers to that. If we pull that up very quickly.

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

comes back in that form, which doesn't actually tell you what led to the cerebral oedema, what's an appropriate step to take?

A. It's to get out the chart and go through it all again and review it. If necessary, with the team, to have a discussion with the pathologists and certainly to discuss it at a mortality meeting.

MS ANYADIKE-DANES: That is what Professor Lucas and Dr Squier, when they were dealing with the brain-only hospital post-mortem in Claire, described as clinicopathological correlation.

A. Mm-hm.

Q. That there would be discussions between the pathologist, who has got as far as he can get, and between the clinicians, who have their own views and treated the child, and from those discussions should emerge a clearer idea, if it can be done, as to why the child and how the child died; would you accept that?

A. Yes.

Q. And from your point of view, when is the place or what's the forum for the clinicopathological correlation?

A. The forum is a meeting with the relevant clinician and pathologists and all the other -- as many other clinicians, and ideally pathologists as can be present.

Q. Should that happen routinely or only in problematic

cases?

A. No, it should happen routinely.

Q. When I asked Dr Chisakuta that, his view was he had never attended a meeting like that and didn't actually know they took place.

A. Maybe he didn't recognise the name clinicopathological meeting. I think "mortality meeting" is the word that's used now. Because we would try and do the same thing at the mortality meeting and certainly at the neurology rounds, the neurology scenario in the Royal, which is different from the paediatric one, it was a weekly meeting and oscillated between neurology, neurosurgery, and neuropathology, and the neuropathology week was autopsies, biopsies and a clinicopathological discussion.

Q. Dr Mirakhur referred to grand rounds; is that what you mean?

A. Yes, the same, I suppose.

THE CHAIRMAN: If you have that meeting and the cause of death still isn't clear, what's the next step? I can put it bluntly to you: do you going back to the coroner and say: we did a hospital post-mortem and we still don't know why this child died?

A. I think, yes. In that circumstance. There are still some cases where they're medically-complicated

neurological cases where it's not a coroner's issue and there's still -- it's at the limit of knowledge, perhaps, but that's a different scenario.

THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: Yes. On your evidence, this one actually didn't make sense, so that's a different scenario from feeling you're at the limit of clinical knowledge.

A. Yes.

Q. If I then turn to the fora where all this might come out. In your view is this an adverse incident, Lucy's death?

A. I think, yes, it would qualify as one.

THE CHAIRMAN: I think, doctor, if we're going to get into that area, we need to break for lunch. Do you mind if we abbreviate lunch until 2 o'clock; does that give you time? Thank you very much.

(1.20 pm)

(The Short Adjournment)

(2.00 pm)

(Delay in proceedings)

(2.05 pm)

MS ANYADIKE-DANES: Dr Hicks, I was asking you about the sequence of things and what I should have pointed out is what I have pointed out to others: although

Professor Lucas had that view about that sequence, it's not a view that another expert of the inquiry had. Her name is Dr Keeling. She did a background paper for the inquiry titled "Dissemination of information gained by post-mortem examination following the unexpected death of children in hospital".

In the course of that she expressed a view on that sequence and we can pull it up. It's 308-020-299. That's the citation that happens at paragraph 11, she says:

"When a post-mortem has not been instructed, a death certificate may be issued by the responsible clinician on instruction from the coroner or by the clinician [and this is the part of it] taking into account information from the pathologist when a hospital post-mortem has been performed."

So that would suggest that, in her experience, it is possible to wait for the hospital post-mortem. So there are two different views about that and obviously we're going to ask Professor Lucas to comment on it. But in any event, I think your evidence to the chairman had been that it's something that should be done promptly; would you accept that?

A. Yes.

Q. The actual timing we had is that Lucy dies on 14 April

and her death certificate is eventually written on 4 May. So that's very nearly three weeks. Can you comment on whether you think that's an appropriate period of time?

A. That seems a delay to me.

Q. That seems too long?

A. Yes.

Q. In fact, it would seem that what actually prompted it then is that the family were getting in touch with the hospital, not because the clinicians themselves took a decision, let's issue the death certificate, it was in response to a query from family members. So we don't exactly now how long they were waiting for, but whatever it was, you think three weeks is a bit too long?

A. Yes. I would normally expect it to have happened the day of the post-mortem. At the bottom of that form you showed me that Dr Stewart had completed, there's a place for a telephone number to where the interim results of the gross findings will be telephoned to. I think, as I put in my witness statement -- and that's normally what would happen. After that discussion with the pathologist and the consultant in charge, they would write the death certificate -- or not, I suppose.

Q. Thank you very much. So then I think I had just asked you, when we broke for lunch, whether you would have

expected Lucy's death to have been reported as an adverse incident.

A. I think, taking into account all the findings of the case, yes. You know, the problem is that the issue of the fluids related to another hospital.

Q. I was going to ask you about that. If you have a death in the Children's Hospital which would seem to relate to treatment from the referring hospital, what do you do about that?

A. Well, I'm not sure what they're doing now.

Q. What did you do in 2000?

A. The incident reporting system was undergoing change at that time, if I recall right. We'd had a really very inadequate system of reporting clinical incidents, which was really underused, and a new reporting system came in somewhere around that time, I'm not exactly sure where, with an IR1 form, I think it was called.

Q. Yes.

A. And even though that was inadequate for some circumstances, that's the form that you had to advise people, to use to trigger the adverse incident process.

Q. If an adverse incident had not been reported pretty much at her death, but the post-mortem report had been received and it was thought that that really didn't advance matters and things were still really quite

confused, could it happen then?

A. Well, it could have. It wasn't designed for that to happen, which made it difficult to use, but it could have, I think.

Q. And could it be the result of any review meeting that there might be -- for example, at the mortality meeting -- that it's reported as an adverse incident?

A. Yes.

Q. If a death is reported as an adverse incident, what are the consequences of it?

A. Well, it would be followed up through a process. The form is completed and copies go to various places, a copy goes -- well, this is what came in -- I'm not sure exactly when it started because there was quite a lot of training and so on required about it. But a copy of the form would go to the clinical director and a copy of the form would go to the risk management office.

Q. So you would have seen the form?

A. Yes. Presumably. Presumably, if it had been an anaesthetist filling it in, they would have sent it to me rather than the clinical director of ATICS.

Q. Once the form gets received, what happens then?

A. You decide the action. I just cannot remember the exact details of the process, but the action will depend on

what the nature of the incident is because most incidents are in, comparison to this, relatively trivial, but they would need to be investigated in one or another way. For an incident like this, then the clinical director would need to undertake to set up an investigation, probably in liaison with the medical director.

Q. Yes. As you've said, the treatment, the substantive treatment actually happened in a different hospital. Even if that's the case, is there still some merit from your point of view of looking at the circumstances for learning in your own hospital, even though those deficiencies didn't happen in your hospital?

A. Mm, I think there is.

Q. There is still?

A. Yes.

Q. And if you do that and you come out with some views, how does that, if at all, get transmitted to the referring hospital?

A. I'm not sure what the system would be because I don't actually recall the system, even as it was latterly when I finished, including explicit guidance on that point. It may have been there. I simply don't remember.

Q. I understand. I don't want to press you if you're unclear about it, but can you ever recall that

happening, that as a result of an investigation like that, a decision was taken that we should really communicate some of this to the referring hospital?

A. My mind's a bit of a blank about that. I'm sure there will have been. It won't happen often, obviously. I can't think of a specific example, I'm afraid.

Q. When you say it wouldn't happen often, is that because the circumstances are just rare when you receive a child who dies in circumstances where the treatment that is at issue all really happens at the referring hospital, or is it because there's a certain reluctance to be seen perhaps to be critical?

A. Well, I think there would have been a reluctance, certainly at that time.

Q. In 2000?

A. In 2000, to institute a critical incident report regarding another hospital. That's not to say people might not have done something individually. But to trigger the mechanism, I think people were still reluctant to do that, and the process of training and so on about that was ongoing for some time.

Q. Were you aware of a group called the Critical Incident Review Group?

A. Um, I probably -- is that within the Royal?

Q. Yes, it's within the Children's Hospital. Dr Chisakuta

was a member of it and then latterly became a chairman of it.

A. Yes, I do recall that when this whole process of critical incident reporting came in I initially, as clinical director, sort of led and then found that I simply couldn't do it, there was too much involved in reviewing it. So I believe it was Dr Chisakuta who undertook to lead that on behalf of the directorate at that time. I don't remember the name, but --

Q. That's apparently what it was called. He said they looked at them periodically, sometimes weekly, the deaths that had happened, and in a multidisciplinary way.

A. Yes.

Q. That was part of it. He happened to be the clinician on it, but the intention was to see what lessons might be learnt out of the scrutiny of what had happened. But that couldn't happen unless a critical incident form had been completed and sent in, and he said no matter how much one might think so, unless you did it yourself or somebody else sent in a form, it didn't get to the group for them to consider it.

A. Yes.

Q. He also went on to say there wasn't actually any definition of what was an appropriate critical incident

and it was left, it would appear, to the clinicians themselves as to whether they thought it was an incident that should be reviewed. Would you have thought that sort of self-reporting -- not necessarily about yourself, but reporting in that way adequate if you're trying to establish a system?

A. I think certainly nowadays that wouldn't be seen to be adequate, I suspect, because all the systems for review are strengthened and increased over what they were then. At the time it was a significant change in how things had been before. I would have seen it, I think, as part of an incremental process that would need to be built up.

Q. So you're refining it and developing it?

A. Yes, and it was led, obviously, by the Trust executive and by the department, and their indications about -- and I suppose the law, the statutory duty of safety and so on.

Q. Who was in charge of developing that whole system?

A. Well, there was a clinical -- there was a Trust clinical risk committee, I think, or risk management committee led by the medical director. So they would, I think, have been in charge of doing that.

Q. Was that something you had anything to do with?

A. I was part of that committee, but I had great trouble --

one of these things when you have a busy clinical load, timing of meetings is sometimes impossible and I think Dr Chisakuta took over from me in attending that because I simply could not make it to all the meetings because of clinics and things.

Q. I understand. Let's go on to the mortality meeting. That is a system that has been ... Sorry, just before we do that, on the adverse incident reporting, what steps did you take to ensure that your staff knew what they were required to do and in what circumstances they were required to do it?

A. When that system was introduced, there was a series of training sessions which people -- which was a requirement to go to, as I recall. You had to sign up to go to it and you were chased if you didn't go. At that, there was a process of -- it was probably a half day or possibly a full day's session. It wasn't simply half an hour. You were taken through the new form and the process of reporting it and what was involved in it.

Q. What was the system for monitoring and evaluating that that was all working as it ought to?

A. This was led from the central trust department, and I think they would have had the information from the directorates about how that had gone, making sure that everyone had attended, and also producing reports on

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

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

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

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

changes to practices, or whatever it is that is necessary, with a view to reducing the chances of that happening again?

A. That would be one of the --

Q. So if, as in the case of Lucy, you get to that stage, which was at August of that year, and the consultant still doesn't know why she died, how do you move forward in a mortality meeting?

A. Well, one of the ways of moving forward is for the case to be just presented in detail so that everyone can, as it were, apply their experience and knowledge to it.

Q. Yes, but when I had asked Dr Taylor about that, he said a mortality meeting isn't actually the place where you could do that. Firstly, because you don't actually have the time to do that. In Lucy's case, there were five deaths scheduled to be presented that day. And he said that's not the place where you can start having a clinical debate about what the actual cause of death might be. That's the place where you start thinking: right, the child died like this, so perhaps we should change our systems in this way or that way. And that's why I've asked you the question. If you get to the stage where the mortality meeting has been scheduled and the presenter, the child's consultant has to say, "I still don't know why this child died", what do you do

about a case like that?

A. Well, if that happens at the mortality meeting, then in a circumstance where you feel you should know why the child died, in other words not one of these complicated cases I have talked about where, after an enormous amount of investigation, you still don't understand the disease process, it's some odd thing, then that needs to be looked at further.

Q. What would be the way in which that could happen?

A. Well, that could be done by the pathologist or the lead clinician or the audit coordinator could undertake that or another clinician in the specialty perhaps.

Q. Could that itself lead to a review into the child's case, the fact that you have got to that stage? By that time you would know that there's no coroner's inquest, the death certificate -- we've had a hospital post-mortem, we've got a death certificate. You would know that you're at the end point of those sorts of investigations or opportunities for investigation. Does that of itself trigger in some way a review into the case for how we could have got to this stage and the consultant who was in charge of her care doesn't actually, from his point of view, really know why she died?

A. It should do.

Q. It should do?

A. Yes.

Q. Is that in and of itself a thing to be reviewed as to how the death can have got to that stage without anybody knowing?

A. Yes.

Q. Or at least without the consultant knowing?

A. Yes, I think so.

Q. In those circumstances, would you expect to hear of a case like that?

A. Yes.

Q. And if you've heard about it, what do you do about it?

A. If you have heard about a case like that where there are unanswered questions, there's something not right about it, then I think you have to trigger a -- undertake to trigger an investigation by yourself, probably in consultation with the medical director or the director of --

Q. Which could be an ad hoc investigation really?

A. Yes. It could be set up to investigate that particular case and have it reviewed.

Q. Yes. Leaving aside that instance, I can pull up the attendance sheet, which is 319-023-003. The only person on that sheet who seems to have had anything to do with Lucy's care was Dr McKaigue, and he was the receiving

consultant paediatric anaesthetist. You can see his signature on the left-hand side about halfway down. There doesn't seem to be anybody else there who had anything to do with Lucy's case. And that's why there's -- and nobody, I have to say, can actually remember it being presented at a mortality meeting.

So there's some concern that maybe there wasn't one. In your experience, you're there, I should say, but you didn't have anything to do with her case. In your experience, who presents at the mortality meeting?

A. Either the lead consultant or their experienced junior, specialist registrar, can do it on occasion.

Q. And if for some reason neither of those people can attend, what happens to the case then?

A. It should be put off until a meeting where they can attend.

Q. Would you be surprised about a mortality meeting going ahead in relation to a case where the senior clinicians who had been involved were not present?

A. I would think it highly unlikely. I can't see how it would happen, really.

Q. And if it was put off, who is in charge of making sure it comes back on again?

A. It should go back on to the books in the -- audit coordinator and the secretary, so that they will

reschedule it.
Q. However that happens, in your view this is a case that ought to have been presented at a mortality meeting?
A. Yes.
Q. And whenever it happens, if it did happen, in terms of the things to be discussed, given what you may now know of the case, would you even get into the adequacy of the notes that had come, that had been sent from the referring hospital? If there is concern about whether they're clear, coherent, would that be an issue that's likely to be discussed?
A. It's difficult to discuss things that happened elsewhere when those people aren't there to participate in the discussion, but it probably can happen to a certain degree, but it probably wouldn't --
Q. If it impacted on people's understanding or formulation of what had happened, is that something that could be discussed?
A. Yes.
Q. There is differing evidence on it, but some of the paediatric anaesthetists are of the view that they had a concern about the fluid regime at the Erne.
Dr Hanrahan said he didn't because, in his view, her sodium didn't fall low enough for him to have a concern like that. But Dr Chisakuta, Dr Stewart, their view was

that that was current, that people were concerned about the fluid regime at the Erne.
If that was the view of those clinicians, is that something that you would expect would be raised at a mortality meeting?
A. Yes.
Q. And if when it was --
THE CHAIRMAN: Sorry. I don't think we need to go through all of the issues because I think in general terms the sorts of concerns and issues which have emerged over the last week and a half of evidence should be raised in some form or another at the mortality meeting, shouldn't they? What emphasis is given to them is different to some of the perhaps less serious ones, and that is a matter for conjecture, but the significant issues we've been discussing for a week and a half should be raised; would that be fair?
A. Yes.
THE CHAIRMAN: Thank you.
MS ANYADIKE-DANES: If I can ask you just a few things from your witness statement. As clinical director, how would you have expected learning from the audit and mortality meetings to be disseminated to the wider clinical teams?
A. You mean outside Children's? Well, if something had arisen that involved other teams, the clinical director

or audit coordinator could agree to raise that with other teams. One of the circumstances I remember is we used to discuss some newborn babies who had surgical problems and it was very difficult to discuss those meaningfully because we never had the neonatal team or the obstetricians present and we spent some time trying to improve that so that we could agree how to do that because there would be -- I mean, perhaps relatively minor, but nevertheless important aspects of care and coordination of care that would come up or did come up. So that would be one example.
It turned out to be very difficult to do. I think a separate meeting had to be convened to do that. But you would need to agree -- I mean, the clinical director wasn't always -- couldn't always be at the audit meeting, so in a way it was the -- I would have thought it was the audit coordinator's responsibility to bring it to the clinical director if he or she wasn't already aware of it and they could agree how it could be taken forward.
Q. Dr Taylor had told us that he established a group called the Sick Child Liaison Group, which he would keep you in the loop about, and that was a group actually that was designed to take things from outside the hospital to the district hospitals.

A. Mm-hm.
Q. Was there any kind of liaison or relationship between any of the fora for reviewing cases or investigating cases in the Children's Hospital to get into the Sick Child Liaison Group and thereby find its way disseminated to the district hospitals?
A. Well, that could come up because Dr Taylor would report to the directorate group or sub-directorate group, so he would report issues to that group if they arose, and particularly from -- as would a number of other people about various things. We tried to make sure that we were represented so we could feed back and then determine how that could be taken forward.
Q. But was this something that you, as clinical director, were actually trying to use as a channel for getting learning from the Children's Hospital out to the district hospitals?
A. Yes. That would have been one of the ways to do that.
Q. Was it intended to have that role?
A. I think that was one of the roles, and also to improve, if you like, communication and combined working so that people outside and inside worked together, communicated regularly about problems, not simply when the acute event happened.
Q. And outside of a case-specific review, if I can put it

that way, was there any kind of forum where, in a multidisciplinary way, with you involved, senior staff and managers within the children's services -- I'm thinking perhaps of clinical leads, senior nurses, directorate managers -- could actually meet and discuss issues? Was there a forum for that?

A. We met every week.

Q. That was the meetings you had every week?

A. Yes, we had the sub-directorate meetings, and we sometimes had directorate workshops where we would take a day out. That tended to be for sort of larger development issues rather than day-to-day problems. Our weekly meeting covered a huge agenda of ongoing things to do with all aspects of the directorate.

Q. And would those weekly meetings be minuted?

A. They were, yes.

Q. In your time they were minuted?

A. Yes.

Q. And what happened --

A. They were note-type minutes.

Q. I understand. What happened to that? When you or the group has discussed something and reached a view as to how something might be taken forward and improved, what happens to that?

A. It would depend what it was. For example, as in the

case of Dr Carson writing to all the consultants, I might do that about a particular issue. We might agree that I would write to all the consultants, send out a memo to all the consultants -- ultimately, some of it was done by email, but quite often -- and certainly initially -- it was done by a memo or an actual letter to everyone outlining what the issue was and what we wanted to be done.

Q. And what level of detail could they go down to? Let's say that you had a concern about the standard of record keeping and you had seen a number of cases go through and you were a bit concerned about that. Is that something that the group could decide, yes, we do need to standardise a few forms here. Is that something you could take forward?

A. That was done. Case note review was done as part of the audit time, and a report was generated. We all filled in a pro forma. Now most of the paediatricians used a BPA or Royal College pro forma, which covered inpatients, and certainly in our unit -- and I think they were similar -- the ward clerks randomly selected notes and we sat down and we completed them. We took a pile each, went through them, filled in the pro forma and then had a meeting where we went through it all to outline the problems. I would then generate a report

which I would send to the audit coordinator and also the head of the clerical end because there were various things in it.

Q. What about something like staffing? One of the issues that we've heard about, certainly from Dr Hanrahan, is a concern about the staffing in the PICU and there was a lot of pressure on the anaesthetists there, and that might have had an effect on the amount of time that could be devoted to the sorts of things you would like to perhaps see, which is more consideration of notes, better recording, those sorts of issues that fall by the way if you're really desperately trying to treat patients because you have inadequate resources. Is that the sort of thing that could come to you?

A. Well, it would. There was time set aside for this. The audit time was protected, that clinical work was suspended, non-urgent clinical work was suspended for a time every month so people couldn't say they didn't have time so, that people had time to do that, sit down and do the preparation and have the meeting. Staff were all under pressure, and there's no doubt the anaesthetists were under pressure and the nursing staff -- we had a constant ongoing project to get ICU beds staffed nursing-wise with the Eastern Health Board and the department and the Regional and Medical Services

Consortium. So there's no doubt that people were under pressure. But from the point of view -- there was protected time. What we didn't have in audit was any significant resource to help administer it, and this is why I think, unfortunately, things sometimes went by the wayside, like not bringing a case back when it should have been brought. That may have happened, I don't know that that happened.

Q. You mean what you didn't have sufficient of was resource to manage the governance process?

A. Yes. That's right.

Q. I understand. And then just finally, in certain places in Lucy's notes and other documents associated with her, one sees references to hyponatraemia. There's a reference to hyponatraemia in the history on the EEG report. It just has as a list, it has "vomiting" and "hyponatraemia". The reference is 061-032-098. Then, of course, it's there on the autopsy request form. That is 061-022-073. There's a reference to it in the post-mortem report, 061-009-018. And there is also a reference to it in Dr McKaigue's PICU coding form, 319-019-002. Lastly, it's referred to on the PICU database at 319-067e-003.

And with those references to hyponatraemia, are you surprised that Lucy's case wasn't earlier associated

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. As far as what's demonstrated there, but that to me is not what I seen.
Q. I think what you have told us so far is this: that you, if you like, glanced at the notes, hardly studied them and realised that there was detail that should be there that wasn't there --
A. Yes.
Q. -- offered the nursing team an opportunity to fill in --
A. Yes.
Q. -- if you like --
A. A chronological event.
Q. -- a retrospective note.
A. Yes.
Q. A retrospective note in your view is entirely proper, is it --
A. Yes.
Q. -- as long as you make it clear that it is retrospective?
A. Yes, that you date it "completed after event".
Q. Of course. And was your impression that the relevant members of the nursing team declined that opportunity at that time?
A. They both sat and looked at me blankly and so rather than pushing it further, I said, "I'll leave you to think about it and come back in", being I suppose

diplomatic in one sense and giving them time to consider what they want to do.

Q. Is that the time then that these notes were --

A. I don't know.

Q. Did you not go back and check what had --

A. I went back to them and said, "What are you going to do?", and they said, "We're not adding anything further". But to me that's not what was there. To have that amount recorded in that, I would have thought that was reasonable. But to me, what I looked at had very little written on it.

Q. And you can't help us then in terms of when these additional notes were added?

A. No.

Q. You talked, as I say, to -- when you talked to the police in 2005, you say that you remember directing a nurse to put all records into a sealed envelope.

A. Yes, that if they were finished, to put it into an envelope -- it was just the nursing kardex and the fluid, whatever was there relating to Lucy, not medical notes -- but I didn't look at them again, they were sealed, that was it.

Q. Where did they go?

A. I don't know.

Q. You didn't take command of them?

A. I didn't take them, no. I said, "Put all that into a sealed envelope, please".

Q. Where would they go? Is there a filing cabinet or your desk --

A. Usually they go to the secretaries, probably for filing, into the medical notes when the medical notes are returned.

THE CHAIRMAN: When you were asking for them to be sealed, was that because you realised that something more might happen because of Lucy's deterioration and her transfer to the Royal, or was that a standard instruction on your part to seal the notes?

A. The leg of those kardexes, if a child was transferred out and medical notes went with the child, I would always ask for those sort of notes to be together in an envelope with the child's name and hospital number on, so that at least when the medical notes came back, the nursing kardex and all could be added to the notes.

THE CHAIRMAN: Okay.

MR WOLFE: Just in terms of the medical notes, you didn't see them at all?

A. No. Not that I recall, no.

Q. And so if that's right, when I refer to medical notes, you wouldn't have seen the, for example, biochemistry tests, U&E results?

A. No, didn't see any of them.

THE CHAIRMAN: From what you said a moment ago, you would have expected them to go to Belfast with Lucy?

A. Her medical notes, yes. That's what I believe they had went with her, but I wouldn't have seen them.

MR WOLFE: I don't have the file out with me, but it's my recollection that the Royal also received, for example, the fluid balance chart, the one we've just studied.

A. Yes.

Q. Which, as you say, has problems in it. So plainly, they were still on your desk at that point in the morning. They were put into a sealed envelope, you think, and went off to the secretaries.

A. Mm-hm.

THE CHAIRMAN: Okay.

MR WOLFE: Could I ask you this: apart from recognising, if you like, the holes in the notes, the notes weren't complete and allowing the nurses the opportunity to backfill that if they wished, did you reach any views or have any suspicions about the relevance of the fluid regime for Lucy's deterioration?

A. I said to Mrs Millar that I felt that if she had 100 ml an hour for a number of hours, that may well have contributed to her collapse.

Q. I'll come on to what you said to Mrs Millar in a moment,

but just pausing a moment, you saw a chart which appeared to show and, as the chairman suggests, with a little bit of guesswork or interrogation, appears to show 100 ml an hour from in or about 10.30/11.00. At 3.00, then 500 ml of saline is written in.

THE CHAIRMAN: I'm sorry, no, I don't think, to be fair, the witness hasn't -- I think your complaint is it's not clear to you from the chart what she received.

A. No, it wasn't clear.

THE CHAIRMAN: What you are then saying to Sister Millar is: if she received 100 ml an hour, that would be too much?

A. That's right, thank you.

THE CHAIRMAN: A point I just want to pick up on that is you have said a few minutes ago that you are generally alert to what the fluids should be, but you're no expert in calculating them. Do I take it from that that whether you're an expert or not, giving Lucy 100 ml an hour just looks likes far too much to you?

A. Yes.

THE CHAIRMAN: Thank you.

A. But I wasn't aware of how dehydrated Lucy was or what her bloods results were, but yes.

MR WOLFE: Let me put it in these terms -- and we touched on this a little at the very start: at or around

9 kilograms, coming into the hospital, just a little over, Lucy should have been on 900 ml per day. Dividing that up by 24 hours, that's roughly 30-odd per hour. Is that the kind of thinking you had in your head?

THE CHAIRMAN: Subject to making up for the dehydration, which would increase beyond that.

A. Yes.

MR WOLFE: Well, there's a dehydration issue perhaps, but in terms of Solution No. 18, which you knew to be a maintenance fluid.

A. Mm-hm. You would have expected, if it was just a normal maintenance and she had no dehydration, and not knowing what her dehydration was, you would have expected roughly around 30 ml an hour to be the calculated amount if it was a normal process.

Q. And are you saying that you recognise that 100 ml of Solution No. 18 per hour just wouldn't be appropriate?

A. No. It wouldn't have been, to me I felt that was a lot of -- per hour, that was a lot of fluid to infuse per hour. What I wasn't equipped with is what her blood results were and how dehydrated she was.

Q. Did you put across to the nurses in front of you your concern that that seemed like an awful lot if she did get 100 per hour?

A. One said 100, another said 80, and I said whatever she

got, who prescribed it and is it prescribed? And then when I turned the page over, it wasn't prescribed.

Q. So you had also, just for completeness, an opportunity to look at the prescription?

A. There was no prescription.

Q. If you could take a look at the document at 027-019-063.

A. Yes, but there's no rate.

Q. Let me just unpack what you mean by "no prescription". This document was available to you on the nursing notes, was it?

A. On the fluid balance chart, yes.

Q. Yes. Is that the other side of the fluid --

A. That's the other side of the fluid balance chart.

Q. I understand. What you're saying is it's dated, the type of the fluid is included, it's an IV site, it's signed off by Dr Malik and Nurse Swift, but it doesn't become a prescription because it's not complete?

A. It's not complete.

Q. And for it to be complete, you would expect the period of time for administration, 24 hours, 12 hours or something like that --

A. And the rate.

Q. -- and the rate? I appreciate that, thank you.

The next stage in the chronology, as we understand it, is that at some point that morning you discuss

matters with Dr O'Donohoe. And can I ask you about something one of the witnesses from the Royal College of Paediatrics and Child Health has brought to our attention? Could I have up on the screen, please, WS298/3, page 12?

This is a draft of a report which was compiled by Dr Boon of the Royal College and Dr Moira Stewart of the Royal College. Just to put it in context for you, back in 2002, they came to the Erne to investigate certain allegations with regards to the, if we put it in general terms, conduct of Dr O'Donohoe. And you contributed to that external review by speaking, I think by telephone, with one of the doctors and in person with the other.

What they have recorded appears to concern your discussion with Dr O'Donohoe on the morning of 13 April 2000. You can see there that they're saying that you weren't on duty when the child was admitted, you saw the nurses the next morning and, by implication, they didn't express any concern.

Then you reported to the review a conversation with Dr O'Donohoe when he said to you:

"What are you going to do with the IV fluids your staff got wrong?". In response, you are recorded as having said, "Who prescribed the IV fluids?". And then you have gone on to say to the review that there had

been a nursing error in totalling the fluids, what we've just looked at in the fluid balance chart presumably. And you have told the review that:

"[You] felt Dr O'Donohoe was trying to instil a blame culture relating to the particular case."

Does that record chime with your memory of 13 April and your conversation with Dr O'Donohoe?

A. No. I didn't even remember having met with them, but obviously I had. But what I remember clearly from Dr O'Donohoe on the 13th morning was when he came back. He swung into the treatment room and asked me, "What the hell happened here last night?", and I said, "I don't know, Jarlath, you tell me". He may well have spoken to me the next day about that, but that day that was my only conversation with him because he was very -- his eyes, you know, seemed to be bulging in his head and he was irate, so I thought, "I'm not going to get into a conversation with you".

Q. So just to put this into context, this is Dr O'Donohoe coming into the hospital having been up to the Royal presumably?

A. Yes.

Q. And you have had your meeting with the nurses, you have had the discussion about the notes, you're working in the nursing unit --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

dehydration. I wasn't aware of what percentage of dehydration Lucy had.

THE CHAIRMAN: Okay, Mr Simpson?

MR SIMPSON: Yes.

MR WOLFE: Sir, I know the stenographers have asked me for a short break. I have about ten minutes to do.

THE CHAIRMAN: Would you mind taking a break for about ten minutes? We are going to get you finished within quarter of an hour of coming back and then we will get back on to the other issues I have to raise.

Thank you very much. We'll resume at 4.10.

(4.00 pm)

(A short break)

(4.12 pm)

MR WOLFE: Sister, just one point before moving on to discuss your meeting with Dr Kelly, which occurred on 23 June 2000. As it appears on all of the documents before the inquiry, there was a prescribing error in Lucy's case in that Staff Nurse Swift would claim to have heard that she should infuse 100 ml per hour until the child urinated --

A. Yes.

Q. -- whereas Dr O'Donohoe believed that he had said a bolus of 100 ml followed by 30 ml per hour of Solution No. 18. Was that issue, that clear error or

that miscommunication, brought to your attention?

A. Yes, I was aware that Jarlath O'Donohoe had felt he had stated that and Bridget(?) stating the other, but when it was raised, I don't know.

THE CHAIRMAN: Is that something that you picked up as these events went on, or was it something which was discussed with you at any time during your input into the investigation?

A. I had an awareness, but I can't recall that we discussed it --

THE CHAIRMAN: Or where it came from?

A. Yes.

THE CHAIRMAN: Okay.

MR WOLFE: I'm wondering when it emerged during your meeting with Dr Kelly. Dr Kelly has said to us in his witness statement that, on 23 June, he met with you to discuss Dr Quinn's opinion in relation to Lucy Crawford.

Let me ask you this: did you know that a Dr Murray Quinn had been retained to carry out, if you like, a paper review or desktop review of Lucy's management?

A. Yes, I was aware of that, but we hadn't met with Dr Quinn.

Q. As I say, one purpose of the meeting was to discuss Dr Quinn's report, according to Dr Kelly. There were

two other purposes of the report: one was to look at Dr Asghar's letter, which had come in at or about that time, expressing concerns about Dr O'Donohoe; is that right?

A. I was aware that Dr Asghar was unhappy with Dr O'Donohoe.

Q. And the third purpose of the meeting was to discuss your view of Dr O'Donohoe's professional competence. Could we have up on the screen, please, the note of that meeting? It's at 036A-007-013. It's a note which is substantially redacted because it concerns issues of competence, et cetera, which are not relevant to this inquiry.

But the bit that's relevant, about a third of the way down the page, is this: Dr Kelly took you through the Lucy Crawford case and outlined the report from Dr Murray Quinn, consultant paediatrician, Altnagelvin. If I could pause there. Do you have an independent memory of this meeting?

A. No.

Q. Do you recall how long it might have lasted?

A. No.

Q. It records there the report of Murray Quinn was outlined to you. Can you recall ever seeing that report?

A. Never seen the report.

Q. Well, can you help us at all, when it describes the report as having been outlined to you, what format that might have taken?

A. Well, looking at this here, it would appear, even though I don't remember this, that he obviously has discussed it briefly with me.

Q. Yes, you can see the third sentence where it attributes to you the fact that you're noting that:

"... Dr Quinn felt it unlikely that the fluid regime prescribed or the initial management of the child contributed to the death."

Does that help you at all? Does that suggest you might have been reading the report and noting that fact?

A. No, I don't remember seeing the report. I was not actively involved in any of that investigation.

Q. Do you know why you were being spoken to in relation to this report?

A. Dr Asghar was not happy with Dr O'Donohoe, there were issues between the two, and I had spoken to Dr Asghar and said, "If you have concerns, you need to raise them". And I felt that I probably was asked to be -- I suppose was spoken to because of that, on the back of that.

Q. Again, I realise I'm probably pushing your memory too far, but if I can ask you this: where you're apparently

noting that the fluid regime prescribed, according to Dr Quinn, did not contribute to the death, can you help us at all on whether you're commenting on that or whether you're expressing support for that view or whether you even understood the view?

A. I wouldn't have understood the view because I didn't see the notes, so it was obviously a conversation, but ... (Pause). I couldn't make any comment on that because I didn't have all the details relating to Lucy.

Q. I can see you're still trying to digest this.

A. Yes.

Q. Take your time by all means. (Pause). If I can reassure you, the redacted portion of the document is unrelated to Lucy, and that is why it has been covered up.

A. Okay:

"Sister Traynor did not feel that there was any significant time period when unobserved anoxic events may have occurred."

That wouldn't be something I would have been making any comment on.

Q. An anoxic event is a deprivation of oxygen for a significant period of time.

A. Yes. I would take it to be that. It's not terminology I would use.

Q. So again, in terms of this note, I can see that in the last sentence Dr Kelly is indicating that:

"It was important to reassure staff as much as possible at this stage."

We'll obviously hear from Dr Kelly in relation to this, but can you help us at all on whether you think you might have been shown the report simply to reassure you that in terms of the management of the child, the Trust, through its investigation, had reached this view that there was nothing to reproach staff about?

A. I can't comment on that because I don't recall ever seeing a report from Murray Quinn. I would have got a verbal report, possibly, you know. I would feel that certainly is what I might have got, but it wouldn't have been formally discussed.

THE CHAIRMAN: I think to be fair to Dr Kelly, he doesn't say in that note that you got a report; he says he took you through the case and outlined the report, which suggests to me -- and we'll hear from Dr Kelly -- that there's some sort of summary given.

A. He might have made a general comment or a general run of sentences on it.

MR WOLFE: I know we've touched on this already, but had there been an assumption on your part up to this point that the fluids might have caused some --

A. Yes.

Q. -- problem for the child?

A. Mm-hm.

Q. Did the outcome that you were apparently being told about at this meeting come as a surprise to you?

A. They're -- and I'm speaking "they" in brackets -- the medical staff are more better qualified to make that assumption, but I would have thought that if she got 100 ml an hour for a number of hours, I did have that concern that it contributed to her collapse.

THE CHAIRMAN: She doesn't remember the meeting, she can hardly remember whether she was surprised or not.

A. Yes, thank you.

MR WOLFE: In fairness, what I'm putting to you is, I suppose, in another way the conclusion of the report. Leaving aside this meeting, did it emerge for you and the staff in some other form that the fluid management of the child was regarded as not beings culpable?

A. We were never formally notified to that effect either.

MR WOLFE: Right, very well. I have no further questions.

THE CHAIRMAN: Thank you, Mr Wolfe.

Any questions from the floor for the sister? No? Sister, thank you very much for coming along, you're free to leave, thank you.

(The witness withdrew)

Okay, ladies and gentlemen, let me turn now to the issue which I said I would raise before we finished today. It's about the request on behalf of Dr Taylor, through his legal team, that Professor Kirkham should be called to give evidence in Raychel's case and also she should be asked to review the other deaths which are the subject of the inquiry.

I need to give you some background before I open up the discussion. You'll remember that professors Kirkham and Rating gave evidence here together on 14 January. At some point after their evidence was complete, I was advised that Professor Rating had written to the inquiry again and had sent in a further note of his comments on his own evidence, points that he didn't think he had made clearly and yet more papers to refer to. I can only describe it in those general terms because I have not seen what Professor Rating sent in and I have deliberately not seen it for three reasons.

The first reason is that I have said publicly before and have required the parties to abide by this that I will not accept volunteered statements from witnesses without my prior approval. That step was taken towards the end of Claire's case in order to stop last-minute and uninvited statements by witnesses. And I thought that that should extend to an inquiry expert witness as

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

She says:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Submissions by MR UBEROI

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

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

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

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

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

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

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

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

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

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

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

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

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

Professor Kirkham.

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

THE CHAIRMAN: That's not a rebuttal document in my eyes. I can't emphasise enough the advisers are just doing that; they're not giving evidence.

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

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

MR UBEROI: That must be right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR UBEROI: I understand that and I see the sense in it. That leaves the question of the Lucy Crawford potential report out of the additional deaths.

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

THE CHAIRMAN: I'll come back to you if I need to. Thank you very much.

Submissions by MR COUNSELL

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

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

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

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

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

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

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

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

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

absence of a much greater drop in sodium.

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

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

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

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

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

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

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

take into account.

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

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

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

MR COUNSELL: No.

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

THE CHAIRMAN: Right.

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

Submissions from MR SIMPSON

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

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

advance of coming to give evidence to say what they wanted to say and I really am very reluctant for them to start extending debates after the event to take us even further because literally we would never end doing that.

MR SIMPSON: I think that's right. I can deal very shortly with the Lucy Crawford aspect of the matter. We have set that out in our letter. I have no further submissions to make, sir.

THE CHAIRMAN: But you take the view that it could only be done with the consent of the Crawfords?

MR SIMPSON: Yes, absolutely. I appreciate the family have been reluctant to answer correspondence, but I do think --

THE CHAIRMAN: I think in this case I'd need more than a silence from them. I would need an explicit consent.

MR SIMPSON: We've made that clear in our letter and that is our position, sir.

THE CHAIRMAN: Okay, thank you. Mr Lavery?

Submissions by MR LAVERY

MR LAVERY: Mr Chairman, first of all, in relation to the point about Professor Rating's reports, which you've indicated that you have not yet even yourself had an opportunity to read, I can see the logic in that and I know your views, Mr Chairman, in relation to witnesses producing a running commentary on the evidence.

Although having said that, this is obviously a rapidly-developing area of medicine. Views are changing on a regular basis.

THE CHAIRMAN: Isn't that exactly the reason why I have to cut it off at some point?

MR LAVERY: On the one hand, is that not more of another reason to have a look at the evidence?

We endorse, on behalf of the Western Trust, Mr Uberoi's comments insofar as it relates to the recall of Professor Kirkham. In our respectful submission, it goes to the crux of the inquiry. When one looks up at the board, this is an inquiry into hyponatraemia-related deaths. Professor Kirkham, as I understand it, isn't denying that hyponatraemia wasn't in any way related to these deaths, but her view may, on one view, be developing because in the final report that she has put up, she's conceded that it is possible that the cerebral oedema in Raychel's case was caused by dilutional hyponatraemia. She's used the word "possible". Professor Rating has said in his evidence he's satisfied that it is consistent with dilutional hyponatraemia.

THE CHAIRMAN: In Adam's case?

MR LAVERY: In Adam's case.

THE CHAIRMAN: I'm sure you'll correct me if I'm wrong, but the distinction between them in Adam's case was

Professor Kirkham was saying that dilutional hyponatraemia couldn't account for the cerebral oedema without more.

MR LAVERY: She did, and you questioned her on that quite closely. Yes, I accept that, Mr Chairman. She wouldn't accept that hyponatraemia had anything to do with Adam's death.

THE CHAIRMAN: She said you can get hyponatraemia, but hyponatraemia doesn't lead on to cerebral oedema.

MR LAVERY: Yes, she did say that. But in Raychel's case she's saying it's possible. The point I'm making is if one had Professor Kirkham and if one did recall Professor Rating and had them both giving evidence on this point, it may be that their differences on the issue would narrow.

THE CHAIRMAN: So on this suggestion --

MR LAVERY: You indicated previously, Mr Chairman, I think in response to Mr Uberoi's submissions, that if you were going to call Professor Kirkham, would you also then have to call Professor Rating?

THE CHAIRMAN: That's the query.

MR LAVERY: I disagree with Mr Uberoi on that point and I think one would have to call him and it would be useful for the inquiry to have evidence from both, Professor Kirkham and Professor Rating.

THE CHAIRMAN: Right. Thank you very much. Is there something more?

MR LAVERY: No.

Further submissions by MR COUNSELL

MR COUNSELL: I wonder if I could come back? I have not seen the letter which raises the question of consent. Perhaps, in due course, I could be provided with it --

THE CHAIRMAN: Yes, of course.

MR COUNSELL: -- and we can consider it.

The alternative, in my submission, if that is the case that Lucy Crawford's parents need to give their consent -- and I don't quite follow why it should be that Dr MacFaul has been able to give evidence on the same circumstances and yet another expert should not -- this inquiry should not consider any further criticism of Dr Quinn on this issue because it would be unfair to do so in the absence of the inquiry being able to explore whether that criticism was merited.

THE CHAIRMAN: Thank you.

Further submissions by MR LAVERY

MR LAVERY: Can I make one final point? You have indicated that Professor Kirkham's evidence is not yet complete and that you're expecting further evidence from her.

THE CHAIRMAN: We stopped at a point because what you have are the exchanges that we had and the last exchange that

we've provided is asking her to explain her call for three more expert reports plus extended family records. As it turned out, when she responded to that, she acknowledged that she had in fact seen one of the expert reports. On the response that she made, she was still calling for two further expert reports for Raychel's records and for the family's records.

MR LAVERY: Do we take it from that that the inquiry is not going to pursue a further statement from her?

THE CHAIRMAN: That's the point of this afternoon's discussion. Whether, for instance, the inquiry engages yet further experts in order to brief Professor Kirkham to her satisfaction to finally produce a report and to ask the Ferguson family for their consent for further records from the family to be sent to Professor Kirkham. That's one option. Another is simply to say to Professor Kirkham, we have to draw a line somewhere, we will call you to give evidence on the basis of the information we have.

Mr Sharp, you're neutral?

MR SHARP: Neutral, yes, chairman.

THE CHAIRMAN: Mr Hunter, do you have anything to say? I think the specific point for Adam's mother is whether I should look at Professor Rating's additional representations.

MR HUNTER: That's correct, sir, but I would echo what you said earlier: that at some point a line has to be drawn under the evidence. I have to be very conscious of the effect this process is having on my client. This process is an ordeal for her.

THE CHAIRMAN: Yes.

MR HUNTER: She, I'm sure, is as anxious as you are to have the matter come to a conclusion.

In relation to Professor Kirkham's evidence and Professor Rating's evidence, we have heard extensively on the subject. In my view, it has been canvassed -- and rightly so -- because, of course, Professor Kirkham's views were diametrically opposed to all the other experts', and that is a point in itself, sir. This inquiry does not come down to Professor Kirkham versus Professor Rating. It encompasses a huge amount of evidence from other expert witnesses, which are all relevant. That's that point.

In relation to using Professor Kirkham for any of the other deaths in the inquiry, sir, that might seem to give the impression that Professor Kirkham's views are being preferred over Professor Rating's. From that point of view, I would certainly be reluctant to see that happen.

THE CHAIRMAN: Well, I should say I'm reluctant to go down that line that Mr Uberoi suggested, which is in effect to make a decision at this stage that I prefer Professor Kirkham to Professor Rating and therefore if we're to pursue any more paediatric neurological issues, I'll go with her alone, particularly when she is -- whether she's right or wrong, virtually every other expert has disagreed significantly with various points that she has made.

MR HUNTER: That's correct, sir. At the end of the day, it's a matter for you as to what weight you attribute to each of the experts and to the evidence.

The final point I'll make on that is, of course, throughout the debate Professor Kirkham had raised three views as to possible alternative causes for Adam's death. As the matters were explored, she basically abandoned two of those. Her words in relation to those were -- and I'm talking about the cerebral venous thrombosis and the developmental delay -- her final words on that were that in Adam's case both those were "possible, but not probable". Those are her words, not mine. And at the end, she was left then dealing with PRES and her final position on that was that it was her view that PRES was possibly the cause of Adam's death on the balance of possibilities.

THE CHAIRMAN: That was on the basis that it couldn't be ruled out.

MR HUNTER: Yes, correct. I suggest to you that the other experts -- and by that I mean, of course, Dr Coulthard, Dr Haynes, Professor Gross, the other pathologists -- they put it much, much further than that. They don't have any doubts.

THE CHAIRMAN: Yes.

MR HUNTER: So, sir, at the end of the day, it's a matter for you.

THE CHAIRMAN: Okay. Just before I turn on to Mr Quinn.

Mr Uberoi, if I went down the line that you're suggesting and you were encouraging me to take the view that Professor Kirkham is clearly better than Professor Rating, so if I'm going to continue with a neurologist, it should be Professor Kirkham, what if I took the other view? What if I took that I prefer, in the round, Professor Rating's evidence taken together with the other experts', so not pursue Professor Kirkham?

MR UBEROI: My submission is contingent upon you allowing yourself to form some preliminary view in favour of Professor Kirkham over Professor Rating. You have my written submissions on the point. I don't wish to engage with Mr Hunter on an interpretation of her

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

THE CHAIRMAN: Thank you.

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

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

THE CHAIRMAN: I don't think there is any suggestion that so far that, if Professor Kirkham's remit is to continue or to be extended, it should extend into Claire's case. I will leave that as it stands and, if on behalf of the Roberts family, anybody wants to say anything about that at the start of next week, I'll take it, but I don't think that anyone is suggesting that. Turning to Raychel?

Submissions from MR COYLE

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

If it were the case that you were to allow

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

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

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

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

MR COYLE: Yes.

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

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

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

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

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

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

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

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

THE CHAIRMAN: Thank you very much.

Ms Ramsey for Miss Mitchell?

Submissions from MS RAMSEY

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

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

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

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

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

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

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

MR COYLE: Yes, sir.

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

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

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

MR COYLE: Yes.

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

MR COYLE: Yes.

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

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

terms of that exercise.

THE CHAIRMAN: Yes.

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

THE CHAIRMAN: Ms Anyadike-Danes?

Submissions from MS ANYADIKE-DANES

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

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

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

the formal tests were taken.

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

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

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

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

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

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

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

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

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

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

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

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

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

Allen Arieff responded to that and he said:

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

And he referred to various research that was carried out.

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

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

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

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

THE CHAIRMAN: Well, we don't.

MS ANYADIKE-DANES: Exactly.

THE CHAIRMAN: Thank you.

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

this transcript and I will pick up with them next week whether they have anything to add and maybe you'll come back to me next week as well, Mr Coyle.

10 o'clock on Tuesday morning. Thank you.

(5.30 pm)

(The hearing adjourned until 10.00 am on Tuesday 11 June)

I N D E X