

1
2 (10.00 am)
3 (Delay in proceedings)
4 (10.09 am)
5 THE CHAIRMAN: Good morning. Just before we start,
6 Mr Lavery, I'm grateful to the Belfast Trust for the
7 information we received yesterday about the supply of
8 Solution No. 18. Could I ask if we could bring up two
9 documents side by side? The first is 319-087c-003.
10 That's the graph we've looked at a number of times.
11 We've now got a new graph, which has been provided to
12 show us whether the trend in that original graph is
13 representative or not. Could we call up then
14 321-034b-002?
15 You'll see from that that, on the new graph, we have
16 the annual purchases of Solution No. 18 from 2000, in
17 effect, to date. You'll see from it that, as we had
18 seen from the first seven months of 2001, the purchases
19 of Solution No. 18 were dropping. On my rough
20 calculation in the last five months of 2001, there were
21 about 400 more ordered for 2002, there were only 344,
22 and then the purchasing fell away and has been
23 maintained at a very, very low level since.
24 I would simply like the answer now to one basic
25 question: what happened in the Belfast Trust around

1 The other issue, which is for the Western Trust, is
2 we received yesterday the Western Trust inquest file,
3 which would really have been the Sperrin Lakeland
4 inquest file. There's about 600 pages in it, we
5 received it for the first time yesterday morning, and
6 I'm simply setting out two points: one is that's
7 entirely unacceptable and, secondly, Ms Simpson, if
8 information emerges from this file and we have to recall
9 witnesses, we will do that and it will be the Trust's
10 fault. Thank you.
11 Mr Wolfe?
12 MR WOLFE: Good morning, sir. The next witness is
13 Dr Jarlath O'Donohoe, please.
14 DR JARLATH O'DONOHUE (called)
15 Questions from MR WOLFE
16 MR WOLFE: Good morning, doctor.
17 We preface our evidence with all of our witnesses by
18 asking them to confirm whether witness statements or
19 reports which have been provided to date are to be
20 adopted as part of their evidence -- and, in your case,
21 your evidence -- in addition to the oral evidence that
22 you will give today. So the format is for me to run
23 through the witness statements and reports that you have
24 provided to date and then to ask you that question.
25 So in terms of the statements that you provided to

1 about 2000/2001, or particularly 2001, which led to the
2 purchases of Solution No. 18 dropping? Something
3 happened, Mr Lavery. Nobody has told me yet, I don't
4 believe that nobody knows, and I would really like an
5 answer to that question. It might have nothing to do
6 with the inquiry, it might have something to do with the
7 inquiry, but it fits in pretty closely with what
8 Dr Nesbitt says he was told by the Royal Trust when he
9 contacted them after Raychel died, and I simply don't
10 believe that nobody knows. I have already heard
11 evidence that a decision about this would have had to go
12 considerably up the line.
13 MR LAVERY: Yes. The inquiry can be assured, Mr Chairman,
14 that the Trust are making every effort possible to try
15 and find out how this came about and they are trying to
16 get an answer. I appreciate it's unsatisfactory at this
17 stage that there is no answer to that, but I can assure
18 you, Mr Chairman, that all efforts be being made.
19 THE CHAIRMAN: Well, since the purchasing of Solution No. 18
20 fell away to a minimal level and stayed at that for
21 a decade, somebody within the Trust must know why that
22 happened. In fact, there must be a whole range of
23 people in the Trust who know why that happened. This is
24 hardly a state of knowledge which is confined to
25 a single person, so I would like to be told.

1 the inquiry under series 278, that is witness
2 statement 278, you have provided two witness statements:
3 one dated 16 January this year and one dated 4 March
4 this year; you'll remember that?
5 A. I do remember providing those statements, yes.
6 Q. Secondly, going back to May 2000, and 3 May 2000 in
7 particular, you provided an account in the form of
8 a letter or report to the Sperrin Lakeland Trust further
9 to their internal review into the case of Lucy Crawford.
10 A. Was that a letter addressed to Mr Kevin Doherty?
11 Is that the one you're referring to?
12 Q. No, it's a letter that was addressed to Dr Anderson.
13 A. I'm sorry, May 2000?
14 Q. May 2000.
15 A. Sorry, I misunderstood. 2000, yes. I did a letter to
16 Dr Anderson, yes.
17 Q. For reference purposes, that's 033-102-293. Then
18 further to that, doctor, you provided some accounts in
19 advance of the inquest. The inquest took place in 2004,
20 you will recall.
21 A. Yes, I recall that.
22 Q. Prior to that, you sent to Dr James Kelly,
23 24 August 2003, a statement, which I can bring up on the
24 screen if you have trouble remembering it.
25 A. I have one in front of me, which I don't see the date on

1 and I'm not -- or a number, so I don't know which one
2 you're referring to with this particular one.
3 Q. That appears to be the one that you provided back in
4 2000 to Dr Anderson. If we could perhaps have up on the
5 screen --
6 A. My recollection was that I did my -- my account to
7 Dr Anderson was in terms of a letter, "Dear
8 Dr Anderson", if you understand what I mean rather than
9 that, but I may be mistaken.
10 Q. There was a covering letter.
11 A. I see, sure, yes.
12 Q. If we could have up on the screen then the report or
13 letter you sent to Dr Kelly, 24 August 2003. That's
14 047-053-148; do you see that?
15 A. I see that, yes.
16 Q. It moves into a second page. Perhaps we could have both
17 pages up together, please. Perhaps it's useful to
18 highlight it in passing, we'll come back to it in more
19 detail later today, but by contrast with the report that
20 you provided to Dr Anderson back in 2000, you can see
21 at the bottom of the left hand page, Dr O'Donohoe, an
22 explanation. You say:
23 "The only respect in which this report differs from
24 the previous version is in respect of the infusion of
25 500 ml of normal saline, which I did not refer to in the

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1 A. I can't remember. I don't know what Mr Doherty did with
2 the statement, I don't know that sequence, but I'm not
3 arguing that it wasn't. It is a report I have done, if
4 that's the immediate question in hand.
5 Q. That's the preliminary question and, as I say, later
6 we'll get into perhaps asking you some questions about
7 what Mr Doherty or yourself did with the statements to
8 get them to that form for the coroner.
9 Then, doctor, to finish the piece in terms of
10 accounts that you have placed on paper, the Police
11 Service of Northern Ireland interviewed you
12 in April 2005 and you were interviewed over a series of
13 three sessions. You'll remember that?
14 A. I do remember, yes.
15 Q. For reference purposes they can be found at 115-051-001.
16 That was a statement provided by you and then a series
17 of interviews, as I said, in 116-008 through to 116-010.
18 I take it, doctor, that you have a broad familiarity
19 with the accounts that you have provided to date and
20 I ask you: do you wish to adopt those as part of the
21 evidence that you are going to give to the inquiry?
22 A. Yes, there's no changes that I particularly wish to make
23 to them.
24 Q. Do you have your curriculum vitae beside you?
25 A. I do, yes.

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1 version I sent to you previously."
2 Do you see that?
3 A. I do, yes.
4 Q. And then you go on, on the right-hand page, to reflect
5 upon some of the medical literature dealing with the
6 whole issue of hyponatraemia.
7 A. That's right, yes.
8 Q. So that report was provided to Dr Kelly, but in terms of
9 what eventually went to the coroner and was accepted by
10 the coroner under the coroner's rules, if I could have
11 up on the screen, please, 013-018-066. You can see
12 at the top of the page, "Received pursuant to rule 17".
13 We have obtained this document from the coroner's file.
14 A. That was the letter I was referring to as addressed to
15 Mr Kevin Doherty.
16 Q. Ultimately, this document was committed to the standard
17 deposition form, which the coroner uses, but this is the
18 document that appears on the coroner's file. One can
19 see from that document, by contrast with the letter that
20 you sent to Dr Kelly, that the portion at the bottom of
21 the page in which you critiqued the use of 500 ml of
22 normal saline has been removed and that's an issue
23 I will investigate with you later. But it appears that
24 this is the statement that was ultimately sent to the
25 coroner.

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1 Q. And a number of brief questions arising out of that.
2 The reference for it is 315-017-001. As appears from
3 a combination of your CV and your witness statement to
4 the inquiry, you graduated from medical school at
5 University College Dublin in 1978; is that correct?
6 A. That's right, yes.
7 Q. And you became a member of the Royal College of
8 Paediatricians in 1986 and a fellow of the Royal College
9 in 1995?
10 A. I believe that's correct, yes.
11 Q. As we see from your CV in front of us, your traineeship
12 was broadly conducted in hospitals in the Republic of
13 Ireland, before moving to London?
14 A. That's correct. Paediatrics exclusively in -- I didn't
15 do any paediatrics in Dublin.
16 Q. Yes. You obtained a further degree, a Masters degree in
17 biochemistry in 1985 to 1986 --
18 A. That's correct, yes.
19 Q. -- before taking up your first consultant post in the
20 Middle East in Saudi Arabia in the years late 1986
21 to March 1988 --
22 A. That's right, yes.
23 Q. -- before returning to the UK and taking up a senior
24 registrar's role in Westminster Hospital, and then
25 moving to a consultant's post in 1992 in Roehampton?

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1 A. That's right, yes.
2 Q. And you came to the Erne Hospital, as it was then know,
3 in Enniskillen in July 1997?
4 A. That's correct, yes.
5 Q. And you took up a post as a consultant in paediatrics?
6 A. That's right, yes.
7 Q. As I think you have said, your career has been in the
8 field of paediatrics.
9 A. Pretty much, yes.
10 Q. So by the time you came to care for Lucy Crawford in
11 2000, you had approximately eight years' experience as
12 a consultant paediatrician, approximately three of which
13 had been spent in the Erne Hospital?
14 A. That's about right, yes.
15 Q. I think there is a typographical error in your first
16 witness statement, where you stated that you came to the
17 Erne in 1987. But I think you tidied that up in a --
18 A. That's correct. I made a mistake in that.
19 Q. And indeed you tidied that up in a second statement.
20 A. I believe so, yes.
21 Q. You are now retired from work as a medical practitioner;
22 is that correct?
23 A. That is right, yes.
24 Q. And prior to your retirement, doctor, you faced charges
25 before the General Medical Council of serious

1 professional misconduct --
2 A. That is correct, yes.
3 Q. -- arising out of your acts and omissions in relation to
4 the care of Lucy Crawford?
5 A. That is correct.
6 Q. And in 2009, some of those charges were upheld against
7 you, and that's a matter of public record?
8 A. Yes.
9 Q. It emerged last week, doctor, when the solicitors
10 representing Dr Dara O'Donoghue, who at that time worked
11 in the Royal Belfast Hospital for Sick Children -- it
12 emerged, because information was volunteered, that he is
13 a distant relation of you.
14 A. That's correct, yes.
15 Q. You are obviously aware of that?
16 A. Yes, I am.
17 Q. Do you know that gentleman well?
18 A. I wouldn't say I know him well. I have met him in the
19 context of work issues and I think we have -- once we
20 knew who each other was, we have met at family
21 occasions, funerals and weddings and so on.
22 Q. He was the doctor who was charged with responsibility of
23 signing off on Lucy Crawford's medical certificate of
24 the cause of death.
25 A. I believe so, yes.

1 Q. Have you had any discussions with him about that medical
2 certificate?
3 A. No.
4 Q. Have you had any discussions with him about the care,
5 treatment and death of Lucy Crawford?
6 A. No, I don't think the last time I met him, which was
7 probably a couple of years ago now -- I don't know that
8 I realised -- I was aware at that stage that he had
9 signed the death certificate. I hadn't seen him as
10 being someone who was greatly involved, shall we say.
11 I hadn't spoken to him at the time, so, no, I haven't
12 discussed it with him.
13 Q. You have said, doctor, in your witness statement to us
14 at 278/1, page 14 -- It's question 25.
15 At question 25, doctor, you're asked how you would
16 categorise the quality of care which was provided to
17 Lucy at the Erne Hospital. You have said candidly:
18 "I would now categorise Lucy's care at the Erne as
19 inadequate. As Lucy's consultant, I should then have
20 written out the prescription for Lucy's fluid management
21 and I should then have ensured that my junior medical
22 staff and my nursing staff understood that
23 prescription."
24 And that's presumably a view you continue to hold?
25 A. Yes.

1 Q. And indeed, elsewhere in your statement you've expressed
2 your regret about Lucy's death and you've expressed
3 appropriate condolences. The purpose of this part of
4 the inquiry, doctor, is not so much to focus on the
5 quality of Lucy's care, because that strictly falls
6 outside of the inquiry's terms of reference,
7 nevertheless of course we will have to touch upon
8 aspects of Lucy's care, but the main purpose of this
9 part of the inquiry, doctor, is to examine the
10 opportunities that were available to those who had
11 dealings with Lucy, in the broadest sense, and to
12 explore why opportunities weren't taken at the earliest
13 possible stage to identify accurately the cause of her
14 death and to report that into the system; do you follow
15 that?
16 A. Yes, I understand what you're saying.
17 Q. You have said -- again if we could have this up on the
18 screen, please -- in the course of the evidence that you
19 gave to the General Medical Council -- if we could have
20 163-003-017 -- and in the course of the panel's
21 questions to you, doctor, a Dr Smith said to, you just
22 between D and E, if you can follow the lettering in the
23 left-hand margin:
24 "I would have thought you would have said to
25 Dr McKaigue [that's the doctor you were handing Lucy

1 over to in the Royal Belfast Hospital], 'This little
2 girl came in, she was moderately dehydrated, we set off
3 such-and-such fluid and, for reasons that I just cannot
4 comprehend, things have gone wrong'. That is basic
5 information, is it not?"

6 And you can see your answer:

7 "I think that under those circumstances you start or
8 I tend to start from the other end, which is the problem
9 you have in front of you. The problem we had in front
10 of us was a child who had deteriorated drastically and
11 who needed ventilatory support, which we did not have
12 facilities for. This was the basis for the request for
13 a transfer. It did not occur to me that this was
14 a fluid balance issue. I accept that, in retrospect,
15 that probably should have occurred to me, but I did not
16 leave the hospital thinking that this was primarily
17 a fluid balance issue."

18 It's around that whole area I wish to spend some
19 time today examining, doctor. Do you have anything to
20 say before we set off on that journey in terms of,
21 broadly speaking, what more you could have done
22 following your treatment of Lucy to shine a light and to
23 identify why her condition had deteriorated?

24 A. My response, when I was subsequently contacted by the
25 intensive care doctor from the Royal, Dr Crean, he

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1 I didn't then try to undertake a detailed analysis
2 of the case and possibly I should have. I suppose my
3 concern might have been that would have been seen as an
4 attempt to interfere with what I'd asked Dr Kelly to do
5 if I had devoted too much time to ...

6 Q. Okay, we have your broad position out in front of us
7 now. As you have said to the GMC:

8 "In retrospect, it probably should have occurred to
9 me, but it didn't."

10 And we'll examine in due course whether in fact
11 there were other steps that you could or should have
12 taken.

13 Before doing that, in terms of your knowledge of the
14 whole area of electrolyte imbalance, hyponatraemia, the
15 importance of appropriate fluid management, those kinds
16 of issues were part of your stock in trade as
17 a consultant paediatrician in the year 2000; is that
18 fair?

19 A. That's a fair comment, yes.

20 Q. You have told us in your witness statement to the
21 inquiry, the reference is 278/1, page 2, that:

22 "As an undergraduate, issues of fluids and
23 electrolytes were introduced in the pre-clinical years."

24 These issues were taught in what you describe as:

25 "... a didactic form, but in later clinical years,

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1 brought to my attention the fact that he thought there
2 was a discrepancy between the information relayed and
3 what was written. I notified Dr Kelly, who was the
4 medical director at the time, with a view to examining
5 that issue. I didn't see the connection between the
6 circumstances we were dealing with and the fluids. The
7 sodium was 127, that was the number that I was aware of.
8 And one of the statements that you showed me, I have
9 made a comment to the effect that I had considered the
10 possibility of a hyponatraemic convulsion when I had
11 heard about the episode -- I didn't see the episode that
12 she had had -- but I believed that 127 was not a level
13 at which that was a real possibility, a real likelihood.
14 So in that context, it wasn't -- I didn't put the
15 circumstances together to reach the conclusions which
16 have subsequently been reached.

17 Q. So in short, doctor, is your answer that you feel you
18 could have done no more to eliminate the cause of --

19 A. I don't think I could have under the circumstances.
20 I had travelled in the middle of the night and so on and
21 so forth. I had notified at the first opportunity --
22 there are some questions as to the exact time when
23 I spoke to Dr Kelly and so on, but at the first
24 opportunity available I had notified him that a concern
25 had been raised.

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1 through rotations, [you] would have some further
2 discussion of these issues again, mainly in a didactic
3 form, there was a practical application of these ideas
4 in the context."

5 However, if we go over the page, you say:

6 "On qualifying, many practical techniques were
7 acquired from standard handbooks and from earlier
8 occupants of these posts. Practices varied from ward to
9 ward, from consultant to consultant, even in the same
10 ward. Much of the learning was on the basis of the
11 usual practice within the different units."

12 And again, you refer to the standard textbooks.

13 Broadly speaking, doctor, you would have appreciated
14 that in the management of children with conditions such
15 as gastroenteritis, care was necessary when approaching
16 the issue of intravenous fluids.

17 A. Yes.

18 Q. And it would be necessary, in all cases, to approach the
19 management of a child in those circumstances by making
20 an appropriate assessment of the type of fluids required
21 by the child?

22 A. Yes.

23 Q. And thereafter, trying to calculate the appropriate rate
24 and overall volume which a child was to receive?

25 A. Yes.

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1 Q. And there were a number of textbooks or guides that were
2 available to paediatricians to calculate and work from?
3 A. There were, yes.
4 Q. You would also have appreciated that giving a child too
5 much hypotonic fluids could have the potential to upset
6 the electrolytes?
7 A. Yes.
8 Q. And what would flow from that is the possibility of
9 oedema?
10 A. Yes, that's one of the possibilities, yes.
11 Q. Lucy came into the Erne Hospital in the early evening of
12 12 April, and initially you didn't have any dealings
13 with her; isn't that correct?
14 A. That's correct, yes.
15 Q. The doctor on duty, Dr Malik, initially assessed her and
16 made an assessment that she required intravenous fluid
17 management --
18 A. Yes.
19 Q. -- but he wasn't able to achieve cannulation?
20 A. That's correct, yes.
21 Q. And he called you in?
22 A. That's correct.
23 Q. When you were brought in, you applied EMLA cream and
24 managed to cannulate?
25 A. That's correct.

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1 A. Oral rehydration therapy?
2 THE CHAIRMAN: Yes, it has a definite salt content?
3 A. Yes, it has a particular -- standard composition. It
4 comes in a sachet. You make it up with a standard
5 volume of water, so you have a standard concentration of
6 sodium.
7 THE CHAIRMAN: But its make-up is not the equivalent of
8 Solution No. 18?
9 A. It has been given orally, so you can't compare the two.
10 It's not as concentrated as normal saline would be --
11 I can't off the top of my head remember the exact
12 concentration in comparison. I can calculate it if you
13 wish.
14 THE CHAIRMAN: Thank you.
15 MR WOLFE: The instruction that you gave to Dr Malik and
16 Nurse Swift was 100 ml as a bolus --
17 A. That's correct, yes.
18 Q. -- followed by 30 ml of 0.18 saline in 4 per cent
19 dextrose at 30 ml an hour.
20 A. That's correct, yes.
21 Q. And we needn't go into the detail of that or the
22 thinking behind it, save to remark, doctor, that the
23 approach to the fluids that you adopted, taking into
24 account the oral fluid regime in combination with the
25 prescription that you directed, has been condemned by

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1 Q. And you issued what we now know were verbal instructions
2 which you assumed were being recorded by Dr Malik for
3 the intravenous fluids?
4 A. Yes. Might I just draw your attention to what happened
5 in between, just so you're able to understand when I'm
6 talking about fluids? In treating gastroenteritis there
7 are two ways you can administer fluids: one is
8 intravenously and one is orally, oral rehydration
9 therapy. Usually, it's a combination of sugar and salt,
10 which is absorbed very readily from the intestines, even
11 with those with severe gastroenteritis. When I had
12 applied the EMLA cream, it takes a several time to have
13 the effect -- half an hour, three-quarters of an hour
14 would be the waiting time -- during that time my
15 response was to make up some oral solution which
16 I personally administered to Lucy.
17 My view has always been that -- and I think it's
18 a widely-held view within paediatrics -- most cases of
19 gastroenteritis up to the degree of severity of Lucy's
20 case can be managed with oral rehydration therapy.
21 It is not the case that it was my intention that it
22 should be solely confined to intravenous therapy, just
23 to be clear. It is not something that I think has been
24 brought out so far.
25 THE CHAIRMAN: The fluid that is given orally --

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1 the General Medical Council as an inappropriate fluid
2 regime; isn't that right?
3 A. I don't know that the issue of the oral rehydration
4 therapy was considered in any great detail. I haven't
5 looked at those papers for some years now. The issue,
6 as I understood it, was the poor recording and the
7 inappropriateness of using the regime described as
8 "100 ml of saline followed by 30 ml per hour" or indeed
9 what actually seems -- as I understand it is now
10 accepted as what seems to have now transpired is it was
11 100 ml an hour of 0.18 per cent, which I would agree is
12 entirely inappropriate. That was never my intention.
13 Q. If we could maybe have up on the screen, to clarify the
14 point, 163-002-004. What you're going to see up on the
15 screen is the charge or part of the charges that you
16 faced. Perhaps could we have the previous page up
17 alongside it, 003.
18 If I can read from the bottom of the left-hand page:
19 "On April 2000, you made a record of what your fluid
20 management plan for patient A on 12 April 2000 had been
21 as being a bolus of 100 ml over 1 hour followed by
22 0.18 sodium [let's call it Solution No. 18' for short]."
23 Then the charge at paragraph 6 is:
24 "The fluid regime set out at paragraph 4 above was
25 ... (c) not appropriate in any event."

20

1 A. Sorry, I've lost track. Can you remind me where
2 you're --
3 Q. I can.
4 A. Just the last sentence.
5 THE CHAIRMAN: If you jump to paragraph 6(c):
6 "The fluid regime was not appropriate in any event."
7 A. Thank you.
8 MR WOLFE: So what you explained to the GMC, you may
9 remember, doctor, is that you had a particular plan for
10 intravenous fluids which took into account the fact that
11 she already had some oral fluid therapy; isn't that
12 right?
13 A. That's right, and again, the observation was that she
14 took it -- I think I said something like
15 "enthusiastically retained it". Again, another
16 assumption that I made that, in retrospect I should not
17 have, was that the nursing staff would have continued
18 what is standard practice in gastroenteritis which is to
19 continue to offer rehydration therapy on an ongoing
20 basis, and that whatever volumes were taken would then
21 be taken into account when the situation was reviewed on
22 an ongoing basis.
23 Q. Yes. The point I'm making, before we move on, because
24 we don't need to deal with this in any great detail, is
25 the fluid regime that you adopted and directed to the

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1 explicit enough my view that that should have been done
2 and that should have been continued, but I thought the
3 demonstration of me having done it and administered it
4 myself would have been enough, in practical terms, to
5 say: we continue with standard management of
6 gastroenteritis in this child. There was no instruction
7 given that she was not to be given any oral fluids, for
8 example. But why that decision was taken, I don't know,
9 nor by who.
10 Q. Yes. Happily, doctor, that isn't an issue that concerns
11 us, so let me move on from there. As a matter of fact,
12 intravenous fluids for this child commenced at 10.30 pm
13 or thereabouts on the evening of 12 April 2000.
14 A. I believe so. I don't remember the exact time, but that
15 sounds right, yes.
16 Q. We know from in or about that time, she was infused with
17 100 ml per hour of Solution No. 18.
18 A. I believe so, yes.
19 Q. And those fluids continued until after her seizure at or
20 about 3 am on 13 April, when Dr Malik stopped the use of
21 the Solution No. 18 and moved to a regime of normal
22 saline, which was run in freely.
23 A. I believe so. I'm not entirely sure at what time the
24 normal saline was started. I don't think, even in
25 retrospect, I'm exactly clear when that was started, but

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1 nurse and to the doctor was criticised and upheld, if
2 you like, as being inappropriate. That is charge 6(c).
3 A. Yes.
4 Q. But as we know, as a matter of fact, this child did not
5 even get the inappropriate fluid regime that you had
6 intended for her.
7 A. If I might, just to complement it, did the child get the
8 more appropriate fluid regime, which I had intended,
9 which was ongoing oral rehydration therapy?
10 Q. That might be a matter of conjecture, but certainly --
11 A. If you're talking about what my regime was intended to
12 be, then if you look at the fact that I made up the
13 solution and gave it to her myself, that was
14 a relatively unusual thing and that would not be
15 a normal part of nursing practice. I thought I had very
16 forcibly made the point that in this particular case
17 that oral rehydration therapy was appropriate. She had
18 been some two-and-a-half, I think, or three hours before
19 I was called, during which time she had been given very
20 little fluid. And what she had been given as
21 I understand, as I remember, was, for example, diluted
22 orange squash, for example, which is of no value in the
23 context of treating somebody with gastroenteritis. What
24 should have been done was what I did, which was the oral
25 rehydration therapy. Now it may be that I didn't make

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1 the timings are approximate, as you say.
2 Q. You say that because, in fact, at one time or another,
3 you say that you were led to believe that the normal
4 saline was commenced at or about 2.30, following the
5 first episode of diarrhoea. That was a view that you've
6 expressed from time to time and you seem to be relying
7 on information supplied to you by Dr Malik to have
8 reached that view.
9 A. That's correct. I don't remember the exact terms of the
10 question, but it was to do with the fact that the
11 intravenous fluids were running when I noticed they were
12 running freely, that is to say not controlled by an
13 infusion pump. My recollection was I asked him how did
14 that -- what was the reason for that. And he referred
15 to the episode of diarrhoea that she had had.
16 Q. Yes. That was the fluid situation as a matter of fact.
17 What you had directed had not been followed, she got
18 a combination, one after the other, of an inappropriate
19 amount of Solution No. 18, followed by an inappropriate
20 amount of normal saline; isn't that right?
21 A. That's correct, yes.
22 Q. In terms of Lucy Crawford's condition, when you came and
23 saw her on the evening of 12 April, you would have
24 recognised that she was dehydrated; isn't that right?
25 A. Yes.

24

1 Q. And a number of factors suggested that. First of all,
2 there was a history on admission of her having been
3 vomiting everything that she was eating and drinking.
4 A. Correct, yes.
5 Q. You were aware of a capillary refill in excess of two
6 seconds?
7 A. Can I say I'm not entirely sure that is actually true?
8 That is taken from Dr Malik's recording. He uses
9 a symbol -- are you familiar with the symbol for less
10 than or greater than that? -- and in actual fact it's
11 not terribly uncommon for people to use that symbol
12 in the wrong direction. To record something as
13 a capillary refill of greater than 2 seconds doesn't
14 make any sense because if you're counting 1, 2, 3, 4 --
15 which is how you count it -- you would record capillary
16 refill 3, 4, 6, whatever it was.
17 I can't say that I know this for sure, but my belief
18 is that Dr Malik intended to write "less than 2
19 seconds". I don't believe writing "more than 2 seconds"
20 in that context makes any sense. If it's 3, that's
21 a huge world away from being 6, for example, or 7, if
22 you understand what I'm getting at. So to write "more
23 than 2" really makes no sense and it is a symbol which
24 I quite commonly see being used incorrectly.
25 Q. Leaving that point to one side, what were the other

25

1 A. That is a factor. It is not the case that the level of
2 urea parallels the degree of dehydration. It is not --
3 and I think this is uncontroversial when I say this.
4 It is not a good indicator of severity of dehydration.
5 People try to -- because it's a number, there is often
6 a tendency to take it that because it's a number, it's
7 therefore objective and tells you more than normal
8 clinical examination does, but that is not the case.
9 But it does indicate that she was dehydrated if that's
10 the question, but it doesn't tell you about the degree
11 of dehydration.
12 Q. In any event, taking the factors that you took into
13 account, you recognised that this was a child with
14 moderate dehydration?
15 A. Moderate dehydration would be the usual description,
16 yes.
17 Q. And the fact that she was of moderate dehydration is
18 a pertinent factor to be taken into account when
19 assessing the appropriate fluid regime for a child?
20 A. It is, yes. The degree of dehydration is important.
21 Q. And publications such as Advanced Paediatric Life
22 Support, they tell us that in relation to moderate
23 dehydration, you need to calculate an amount for
24 replacement fluid; isn't that right?
25 A. That's correct, yes.

27

1 factors, if any, that you took into account in
2 identifying dehydration as an issue here?
3 A. One of the most important ones was I made up the oral
4 rehydration therapy solution, as I indicated. I then
5 gave it to her, and she took it, and I think the word
6 I used was enthusiastically. I don't know whether
7 you have tried to taste this solution yourself, but it's
8 not something you take unless you're dehydrated and you
9 need the fluids. First of all, it told me she was
10 dehydrated, second of all she was alert and conscious
11 enough to respond when offered fluids. So even in that
12 small gesture, that small intervention, there was an
13 enormous amount of information which has not been maybe
14 acknowledged that would tell you a lot about the
15 situation. The presence or absence of thirst, for
16 example, is recommended by the World Health Organisation
17 as one of the ways of looking at dehydration. If
18 a child can't respond when you offer fluids, then the
19 child is becoming so unwell that it's becoming shocked.
20 If the child doesn't wish to take fluids, the standard
21 view is that the child isn't dehydrated enough for it to
22 be terribly urgent, if I can put it like that.
23 Q. Urea was raised at 9.9.
24 A. That's correct.
25 Q. Is that a factor?

26

1 Q. And obviously a type of fluid for replacement?
2 A. That's correct, yes. It doesn't -- and it's one of the
3 limitations of the approach adopted by the Advanced
4 Paediatric Life Support is that it is not a manual for
5 the treatment of gastroenteritis. So it doesn't, for
6 example, refer to oral rehydration therapy as far as
7 I can recall, at the moment -- I haven't looked at the
8 manual for a little while. So as an indication of how
9 to treat gastroenteritis it is incomplete. I'm not
10 arguing with the general principles that are outlined in
11 it, but in terms of treatment of gastroenteritis it is
12 an incomplete guide as to how you should try to treat
13 gastroenteritis.
14 Q. And as well as replacing fluid with the appropriate type
15 of fluid, there's also a need for ongoing maintenance?
16 A. There is, yes.
17 Q. You would presumably agree, doctor, that 100 ml per hour
18 of Solution No. 18 was not the appropriate fluid for
19 this child?
20 A. Yes.
21 Q. You recognised the need to give normal saline --
22 A. Yes.
23 Q. -- as part of the --
24 A. I used the word "bolus" and I was very clear -- and
25 I think I have been on a number of occasions -- as

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1 saying I should have appended to that the words "normal
2 saline". I didn't because -- and again, I have to
3 accept this is a defect on my part. My presumption was
4 that "bolus" was synonymous with something like normal
5 saline. You had some discussion with Dr Auterson about
6 the alternatives, I think, in recent times, but in
7 practical terms, in paediatrics, it comes down to normal
8 saline.

9 Q. In terms of the fluid that was used from about 10.30
10 that night, you will have observed the views expressed
11 by, among others, Dr Sumner --

12 A. Yes.

13 Q. -- at the time of the inquest?

14 A. That is correct, I have, yes. I've seen his report,
15 yes.

16 Q. If we could have up on the screen, please, his opinion.
17 It's 013-036-140. At the top of the page he says:

18 "4 per cent dextrose/0.18 per cent saline is
19 a totally inappropriate fluid to make up deficits from
20 vomiting and diarrhoea. The dextrose is immediately
21 metabolised and so this solution is effectively
22 providing only water. An appropriate fluid would be
23 normal 0.9 per cent saline with a potassium supplement."

24 Is that a view with which you would agree?

25 A. There's nothing about it I disagree with, if I can put

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1 inquest, of course, is the connection between giving
2 this totally inappropriate fluid, which it appeared to
3 Dr Sumner had been given to make up deficits, that was
4 his impression, that that's what had been done here.

5 A. Yes, I believe that was his impression.

6 Q. And his impression, just so that we can understand where
7 we're going from this, was this was a child who was
8 dehydrated, she had an episode of vomiting after being
9 admitted to hospital, followed by an episode of
10 diarrhoea, and through all of that period of time she
11 was on Solution No. 18.

12 A. Yes.

13 Q. And so taking the dehydration and these gastric losses
14 into account, his point is Solution No. 18 is totally
15 inappropriate.

16 A. Yes. I believe that is his point, yes.

17 Q. And then we need to understand, doctor, what is the
18 problem caused by this inappropriate fluid regime. And
19 Dr Sumner again sets that out if we can have
20 013-036-141. What he says, about halfway down that
21 page, is:

22 "She came into hospital somewhat dehydrated from
23 vomiting and there was additional loss from diarrhoea.
24 So she was given an excess volume of intravenous water
25 to replace these losses.

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1 it that way, but I'm not sure -- yes, yes -- no, I agree
2 with that, yes. There are parts of it -- for example,
3 the last line is about ongoing losses and I'm not sure
4 if he was -- in that, I think the reservation I had was
5 the possibility that he was suggesting you could predict
6 was the ongoing rate of loss was going to be and
7 therefore you could add more on top of that for a
8 prediction of ongoing losses, which is an approach some
9 people have suggested. I think that was the reservation
10 I had about that, but the broad outlines of what you
11 have read out I'm agreeing with.

12 Q. I suppose the implication there is that you would keep
13 a child under close observation and if there's evidence
14 of severe vomiting or diarrhoea, that you might
15 re-examine the position?

16 A. Yes, it's not a -- a fluid regime in the context of
17 gastroenteritis can't be something that you write down
18 once and that's it for the next 24 hours. The diarrhoea
19 and vomiting might stop, in which case you wouldn't
20 force a child to continue not to eat, for example. The
21 diarrhoea or vomiting might have worsened substantially,
22 in which case you would have to change your approach.
23 So you start out with a regime and you have to be open
24 to the possibility of continuous modification.

25 Q. And then, doctor, one of the issues that emerged at the

30

1 "I think that the excessive volumes of
2 dextrose/saline in the face of losses of electrolytes
3 from vomiting and diarrhoea caused an acute serum sodium
4 dilution, which in turn caused acute brain swelling."

5 So that was the mechanism for the cerebral oedema,
6 leading to Lucy's untimely death.

7 A. That is correct, yes.

8 Q. And that's what, as we know, was accepted by the coroner
9 as part of his verdict.

10 A. I believe so, yes.

11 Q. And again, I trust, doctor, that you accept all of that?

12 A. I do. If I may say, Dr Sumner's was the first analysis
13 of the situation that I had seen which clarified it
14 in the way that you have just put. The only other point
15 I would draw your attention to is that the serum sodium
16 he's referring to as being hyponatraemia is less than
17 128. And I think in his original statement, when he
18 does that, he references his own textbook. So you're
19 talking about a level of 127, which is a unit of one
20 below the level that Dr Sumner says constitutes
21 hyponatraemia, so, if I can put it like this, just
22 having shaded into the hyponatraemia. The thing that
23 Dr Sumner pointed out, which I hadn't fully appreciated,
24 was that the use of the normal saline would lead to an
25 increase in the serum sodium, and therefore the number,

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1 which is 127, might not be a reflection of what had been
2 in place at the phase when things went wrong.

3 I think my misunderstanding was possibly, although
4 I wasn't conscious of it at the time, possibly thinking,
5 well, if -- if somebody had asked me the question, I
6 imagine I would have said something like: if the sodium
7 comes up, then the cerebral oedema should reduce. If
8 the thought had occurred about the sodium having
9 changed, I would have initially expected the child's
10 condition to improve, although once you realise it's
11 a matter of coning, then the situation does become
12 irreversible, so that logic doesn't then apply.

13 Q. That's one issue, the fact that normal saline had been
14 run in, which may have skewed the results, if I can put
15 it in those terms. A second issue, which we'll look at
16 and unpack in a moment, is the question of the rate of
17 drop, in other words she dropped from 137 to 127 in
18 a short period of time.

19 A. Yes. Dr Sumner expresses his view very clearly and, if
20 I may say so, very convincingly. Some of the other
21 publications on the matter of hyponatraemia and --
22 I think I may be quoting the name incorrectly, but
23 Arieff is the name which sticks in my mind from my
24 reading -- was somebody who had done a lot of research
25 on hyponatraemia, in adults I accept, rather than

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1 A. I don't believe I saw that report or any of the
2 documentation that was to be presented at the coroner's
3 inquest until very shortly before the inquest. To the
4 best of my recollection -- and this is not a very
5 certain recollection -- I didn't see this report until
6 after the inquest. My recollection is that the Trust
7 held a meeting with a senior counsel and invited
8 a number of members of staff who were to attend the
9 inquest to attend and then gave us a copy of, I think,
10 a two-page statement, a two-page summary of what the
11 Trust had done in terms of the Trust's enquiries. I'm
12 not sure -- to the best of my recollection I didn't see
13 Dr Sumner's report before the inquest. I may be
14 mistaken on that, but ...

15 Q. It was the case, doctor, in 2002 that Dr Kelly, on
16 behalf of the Trust, had instructed the Royal College of
17 Paediatrics and Child Health to carry out a second
18 external review or a second review, this time a review
19 that involved coming into the Erne to interview various
20 staff about what had happened in various situations,
21 including around the whole care of Lucy; you'll remember
22 that?

23 A. I do, yes.

24 Q. And in a report published for the Trust in or
25 about August 2002, the Royal College concluded that Lucy

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1 children. He was, as I remember, very enthusiastic --
2 that maybe is not a good word -- in the belief that the
3 rate of fall was not important. So I have come to
4 accept Dr Sumner's -- particularly Dr Sumner's
5 conclusions as the best explanation for what happened.
6 I'm not sure that if you step back to the time when it
7 did happen, even if it had occurred to somebody -- and
8 it didn't occur to me, I'll be honest -- I'm not sure
9 that I would have necessarily seen it in the same light
10 as Dr Sumner has done.

11 Q. Let me just move to those issues in a moment, but what
12 I wanted to ask you is this: you say it wasn't until you
13 saw or perhaps heard from Dr Sumner in relation to these
14 points --

15 A. I saw the report. I have never spoken to him, I don't
16 think.

17 Q. It was only when you saw the report then that you became
18 aware, convincingly perhaps, of the connection between
19 the fluid regime and the cerebral oedema; is that fair?

20 A. Yes, I think that would be fair comment.

21 Q. And you would have had access to that report,
22 I understand, via Dr Kelly. He was supplying it to you
23 in preparation for the inquest because he had been sent
24 it, I think, by the coroner. That would have been 2003;
25 isn't that correct?

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1 had died of previously unrecognised hyponatraemia; do
2 you remember seeing that report?

3 A. I'm sure I have seen the report. It's not one that
4 I can call to mind at the moment. I'm sure I must have
5 been shown it.

6 Q. You have said to us that it wasn't until 2003 or shortly
7 before the inquest that you drew the connection between
8 the fluid regime and the death of Lucy. Does that
9 not --

10 A. The fluid regime leading to a serum sodium which was
11 much lower than the one that had been recorded and
12 subsequently producing the cerebral oedema. That
13 sequence of events, which is what I understand is
14 broadly accepted -- and it seems correct to me to be the
15 circumstances -- that connection -- my recollection is
16 it was Dr Sumner's report which was the most convincing
17 account of that.

18 Q. In advance of seeing Dr Sumner's report, were you not
19 aware that it was the process leading to hyponatraemia
20 that caused the cerebral oedema?

21 A. As I understand it, it's the hyponatraemia which causes
22 the cerebral oedema. It changes the concentration of
23 sodium on the different sides of the brain, thereby, as
24 it were, sucking water into the brain, if I can put it
25 like that. That is my understanding. Again, if I've

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1 misunderstood some of the reports -- but that is my
2 understanding of the situation.
3 Q. The sole point I'm putting to you is this: there were
4 two Royal College reports.
5 A. That's right, yes.
6 Q. The report that emerged in 2002 is a very clear
7 statement that hyponatraemia was the cause here. And
8 what I'm asking you is: was that not within your
9 knowledge well before the time of the inquest?
10 A. I think the serum sodium they were referring to was 127.
11 Q. Yes.
12 A. And if I remember correctly, there was nothing to say
13 that they believed that the sodium had fallen further
14 than that.
15 Q. Yes.
16 A. I can't remember 2003 well enough to say for sure, but
17 I suspect if you had told me that a serum sodium of 127
18 had produced this profound degree of cerebral oedema,
19 I don't think I would have believed it, to be honest
20 about it.
21 THE CHAIRMAN: Sorry, doctor, Dr Sumner's report simply
22 refers to the possibility that the reading was lower
23 than 127.
24 A. That's right, yes.
25 THE CHAIRMAN: He's referring to it only as a possibility.

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1 that contributed to the hyponatraemia and the problems
2 it causes. So I don't think that at the time in 2000 it
3 was as clear as it has become since that it is now
4 accepted, as I understand it, that the rate of fall is
5 an important issue. I don't believe that was widely
6 accepted at the time.
7 THE CHAIRMAN: Thank you.
8 MR WOLFE: Can I bring you then to 3 o'clock in the morning
9 of 13 April? You are summoned to the hospital from your
10 home because it was reported that Lucy had suffered some
11 form of convulsion.
12 A. That's correct, yes.
13 Q. And you made your way there quickly.
14 A. Yes, there wasn't a lot of traffic. I don't live very
15 far away. I didn't record how long it actually took,
16 but it was promptly.
17 Q. And upon your arrival, you were presumably greeted by
18 a scene of some panic?
19 A. Yes.
20 Q. And you would have observed that Dr Malik was manually
21 ventilating the child?
22 A. He was bagging in the sense there was a bag and mask.
23 The child wasn't intubated until Dr Auterson -- my
24 recollection is that I attempted intubation and was
25 unsuccessful and then waited for him to arrive to

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1 A. Yes.
2 THE CHAIRMAN: But what he does say is that the drop to 127,
3 the rate of that drop and then the exacerbation of the
4 situation by giving 500 ml of normal saline was the
5 combination which killed Lucy.
6 A. Again, I may have misunderstood and maybe the degree of
7 convincingness of that report may have been based on my
8 seeing what Dr Sumner had said and saying there is
9 a possibility that it was lower than that. He can only
10 say a possibility in the sense that there was no
11 measurement. He did say that he believes that the fall,
12 rate of fall, was relevant. What I have tried to say is
13 my understanding -- I can't remember when this
14 understanding changed -- was that there was a strong
15 view -- for example Arieff is the name that I have in my
16 mind -- that the rate of fall was not the determining
17 factor. In retrospect, again, that may seem illogical
18 or even unreasonable, but my understanding is, at the
19 time -- the context in which hyponatraemia was discussed
20 in practical paediatric terms, I think, at that stage,
21 was of diabetic ketoacidosis and there were changes
22 being made in fluid regimes for diabetic ketoacidosis,
23 but those making those changes were very careful to say
24 that they didn't believe that it had been
25 well-established, you know, that the various factors

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1 complete that.
2 Q. And at that time, there was a drip up, Lucy was in
3 receipt of intravenous fluids.
4 A. That's right, yes.
5 Q. And you would have observed at that time that the fluids
6 were now normal saline?
7 A. That's correct.
8 Q. And plainly that was not something you had prescribed or
9 intended when you left at 11 o'clock?
10 A. If I can go back to the remark I made earlier when
11 I talked about a bolus, my understanding of the word
12 "bolus" -- and again I'm accepting that I didn't append
13 the term "saline" to it, but to me that would be
14 synonymous with saline.
15 Q. Did you expect that the bolus of normal saline would
16 still be in situ at that time?
17 A. No, I hadn't thought it through. I don't know when
18 I became aware that that was actually a change from
19 Solution No. 18 to normal saline. I had some
20 difficulty, maybe is the best way of putting it, in
21 getting a clear account from either Dr Malik or the
22 nursing staff.
23 Q. Yes, but just so I understand your position, it had been
24 your direction to Dr Malik to give a bolus at or about
25 10.30 over the period of an hour?

40

1 A. Yes.
2 Q. And then to commence a regime at 30 ml per hour of
3 Solution No. 18?
4 A. I don't know, and again, I may be mistaken, I don't know
5 that I specified Solution No. 18. It was the commonest
6 solution in use and therefore I'm sure I would have
7 anticipated that it would be Solution No. 18. But
8 I certainly wasn't there to see Solution No. 18 being
9 put up, so when I saw the saline I did talk to Dr Malik
10 to try to understand what was happening. I didn't
11 pursue the issue of what had happened at 10.30, 11.30,
12 and so on and so forth because it was, as you say -- did
13 you used the word "panic" or whatever? -- and it was
14 such an enormous and unanticipated deterioration, that
15 it was very difficult to know how to start to deal with
16 the situation.
17 Q. Could we just turn back to a document we opened earlier?
18 It's in your letter to Dr Kelly, 24 August 2003, where
19 you explain in some detail about the normal saline that
20 was being run in at that time. 047-053-148. If we
21 could look at the bottom half of the page:
22 "I was next called at approximately 03.00."
23 You say:
24 "Since she showed no signs of recovering by the time
25 I arrived and since there was a history of profuse

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1 you're coming in and you are realising that these fluids
2 are being run in freely without being checked by a pump?
3 A. That's correct, yes.
4 Q. And it would have been your perception that this was
5 unusual?
6 A. I hadn't seen it on the children's ward in the Erne
7 prior to that. I have seen it on a subsequent occasion
8 on the same ward.
9 Q. And it would appear from what you're saying that the
10 bag, 500 ml, was virtually complete before you arrived?
11 A. Before I first noticed it. I couldn't in retrospect
12 identify exactly how long after I arrived I saw that.
13 The initial situation was one of a child who was being
14 bagged by the SHOs. In practical terms it was
15 a resuscitation situation. To be honest, I can't say
16 how long it was before I made that observation. It may
17 have been straightaway, but it may have taken some time.
18 I honestly don't know.
19 Q. If you had been in the hospital otherwise than in this
20 emergency situation and had thought about checking up on
21 Lucy, you would have expected to see Solution No. 18 in
22 place at 30 ml per hour?
23 A. I wouldn't necessarily have presumed what would have
24 been running in the sense that, as I mentioned, I had
25 anticipated oral rehydration fluid would be used. There

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1 diarrhoea, I took a specimen for repeat urea and
2 electrolytes. My recollection is that Dr Malik had
3 started the intravenous normal saline before calling me
4 and that the 500 ml given was virtually complete before
5 I arrived."
6 If we could stop there and move to the bottom of the
7 page and we'll come back up again:
8 "The only respect in which this report differs from
9 the previous version is in respect to the infusion of
10 500 ml of normal saline to which I did not refer in the
11 version I sent to you previously. Since this is
12 approximately 50 ml/kilogram, a much larger volume than
13 I would use, I believe this had been started following
14 the first episode of diarrhoea, i.e. before the
15 convulsion."
16 So that was an assumption on your part?
17 A. Which was an assumption?
18 Q. That it had been started after the first episode of
19 diarrhoea.
20 A. Yes. My recollection was it was based on my attempt to
21 elicit from Dr Malik what had happened about the rate of
22 saline. He referred to diarrhoea. My recollection
23 is that the diarrhoea preceded the convulsion and that's
24 the basis for my conclusion.
25 Q. In any event, in terms of the sequence of events here,

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1 could be worsening or improving of the situation in
2 gastroenteritis. So if I had come back two or three
3 hours later and the situation was, from the fluid point
4 of view, was unrecognisable from what I had left it,
5 that wouldn't surprise me hugely because if
6 circumstances changed, people would have to change what
7 they're doing. I wouldn't have considered it abnormal
8 to see a child with gastroenteritis a couple of hours
9 later who was having a different fluid regime from the
10 one I had started previously.
11 Q. The regime you were in a position to observe at some
12 point after arriving was unrecognisable from what you
13 had --
14 A. It was free-flowing saline, which I certainly hadn't
15 directed, no.
16 Q. At that time, did you seek to obtain any background as
17 to how we had reached this position in terms of the
18 fluids?
19 A. I talked to Dr Malik. My initial response was in terms
20 of a resuscitation situation and you have referred to
21 it as being -- I'm not sure if I'm misquoting you when
22 you said a panic situation. But it was a very difficult
23 situation to manage and control, particularly in a ward
24 like the children's ward, where it doesn't occur very
25 frequently. So that was where my main efforts were

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1 directed. I think I said I attempted to intubate Lucy
2 and was unsuccessful. I may have had to call
3 Dr Auterson myself, for example, and to interrupt what
4 I was doing since it was common practice among the
5 anaesthetists not to wish to speak to anybody other than
6 consultants if they were being called in out of hours,
7 for example. So there were a number of things that
8 I was trying to do simultaneously. I didn't, and
9 I think I have said this before, have a clear
10 understanding from the nursing staff, for example, as to
11 which amongst the nurses would be able to tell me
12 exactly what had happened. And you have had access to
13 the General Medical Council records and I'm sure
14 you have seen the account from the nursing staff to the
15 effect that there was no system of allocation of nurses
16 to patients at that stage. I think the phrase one nurse
17 was, "We all used to just muck in", I think was the
18 phrase she used, which is not a circumstance I would
19 have been aware of, nor would I have approved of it.

20 So looking back in retrospect, the fact that I had
21 such difficulty having a clear-cut picture of what was
22 going on is not a surprise at all. It may not be
23 something that you would anticipate.

24 Q. Just to be specific, in terms of the fluids, did you get
25 a clear picture of what fluids she had received prior to

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1 it was -- I asked one person, I'll have to ask the other
2 person who's on her break, and so on and so forth.
3 I don't remember getting a clear-cut account at that
4 stage, no.

5 Q. So were you in the dark in terms of the fluids that she
6 had received, which we now know precipitated this
7 convulsion?

8 A. I wasn't aware until Dr Crean rang. Dr Crean rang the
9 following morning to draw my attention to the
10 discrepancy between what I believed had happened and
11 what he had reason to believe had happened, either on
12 the basis of what the handover had been or what he had
13 seen recorded somewhere else. That was a surprise to
14 me.

15 Q. So until Dr Crean phoned on the morning of the 13th, you
16 were proceeding on the basis that the fluids had been
17 administered as you had intended them to be
18 administered?

19 A. Until such time as free-flowing saline had been
20 instituted.

21 Q. One of the steps that you took during that period was to
22 arrange for repeat urea and electrolyte tests.

23 A. That's right.

24 Q. And when one takes blood for blood tests, electrolyte
25 tests, the tendency is not to take them from the arm

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1 the convulsion?

2 A. No, I don't think I got a clear-cut picture.

3 Q. At that time, during that period of resuscitating or
4 seeking to resuscitate Lucy, you didn't get a clear
5 picture?

6 A. Again, my recollections were I had accounts from
7 individual nurses, but when I tried to ask -- and this
8 is your observation and so on and so forth -- it was not
9 something that I found myself getting an entirely
10 satisfactory answer to. I have no recollection the
11 following morning and when I left the notes, when
12 I informed Dr Kelly, of physically having seen the fluid
13 chart during the course of that episode. That does not
14 mean that I didn't see it, but it would be unusual not
15 to have a clear-cut recollection, you know, physically
16 of what the structure, almost a snapshot ... I think
17 it's possible -- and I can only say it's possible --
18 that I wasn't shown the actual document. I was told,
19 given accounts, and when I asked to see the document
20 I am not entirely sure that the document actually was
21 made available to me.

22 Q. Were you given an account which said, in terms, "This
23 child has had Solution No. 18 at a rate of 100 ml per
24 hour for three and a half/four hours"?

25 A. I can't remember getting a clear-cut statement. I think

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1 where the fluid is running into; isn't that right?

2 A. You would certainly try to avoid that if at all
3 possible. It would give you unreliable results if you
4 did that.

5 Q. Because of the risk that the blood will be infiltrated
6 by some of the fluid?

7 A. Yes.

8 Q. Applying that principle more broadly, would you have
9 thought about the fact that this child has been
10 receiving a great quantity of normal saline for some
11 time and that that might affect the ultimate results
12 I get back?

13 A. I don't think that possibility occurred to me. Normally
14 when you give somebody normal saline, it won't change
15 their electrolyte concentration substantially. One of
16 the reasons why a lot of people have retained the use of
17 0.18 per cent saline, particularly in the United States,
18 and still continue to defend the practice now, is their
19 belief that if you gave normal saline to children,
20 because of the nature of their physiology, their serum
21 sodium would inevitably increase. That is not
22 necessarily the case.

23 Let's say for the sake of discussion, if Lucy's
24 serum sodium had been 127, if it had been taken
25 three hours earlier, she had had the normal saline and

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1 it was still 127, that wouldn't have surprised me very
2 greatly. It would have maintained the situation.
3 Q. Yes.
4 A. I'm not suggesting that I believe that to be the case,
5 but looking back, the most satisfactory explanation
6 is that the serum sodium was probably significantly
7 lower, so that's not what I'm trying to say.
8 Q. You knew at that time, of course, that the serum sodium
9 was running in before you took the bloods.
10 A. The intravenous sodium, you mean?
11 Q. Yes.
12 A. I believe so, yes.
13 Q. I should have said "the normal saline".
14 A. That's right, yes.
15 Q. In terms of the notes that you made around this time,
16 you didn't, in your note, give any timings or account
17 for the sequence of the normal saline being given,
18 followed by the bloods, or anything of that nature, did
19 you?
20 A. No.
21 Q. Do you think that was an omission?
22 A. I should have recorded the time at which I took the
23 blood. That would be a common thing to do. It's not
24 something that I would have always done at that stage,
25 and in the normal course of events it wouldn't be of any

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1 Q. He's made a number of points. First of all, he said
2 that the electrolyte values came back via a nurse over
3 the telephone at some point during the resuscitation of
4 the child. In other words, you were told and he was
5 told that there was now a serum sodium of 127 and that
6 potassium was low at just something over 2. Do you
7 remember receiving that information?
8 A. I remember knowing about it, but I don't remember at
9 what stage I received the information. I don't know
10 whether he received it first. From what I read, from
11 his written statement, it does appear that it was
12 relayed to him by a nurse first and presumably
13 subsequently to me, but I don't remember the specific
14 detail.
15 That result could be acquired in two different ways.
16 One, it could be acquired over the telephone. Secondly,
17 it could be acquired via a computerised system. If
18 I was looking for the result, for example, one of the
19 things I might have -- Dr Malik or anybody else would
20 have done would have been to go to the computer terminal
21 to try to identify if the number was available.
22 Sometimes you could acquire the results from the
23 computer system. The technician who had done the test
24 would put the results into the computer system before
25 then ringing the ward. So I am afraid I cannot

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1 great importance to record at the time whether you took
2 the specimen one hour ago or two hours later. It would
3 not normally make that much difference, but it is an
4 omission in somebody who is seriously ill like that not
5 to record the time at which you took specimens.
6 Q. Dr Auterson was summoned to assist you in stabilising
7 the child; isn't that correct?
8 A. That's correct, yes.
9 Q. And even before Dr Auterson arrived, you were aware that
10 the child's pupils were fixed and dilated?
11 A. That's correct, yes.
12 Q. And so you were faced with a situation where there had
13 been some catastrophic neurological development.
14 A. That's correct, yes.
15 Q. And with her pupils fixed and dilated, the prospects for
16 Lucy, even at that point, must have appeared to you as
17 bleak?
18 A. Yes.
19 Q. Dr Auterson has given evidence to the inquiry. I'm not
20 sure if you have had an opportunity to examine his
21 transcript.
22 A. I have seen his statement. I got access to his
23 transcript last night and I went through as much of it
24 as I could, but I can't say that I'm entirely familiar
25 with the details. I have tried to read it.

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1 disentangle at what time that result became available to
2 me at, nor indeed how.
3 Q. Do you think you knew it before leaving for the Royal?
4 A. I believe I did, yes.
5 Q. He has told the inquiry that observing Lucy's
6 neurological condition, receiving the results of the
7 electrolyte tests and considering the fluid balance
8 charts, he was able to conclude that the fluids had
9 caused hyponatraemia, which in turn had caused the
10 cerebral oedema.
11 A. That was my understanding on reading his witness
12 statement and from what I could gather from the
13 transcript that I was able to work through.
14 Q. In the transcript of last Friday, the reference is
15 page 136, he said that at the time of resuscitation you
16 knew what the electrolytes were and he assumed that you
17 would, just like him, join up the dots and be in
18 a position to work out that too much fluid had been
19 given to this child.
20 A. From Dr Auterson's statement, he is saying that he was,
21 I think -- I hope I'm not misunderstanding -- he was
22 saying he was very clear from very early on that that
23 was the sequence of events. I have to say that I was
24 very surprised to see that, for a number of reasons.
25 First of all, if he had known that that was the

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1 issue, then one of the natural reflexes would have been
2 to discuss it with me, and if I was dismissive of the
3 issue, if you're that clear about it, if it was just
4 a distant possibility and I said, "No, I don't think
5 that is really relevant", a discussion might terminate
6 very quickly. But if you were as clear as he was, and
7 I was not accepting of that idea, it's the kind of
8 situation where one would -- I would expect him to be --
9 he is very capable of being as forceful as is necessary,
10 if I can put it like that, having known him for a number
11 of years now.

12 The second thing I would say is that if somebody
13 believed that a patient has deteriorated drastically due
14 to hyponatraemia, low sodium, one of the options is the
15 use of hypertonic saline, that is to say a very
16 concentrated solution of saline. Normally it would be
17 referred to as 3 per cent, something of that sort. So
18 3 per cent more concentrated than would be normal
19 saline, for example. And you would administer that
20 in the hope that it might help improve the situation.

21 I have no recollection of Dr Auterson suggesting
22 that, and indeed Lucy was transferred to the intensive
23 care unit, where treatment would normally be dictated by
24 the anaesthetist. So if Dr Auterson was clear in his
25 mind that that was the case, I would be very surprised

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1 concentrated hypertonic saline, as I have said, and that
2 did not happen as far as I'm aware.

3 Q. Do I infer from what you are saying that you do not
4 accept Dr Auterson's account of being able to make this
5 assessment at the time?

6 A. I can't -- in the context, as I've explained it to you,
7 I can't understand how he would have been clear. I'm
8 not talking about the possibility -- about the idea that
9 a possibility might have occurred to him. I can accept
10 that, and in the heat of the moment no reference is made
11 to it and you don't think it through to the question of
12 any possible treatment. But to be clear as I understand
13 him to be saying from the written transcript, to my mind
14 it's inconceivable that he would not have tried to make
15 it clear. First of all to me or, if he didn't get round
16 to that, to have tried to initiate what was, I think,
17 even at that stage, accepted as a very reasonable form
18 of treatment.

19 THE CHAIRMAN: I think it's accurate to say that he
20 described it as a strong suspicion.

21 MR WOLFE: He moved from a strong suspicion, I think, to,
22 over a period of days, becoming firmer in that view, but
23 can I pick up on one of the points that you've made that
24 he didn't suggest 3 per cent saline as a treatment?
25 It is the case, doctor, that shortly after Dr Auterson's

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1 that he wouldn't have thought to have administered
2 hypertonic saline, even if he didn't believe it was
3 going to make any difference, even if you believe the
4 situation is probably beyond retrieval, it's the sort of
5 situation where any straw that becomes available tends
6 to be grasped at.

7 If I may indicate one straw that Dr Auterson did
8 grasp at, which wasn't referred to and it, I think, puts
9 that idea in context, which was that during the course
10 of the episode that was thought to be a context, Lucy
11 had been given rectal diazepam, which is a standard
12 medication for treating convulsions. Dr Auterson,
13 during the course of the resuscitation, asked for
14 a medication called -- I believe it's called Animate,
15 I think is its trade name; flumazenil is its proprietary
16 name --

17 Q. To reverse --

18 A. To reverse the effects of diazepam, that's right.

19 There was nothing to strongly suggest that doing
20 this, that the diazepam had been of any great
21 significance in the episode that had been seen, but
22 clearly, even a straw as desperate as that was something
23 he was willing to grasp. So if he was convinced that
24 there was hyponatraemia, then the other straw that would
25 automatically come into view was the administration of

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1 arrival you made contact with Dr McKaigue.

2 A. That's correct, yes, in the Royal.

3 Q. Of course.

4 A. Yes.

5 Q. And he suggested a treatment regime that involved
6 mannitol; isn't that right?

7 A. Mannitol and intravenous antibiotics, which we hadn't
8 administered ourselves at that stage.

9 Q. And the mannitol was intended to -- the purpose of
10 mannitol is to excrete water.

11 A. That's right. It would be referred to as an osmotic
12 diuretic and is used in any situation where you think
13 there's a possibility of cerebral oedema.

14 Q. That was the treatment that he suggested?

15 A. That's correct, yes.

16 Q. Were you in a position to tell Dr McKaigue the fluid
17 regime that Lucy had received before then?

18 A. I think I've said that I wasn't able to get a very
19 clear-cut picture in my own mind, so I can't actually
20 say how clear the picture that I relayed to Dr McKaigue
21 would have been. Normally in that context it's
22 a request for a transfer and you give a brief outline
23 indicating the reasons why the transfer seems
24 appropriate. There is often what we might call a
25 question-and-answer session followed by suggestions from

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1 the person on the other end of the phone. I didn't
2 think -- my recollection of the conversation was that
3 there was no information which he was keen to have that
4 wasn't provided for him, but I don't remember any of the
5 details of that conversation.

6 THE CHAIRMAN: Just before you go on with that, Dr Auterson
7 has specifically said that when you and he were trying
8 to resuscitate Lucy, that he had the strong suspicion
9 which he discussed with you while the two of you were
10 resuscitating Lucy at about 4 am, as he describes it; do
11 you agree with him or not?

12 A. No, I do not. If I may just extend my comment, if
13 that's all right --

14 MR WOLFE: Perhaps before you do so, if we could have up on
15 the screen just what he said. If we could have Friday's
16 transcript? Friday was 31 May, page 139. If we go
17 through each of the references. If we start at
18 page 136.

19 At the bottom of the page, in answer to a question
20 from the chairman:

21 "I discussed the possible reason for the thing only
22 with Dr O'Donohoe at the time of the resuscitation and
23 he was aware of the electrolyte results and I assumed,
24 obviously wrongly, that he would mention this at the
25 review."

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1 And the background to that is what he has said in
2 his witness statement to the inquiry. Why he thought
3 you had recognised what had gone wrong was because of
4 the combination of the three factors, the neurological
5 condition, the fluids that had gone in, and the
6 electrolyte results. And all three of those factors, he
7 said, would have made it obvious to himself, yourself,
8 and Dr Malik about what had gone wrong here.

9 A. If the question is -- I'm sorry if I was giving the
10 wrong impression. I am trying to answer the questions
11 as I hear them. But if the question is, "Was it obvious
12 to me at the time?", the answer to that question is no.

13 THE CHAIRMAN: What seems curious to me, to say the least,
14 is that Dr Auterson seems to have understood in the
15 early hours of 13 April what fluids Lucy had received,
16 but you tell me you didn't know. How could Dr Auterson
17 know the fluids which Lucy had received and you not
18 know?

19 A. I'm trying to be as clear as I can in response to what
20 Dr Auterson has said. As I understand it, he's saying
21 he was very clear about exactly what had happened.
22 I find that very difficult to believe if, for no other
23 reason, if I may say so, than I would have expected that
24 he would have attempted to initiate the treatment I have
25 referred to, the hypertonic saline.

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1 If we go over the page --

2 A. Might I comment on that?

3 Q. Yes.

4 A. Dr Auterson in his account, as I have read it -- and
5 maybe I have misunderstood some of them -- there were
6 times in which he was saying I said, "This, this, blah
7 blah blah". Dr Auterson's accounts are at best, I would
8 say, very vague. There's a reference there, for
9 example, if I may, to "the thing".

10 THE CHAIRMAN: I'm not asking for a general commentary from
11 you on Dr Auterson's account. We're asking you for your
12 specific responses to questions, doctor. So let's
13 confine your commentary today on the questions which are
14 asked. I do not want your analysis of what Dr Auterson
15 said. We're asking you specific questions, and the
16 first question which arises from this is that he said:

17 "I discussed the possible reason for the thing only
18 with Dr O'Donohoe at the time."

19 By which he means the time of the resuscitation.

20 A. That is not correct.

21 MR WOLFE: Page 137 then. Line 7. The question posed is:

22 "Question: So it is your evidence that you believe
23 that Dr O'Donohoe recognised, at the time when Lucy was
24 being resuscitated, what had gone wrong?

25 "Answer: Yes."

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1 THE CHAIRMAN: That's a conclusion which you draw from the
2 actions which he took. But he says what led him to form
3 that view was the condition which Lucy had arrived at
4 hospital in, the fluids she received, and the state she
5 was now in. The condition she had arrived at the
6 Erne Hospital in was undisputed.

7 A. Yes.

8 THE CHAIRMAN: You have told me a number of times this
9 morning that you couldn't get a clear picture from
10 Dr Malik and the nurses what fluids Lucy had received.

11 A. Yes.

12 THE CHAIRMAN: Dr Auterson seems to have obtained a picture
13 of the fluids which Lucy had received, and the person,
14 I understand, who he would have spoken to most directly
15 about the fluids Lucy had received was you.

16 A. I don't recall him speaking to me about the fluids,
17 particularly. In a general sense, yes, but I don't
18 recall any specific -- when Dr Auterson arrived, I was
19 hand bagging Lucy. Dr Auterson took over initially --

20 THE CHAIRMAN: Sorry, you had also spoken to him by phone
21 because you --

22 A. Telling him to come in -- not telling him, asking him to
23 come in -- with a view to intubating Lucy where I had
24 been unsuccessful. When he came in, his first action
25 was to start intubation. He had some difficulty --

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1 I think there was a piece of equipment that he was not
2 satisfied with, which had to be -- and an alternative
3 had to be retrieved from the intensive care unit. He
4 then went on to administer the flumazenil and there
5 wasn't that I recall any great deal of discussion about
6 the underlying issues in the terms Dr Auterson is
7 referring to.
8 THE CHAIRMAN: Okay, thank you.
9 MR WOLFE: We move to 139, please, just to complete this
10 sequence. Line 4. He's saying:
11 "It wasn't so much a discussion. I said [that is to
12 you], 'Look, there's the U&E result. It shows
13 hyponatraemia. Maybe she got too much fluid ...'"
14 Did he say that to you?
15 A. I don't recall him saying that.
16 Q. Does it fit logically? This was a child for whom you
17 had sought electrolyte results.
18 A. That's right, yes.
19 Q. You were anxious to learn about her electrolyte
20 status --
21 A. Yes.
22 Q. -- so that you could determine what further treatment
23 would be necessary?
24 A. Yes.
25 Q. And the electrolytes came back showing hyponatraemia;

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1 been used; it could also have been contributed to by the
2 diarrhoea.
3 Q. Of course?
4 A. In the context at the time, what I didn't reach was
5 a satisfactory conclusion -- any real conclusion as to
6 a child in front of me who had deteriorated, as you have
7 said, in a catastrophic way. That was the issue that my
8 attention was focused on. And I could not put the
9 information that was available to me together to
10 construct, if I can put it like that, the explanation
11 which has come to the fore since then.
12 THE CHAIRMAN: If you couldn't reach a conclusion, what
13 suspicions did you have?
14 A. I didn't have any suspicions. I have never seen a child
15 deteriorate in that fashion before. I literally could
16 not understand what had happened.
17 MR WOLFE: You would know that a cerebral oedema can occur
18 when the blood becomes too dilute; isn't that right?
19 A. Yes. I'm broadly familiar with the idea of cerebral
20 oedema, yes.
21 Q. And one of the ways in which the blood can become too
22 dilute is if the body receives an excess of hypotonic
23 fluid.
24 A. That is correct, yes.
25 Q. And the account that you appear to be standing by

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1 is that right?
2 A. That's correct.
3 Q. And you would have, at that time, regarded 127 as
4 hyponatraemia?
5 A. The reference range is 135 to 145 and you would wish
6 results to be as close within that as possible. That's
7 not the same thing as saying that a value of 127
8 necessarily means that you have an explanation for what
9 you see in front of you. I think maybe that's the
10 defect in my understanding at the time. There is no
11 question that 127 is a low value. What I have been
12 trying to say, maybe not terribly clearly, is that it
13 didn't -- I couldn't see that as -- it didn't occur to
14 me that that was the cause of what I saw in front of me,
15 nor did Dr Auterson draw that to my attention.
16 Q. If it was clear to you and Dr Auterson that in terms of
17 what Lucy had received in terms of medical treatment up
18 to that point was merely, albeit significantly, the
19 infusion of hypotonic solution in a quantity that we all
20 now agree was excessive, was it not obvious that this
21 was the kind of factor that would have caused the
22 hyponatraemia?
23 A. By hyponatraemia, you mean the low sodium?
24 Q. Yes.
25 A. Low sodium could be attributed to whatever fluids had

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1 is that at that time of the morning, at least until you
2 received a telephone call from Dr Crean, you hadn't been
3 familiarised with the fluids that she had received.
4 A. I don't recall being aware that it was in any way
5 different from what I had said up to the time that the
6 saline had been started, if that's the question you're
7 asking me.
8 Q. Yes. So you were proceeding upon the assumption that
9 you had directed 30 ml per hour of Solution No. 18,
10 nobody had provided you with a different account, so
11 that's what you assumed she had received up until the
12 administration of the normal saline?
13 A. Yes.
14 Q. And that is an account which, when one views Dr Auterson
15 in the round, seems somewhat odd given that he appears
16 to have had a familiarity with the fluids that she had
17 received?
18 A. I don't wish to be commenting inappropriately, so if my
19 remarks are inappropriate, I apologise. But if you take
20 Dr Auterson as an anaesthetist, working in intensive
21 care, in the round, as you say, one of the aspects that
22 I would have expected of him automatically would be any
23 possible treatment in a disastrous catastrophic
24 situation like that would have sprung to mind and would
25 have been implemented, and that particularly refers to

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1 the hypertonic saline. So if I take it in the round, if
2 I may, I would not reach the conclusion that he had
3 a clear-cut understanding of what had gone on. He may
4 have had thoughts and suspicions, but if he was even
5 approaching a clear-cut conclusion, I can't see any
6 basis on which he would not have at least tried
7 treatment under those circumstances, even if he thought
8 it was a hopeless situation which couldn't be retrieved.
9 So taking it in the round, I don't reach the same
10 conclusion as you do about Dr Auterson's state of
11 understanding that night.

12 THE CHAIRMAN: Thank you very much. We'll take a break for
13 10 minutes and we'll resume.

14 (11.54 am)

15 (A short break)

16 (12.10 pm)

17 MR WOLFE: Just before we move on to the transfer of Lucy to
18 the Royal Belfast Hospital for Sick Children, which you
19 oversaw, doctor, could I ask you two points?

20 First of all, could I have up on the screen, please,
21 220-003-017? This is a report prepared by
22 Dr Simon Haynes in the context of the evidence he was
23 giving to the inquiry as its expert in Raychel's case.
24 You can see there that he discusses the possibility of
25 using hypertonic solution to reverse the effects of

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1 beyond retreat?
2 A. That is possible. It's not something I have ever
3 discussed with him. It is not the way that most people
4 looking at that situation would have looked at it, that
5 there are separate forms of treatment. The fact that
6 the flumazenil didn't work wouldn't tell you about any
7 possibility, however small, of the hypertonic saline
8 working. They're completely different ideas.

9 Q. Could I ask you to look at a statement which Staff Nurse
10 Thecla Jones prepared in anticipation of the inquest?
11 If I could have up on the screen 013-016-052 and have
12 alongside it the subsequent page, please, 053? She
13 recalls that at approximately 3.30, you arrived, blood
14 samples and X-rays were taken as bagging continued, and
15 up at the top of the page she says:

16 "Throughout resuscitation, ongoing discussion took
17 place regarding Lucy's condition. Abdominal X-ray
18 showed a query of abdominal distension, although
19 diarrhoea still persisted. I checked the fluid balance
20 chart and confirmed that approximately 400 ml of 0.18
21 saline/4 per cent dextrose plus the ongoing 500 ml of
22 normal saline had been given intravenous and that Lucy
23 had vomited earlier as well as having diarrhoea."

24 So she's saying in that statement that she checked
25 and confirmed the position with regards to the fluids

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1 hyponatraemia. Is that a report that you are familiar
2 with, doctor?

3 A. No, I haven't seen this one.

4 Q. You haven't read it before coming here today?

5 A. No.

6 Q. He makes the point in the context of Raychel's case.
7 It's about a third of the way down:

8 "Even if hypertonic saline had been in the room and
9 given at that point in time, it is likely, in my
10 opinion, that the situation was by then irretrievable."

11 We don't know what Dr Auterson would say in response
12 to your point about the "try anything" approach that he
13 should perhaps have clutched at the straw of using
14 hypertonic saline.

15 A. He had already clutched at one straw, if I can put it
16 like that, with the flumazenil, but he didn't -- nobody
17 believed, as far as I understood, that this was a likely
18 cause of any problems. It was on that very highly
19 unlikely possibility that there was some very strange,
20 obscure reaction to the medication. So when a straw was
21 available, it had been grasped at, if I can put it like
22 that.

23 Q. It's at least a possibility that, having grasped at that
24 straw that you identify with no effect, that he could
25 have reached the conclusion that the situation was

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1 that had been administered and which were continuing to
2 be administered.

3 A. My understanding is that Nurse Jones wasn't involved
4 in the care of Lucy. My understanding also is that she
5 wrote in some of the numbers, 100 -- there's a sequence
6 of numbers, 100, that's obviously incorrect, 100 over
7 200, I can't quite remember, and she obviously wrote
8 those in. I'm not sure if that's entirely consistent
9 with what she's saying here. She's certainly recorded
10 some of the values that are in that fluid flow sheet,
11 relating to times when she wasn't involved.

12 Q. But the verbs that she is using are "checking" and
13 "confirming", much the same kind of thing that you say
14 you had been doing.

15 A. I'm not saying that she didn't check, I'm not -- in the
16 context, I have no recollection of her discussing that
17 with me. She does say there was ongoing discussion and
18 I'm sure that's right, that would always be the case,
19 but she doesn't make any references to what the
20 discussions were about and between whom. She does
21 immediately follow it with the issue of the abdominal
22 distension and this is somebody who had gastroenteritis
23 and a swollen tummy, and that would be a feature that
24 would be relatively uncommon in gastroenteritis and it
25 would inevitably lead one's thoughts in the direction

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1 of, well, has something else happened in the abdomen
2 that we just haven't figured out, is there some other
3 disease, some other disorder? The structure of what
4 she's saying there, in the context of discussions
5 followed by the abdominal distension, suggests to me
6 that that's what the issue is, but I don't remember that
7 conversation in any detail.
8 Q. Ultimately, when Lucy is stabilised, she's moved to the
9 intensive care unit of the hospital; isn't that right?
10 A. Of the Erne, yes. That's correct.
11 Q. And arrangements were then made in an atmosphere,
12 presumably, of relative calm compared to what had been
13 the case, for her --
14 A. Relative calm I think would be the appropriate
15 description.
16 Q. You have said you have no recollection of Dr Auterson
17 raising particular concerns with you. Did you speak to
18 him at all about what he thought might have gone wrong
19 here?
20 A. I don't recall specifically asking him, no.
21 Q. Is that because you didn't or because you have no
22 recollection?
23 A. All I'm saying -- no, what I'm saying is I don't recall
24 doing so. I don't recall not doing so either, if I can
25 put it like that. I don't recall just raising it with

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1 identified the fact that fluids had been administered in
2 a manner which was not in keeping with your directions?
3 A. That's my recollection of the situation at that time
4 in the morning, yes. I hadn't established the fluids
5 clearly is what I'm saying.
6 THE CHAIRMAN: Well, to put it bluntly, at this point you
7 had no idea what had gone wrong, if I understand your
8 evidence.
9 A. Yes, I didn't understand what had happened. That is
10 true, yes.
11 MR WOLFE: Presumably you were inquisitive as to what had
12 gone wrong?
13 A. Of course.
14 Q. And were you are now at this stage administering
15 treatment on the basis that there might be a cerebral
16 oedema?
17 A. I was administering the treatment on the grounds that
18 Dr McKaigue had asked that I would administer the
19 treatment.
20 Q. Mannitol?
21 A. Mannitol, yes. My observation -- he also asked me to
22 administer intravenous antibiotics, and the reasons why
23 those thoughts would have occurred to him, I would
24 imagine, although I didn't discuss it with him -- it was
25 not an uncommon request from the Children's Hospital or

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1 him.
2 THE CHAIRMAN: Would it not have been an entirely
3 appropriate conversation for you and Dr Auterson to say,
4 however you frame it, whether you're blunt or whatever
5 you say, "What on earth has gone wrong here?"
6 A. Well, yes. I would be surprised, if I'm allowed to say
7 this, if I didn't say that during the course of these
8 episodes.
9 THE CHAIRMAN: And vice versa.
10 A. Yes.
11 THE CHAIRMAN: So the two of you must have been looking for
12 some sort of explanation for what went wrong?
13 A. Certainly, yes.
14 THE CHAIRMAN: So if we assume on that basis that there was
15 a conversation, is it your evidence that you just can't
16 remember what the content of that conversation was?
17 A. I certainly can't remember any conversation that came to
18 any conclusion or raised any possibilities, any specific
19 possibilities.
20 THE CHAIRMAN: Thank you.
21 MR WOLFE: You had a discussion with the parents before
22 leaving for Belfast; is that right?
23 A. Yes.
24 Q. And as I follow your evidence along this chronology, at
25 that stage you're telling this inquiry that you had not

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1 other intensive care units to administer mannitol in
2 people who have had episodes of what one might call
3 cardio-respiratory arrest. The concern, at a minimum,
4 being that during the course of such episodes there may
5 be difficulties that lead to cerebral oedema, which may
6 make the situation worse. So that wasn't an unusual
7 request in my experience of talking to people in the
8 Children's Hospital and undertaking transfers.
9 With the antibiotics, if I may so, just to clarify,
10 that raised the possibility he was worried about
11 a disorder called meningococcal septicaemia, which is a
12 very severe bacterial infection, which can occasionally
13 catch you out without any signs that allow you to
14 recognise it, and that was my understanding as to what
15 he was referring to. But I don't recall that clarifying
16 that very specifically with him.
17 Q. Of course, Dr Malik had been a presence with Lucy from
18 before you got there.
19 A. He had seen her before I had, yes.
20 Q. And what I mean by that, just to be clear -- he had
21 arrived at the point at which she was suffering the
22 convulsion or the seizure.
23 A. I believe he had seen some of it. I think in actual
24 fact most of it was reported to him by nursing staff.
25 The actual abnormal movement episode, if I can use that

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1 phrase, I think either had stopped or stopped very soon
2 after he arrived, so he didn't have a lot of details and
3 it was very difficult to get a clear-cut picture -- it
4 was something nobody had seen before, I suspect, so
5 people found it very difficult to describe it.
6 Q. And he had been in the hospital throughout the night;
7 isn't that right?
8 A. So I believe, yes.
9 Q. Did you seek to ascertain from him whether he had a view
10 about the deterioration?
11 A. I can't now remember such a conversation, no. When
12 he had rung up to describe the episode, it wasn't the
13 sort of description I would expect from an episode where
14 he clearly understood what he was dealing with. So if
15 there was, for example, a febrile convulsion which
16 I mentioned, I would expect a certain quality of
17 description from him, whereas his description of the
18 episode that we're talking was vague, I suppose, is the
19 only word I can think of offhand.
20 Q. So you went in the ambulance with a nurse to the Royal?
21 A. That's correct, yes.
22 Q. Before doing so, you had a discussion with Dr Auterson
23 with regard to the fluids that were now applicable?
24 A. Yes.
25 Q. And he had a view that 40 ml of normal saline was

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1 Q. You said earlier that you now doubt that it was greater
2 than two seconds.
3 A. Yes.
4 Q. Do you repeat the mistake here?
5 A. This was a letter -- you have again referred to -- I
6 think "panic" was the word. This was a letter written
7 in very difficult circumstances. I think I probably
8 just wrote what was -- copied down what was in the
9 notes. When I look at that and I ask myself, "What does
10 that mean?", that doesn't look like something I had
11 thought very deeply about.
12 Q. So you had the notes in front of you as you penned this?
13 A. I would imagine so. What would be referred to as the
14 medical notes, not necessarily the fluid sheets. They
15 were physically separate pieces of paper. They would
16 not necessarily be included.
17 Q. Was the note, this letter, written before you left or
18 was it written in the ambulance?
19 A. No, I wouldn't have thought I could have written it
20 in the ambulance.
21 Q. It was written before you left?
22 A. I presume it must be.
23 Q. And were the notes, that is the medical notes and the
24 nursing notes, brought together on the journey?
25 A. I understood that they had been brought, but I should

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1 appropriate and you thought 30 ml?
2 A. That's correct, yes.
3 Q. Did that discussion not cause you to avert your
4 attention to the fluids that had gone before?
5 A. No, it was a very brief discussion. It wasn't -- there
6 was no kind of in-depth analysis about the situation.
7 Q. And in terms of your conversation with the parents at
8 that stage, you didn't explain to them self-evidently
9 that there had been a problem with the fluids?
10 A. I don't recall. I would be very surprised because
11 I don't believe I understood what had happened. I have
12 no doubt that the conversation I had with them from
13 their point of view was entirely unsatisfactory and that
14 if somebody clearly has no idea where to start thinking
15 about this, it's obviously entirely unsatisfactory.
16 Q. You prepared a transfer letter for the Royal.
17 A. That's right.
18 Q. If we could have it up on the screen, please, it's
19 061-014-038. It's addressed to Dr McKaigue. You're
20 thanking him for accepting Lucy and you set out --
21 perhaps if we have the other side of the page as well.
22 You begin by describing her presentation:
23 "Fever, vomiting, drowsiness. Capillary refill of
24 greater than two seconds."
25 A. Yes. That's right.

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1 possibly say that I was physically hand bagging Lucy, so
2 I didn't have a hand with which to carry anything, so
3 physically I wasn't able to carry anything myself.
4 I presumed -- and I think normally there's a kind
5 of mini-checklist you go through, notes, X-ray, and to
6 make sure somebody has them, as it were, but I didn't
7 bring them myself. I don't think I could have because
8 my hands were otherwise physically full.
9 Q. It was your evidence to the General Medical Council that
10 the notes were brought to the ambulance to Belfast;
11 isn't that right?
12 A. Yes. I believe they were. It was usual practice. It
13 only occurred to me subsequently when I was thinking
14 that it couldn't have been me who brought them because,
15 with my hands physically full, it wouldn't have been
16 possible. But I believe that they were brought.
17 Q. You could have brought them and set them to the side?
18 A. I could have, yes.
19 Q. Presumably, during the journey you swapped with the
20 nurse in terms of the bagging?
21 A. She did some of it. I think I did most of it, but
22 I think she did some.
23 Q. The notes weren't left behind in Belfast, nor copied for
24 Belfast at that point; is that right?
25 A. To the best of my knowledge, I wouldn't have left the

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1 notes in Belfast. There had been some concern expressed
2 in the Erne about notes which had been lost in Belfast.
3 I don't recall -- I certainly didn't photocopy them
4 myself. Normally what would happen when we arrived
5 would be that any notes would be made available to the
6 receiving team, as it were, and if they wished to
7 photocopy them, then they would photocopy them. But
8 I don't remember whether that happened or not.
9 Q. The letter which you prepared for Dr McKaigue doesn't
10 describe the fluids that Lucy had received, either
11 pre-collapse or post-collapse.
12 A. No, it's a very brief letter, written under, I think,
13 very difficult circumstances. It's not a letter that
14 I would say -- and particularly in retrospect, looking
15 back at what has happened over the intervening years,
16 it's not a letter I would describe myself as being proud
17 of, if I can put it like that, but I can understand
18 under the circumstances of trying to achieve a place in
19 Belfast, looking as we were between myself and
20 Dr Auterson, as to how we could ventilate Lucy on the
21 way and undertake a journey, doing something which was
22 significantly outside what I normally do, if I can put
23 it like that. So under those circumstances, with a
24 nurse, accompanied by a nurse that I would not have
25 worked with before -- she was from the intensive care

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1 Q. -- you were aware of the post-collapse fluids --
2 A. Yes.
3 Q. -- the normal saline --
4 A. Yes, yes.
5 Q. -- and you were aware that they had been run in at
6 a rate which you wouldn't have approved of?
7 A. That's correct, yes.
8 Q. And you were aware that that had been done --
9 substantially done, I should say -- prior to the repeat
10 bloods being taken?
11 A. That is correct, yes.
12 Q. And again, those are factors that you should have
13 mentioned in this letter?
14 A. Yes. With enough time and an appropriate situation, I'm
15 sure my letter would have been much more detailed.
16 That is a brief note, written under very difficult
17 circumstances.
18 Q. Of course, arriving at the hospital, you would have had
19 an opportunity to verbally articulate matters that
20 weren't in your letter.
21 A. Yes.
22 Q. And you've told us in your witness statement that
23 you have a belief that you might have verbally handed
24 over the results of the repeat electrolyte tests.
25 A. If I had them, I think it's highly likely, but I don't

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1 unit in the Erne rather than the children's ward. So
2 although it's not a note that I would approve of, if I
3 can put it that way, I can understand how I came to
4 write it in that way.
5 Q. You're not proud of the note, can I suggest, because the
6 purpose of the note should be to inform the receiving
7 hospital of all relevant --
8 A. It should be --
9 Q. -- data surrounding the child's --
10 A. Yes, you would wish to provide as much data as is
11 possible ...
12 Q. And it would have been within your power or knowledge to
13 say that Lucy has had repeat electrolytes done and they
14 now show an electrolyte derangement; isn't that right?
15 A. I can't honestly say that I remembered that I had the
16 results when I wrote the note. I may have had the
17 result and I may not have put it in. That wasn't
18 a conscious decision not to put the electrolyte result
19 in. I can't actually explain why I didn't put that in.
20 Q. If you had it, it should have been put in?
21 A. Yes, I should have put it in, yes. No doubt about it.
22 Q. Moreover, while you tell us that your recollection tells
23 you that you had an uncertainty about the pre-collapse
24 fluids, if I can put it in those terms --
25 A. Yes.

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1 actually remember doing so.
2 Q. The Royal Belfast Hospital's note, which I'm sure you're
3 familiar with, shows that it was a telephone call from
4 an anaesthetist -- and we're presuming Dr Auterson --
5 that revealed to the hospital the repeat electrolytes.
6 A. I have seen that note, yes. I presumed it was
7 Dr Auterson, yes.
8 Q. Moreover, the notes made by the Royal do not indicate
9 any knowledge of the sequence of normal saline flowing
10 and then the repeat blood for electrolytes.
11 A. No, I hadn't realised the significance of that sequence,
12 I think, until I had seen Dr Sumner's report. That was
13 some years later.
14 Q. So you accept that that's not something you told the
15 Royal?
16 A. The sequence, I certainly didn't point the -- I don't
17 think I put any emphasis on the sequence, if I can put
18 it like that. To me, I don't think it was something
19 that I had seen as being important in the context,
20 in the way that we now know that it is important.
21 Q. So you return to Enniskillen with the notes, not having
22 left them or copied them at the Royal for the Royal?
23 A. I can't say that I remember bringing them back, but they
24 were available to me within the next day or two.
25 I hadn't copied them. I can't speak for what might have

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1 happened within the Royal; it wouldn't have been my job,
2 if I can put it like that, to have copied them within
3 the Royal --
4 Q. My point is: did you not volunteer to the Royal that you
5 had the notes with you --
6 A. When we arrived?
7 Q. -- and that they might like to see them?
8 A. I don't remember doing so. I don't remember that part
9 of the discussion well enough to say that I didn't do
10 that. I wouldn't physically have had the notes. This
11 is what I'm saying about the bagging. I'm sure that the
12 notes must have been carried with the nurse who was
13 accompanying me because I was doing most of the hands-on
14 bagging.
15 Q. I don't follow that, doctor. You may well have been
16 bagging and if you were bagging, clearly you wouldn't
17 have had the file in your hand. That's a given. You
18 seem anxious to emphasise that you didn't have the notes
19 personally because you were bagging.
20 A. I'm not disagreeing with you; I'm talking about
21 physically. If you mean -- "Did I physically hand them
22 over?", was that the question?
23 Q. No. The question is a step removed from that. You seem
24 to be anxious to say that you didn't have the notes with
25 you. If the notes were there, they must have been with

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1 Q. But the point is, doctor, you weren't volunteering the
2 notes to the Royal, as it appears, because --
3 A. I don't believe I was volunteering the notes to the
4 Royal, no.
5 Q. Neither you nor your nursing colleague?
6 A. I honestly can't remember what supervened between my
7 nursing colleague and her colleagues or whoever she
8 talked to.
9 Q. As it transpired, Dr Crean wrote what appeared to be
10 a rather frustrated note into the PICU file for Lucy
11 bemoaning the fact that the notes were not with the
12 child and asking for them to be faxed and, of course,
13 they were subsequently faxed.
14 A. Yes. I understand from what I have read that
15 Dr McKaigue was there to receive us when we arrived.
16 I have no recollection of Dr McKaigue saying, "Listen,
17 we need a copy of these notes". He, I would regard, had
18 far more expertise in matters of transfer under these
19 circumstances and, after a very difficult and
20 uncomfortable journey, bagging a child pretty much
21 continuously, I would have anticipated that he would be
22 in a better position to be doing the checklist of things
23 that might or might not be appropriate. And if he had
24 raised the issue that we don't have the notes, clearly
25 we would have responded, so clearly he didn't raise the

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1 the nurse because you were bagging.
2 A. Yes, that's a conclusion or an assumption.
3 Q. The nurse was also bagging as well.
4 A. I did most of the bagging and the amount that she did
5 was relatively short breaks to alleviate the cramp in my
6 hands, to be blunt about it.
7 Q. Of course. But if the notes had been brought physically
8 to Belfast by either of you, why were they not copied
9 for the Royal?
10 A. I can't answer that question. If I hand -- let's say,
11 for the sake of trying to be clear, that the nurse had
12 handed the notes to somebody from -- one of our
13 colleagues from the Royal. Whether they were copied or
14 not thereafter would be entirely within their remit, as
15 it were.
16 THE CHAIRMAN: If they're offered them?
17 A. Yes. If they are offered. I don't specifically
18 remember them being offered.
19 MR WOLFE: You have said, however, that in lieu of not
20 including all of the relevant data in your transfer
21 letter that you relied on the entries on the fluid
22 balance chart to inform the receiving clinicians as to
23 the nature, quantities and timings of the fluids
24 administered to Lucy.
25 A. That would be a source of that information, yes.

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1 issue.
2 Q. Would it be wrong to conclude, doctor, from the poverty
3 of information contained in the transfer letter, allied
4 to the failure to volunteer the notes, that you were
5 seeking to hide relevant --
6 A. It would be entirely wrong.
7 Q. You will have to let me ask the question, doctor.
8 A. I'm sorry. I beg your pardon.
9 Q. I understand your anxiety. Would there be anything
10 in that that you were trying to hide from the Royal,
11 relevant data concerning Lucy's deterioration?
12 A. No.
13 Q. You made it back to the Erne in Enniskillen by
14 mid-morning.
15 A. I believe so. I don't remember the specific times.
16 Q. And you had a day of clinics to do; is that right?
17 A. An afternoon clinic at another site, I think. I didn't
18 have a clinic scheduled for that morning if I remember
19 rightly.
20 Q. And you were returning to Enniskillen with the notes
21 in the ambulance and here was an opportunity to read the
22 notes to discover perhaps what had gone wrong here.
23 A. I can't say that I remember returning to Enniskillen
24 with the notes. I'll have to say that I have never
25 really been able to read a set of notes in the back of

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1 an ambulance if that's the physical idea that you're
2 trying to raise. It is a very uncomfortable and
3 unpleasant experience at the best of times and it's not
4 something that, I think, I would have been able to
5 achieve. To do the recordings of the observations as
6 you're taking the child to Belfast is doable, but
7 I think to be able to read the notes in that sort of
8 analytical fashion, I think, is very unlikely.

9 Q. Presumably, doctor, upon arriving back at the Erne,
10 you're anxious to discover further, because at this
11 stage you really don't have much of a clue on your own
12 account what has happened here, so you're anxious to
13 discover what has happened to this child, are you?

14 A. Yes.

15 Q. And I suppose Dr Malik would have been a reasonable
16 first port of call to speak to about this?

17 A. I don't remember if he was still in the hospital when
18 I got back. I don't remember what his shifts were that
19 day, so he may not have been available. I can't say
20 that for sure.

21 Q. Can you remember who you spoke to prior to Dr Crean
22 calling? And I understand Dr Crean called in during the
23 morning of 13 April.

24 A. Yes. No, I can't recall who I spoke to before that.

25 Q. Do you know Sister Traynor?

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1 transferred to Belfast."

2 So the reference to arrival, that isn't a reference
3 to arrival back from Belfast, is it?

4 A. "When I arrived, I asked Dr Malik", I think that's
5 a reference to when I arrived at 3 o'clock in the
6 morning or thereabouts. That's my understanding.
7 That's the question I was answering.

8 Q. That's your recollection and you don't remember speaking
9 to Dr Malik upon arriving back from Belfast?

10 A. No. I did speak to him some time over the next day or
11 two, and I can't recall when it was, to let him know
12 that either it was my intention to talk to Dr Kelly or
13 possibly I had already spoken to Dr Kelly when I spoke
14 to him, but that was not a discussion of the events of
15 the night in question; that was to explain to him
16 something that I had done subsequent to our last
17 discussion.

18 Q. Let me turn to Sister Traynor's account. In her witness
19 statement to the inquiry -- if we could have up on the
20 screen, please, WS310/1, page 4 -- she recalls, you can
21 see at (iv), that you came into the treatment room where
22 she was preparing to do a nursing task, and you asked
23 what happened here last night. She doesn't recall the
24 time of day this occurred.

25 She says in answer to a question about what you

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1 A. I do, yes.

2 Q. She was on duty that morning?

3 A. I believe so. I have seen a witness statement of hers
4 which said that I did raise the issue with her. I don't
5 recall the specific conversation, but I would have no
6 reason to doubt that I would have. If I'd seen her,
7 I would have raised the situation and told her what had
8 happened.

9 Q. Right. You can't remember that conversation?

10 A. No.

11 Q. I'll see if I can assist your memory in a moment.

12 You have told us that when you arrived back -- if
13 I could have up on the screen 278/1, page 13. In answer
14 to question 23(c) at the top there you are asked:

15 "Could you have determined what fluids had been
16 administered to Lucy by speaking to nursing or medical
17 colleagues who cared for her during your absence? If
18 so, clarify whether you carried out this exercise at any
19 point before or after her death."

20 You say:

21 "When I arrived, I asked Dr Malik and the nursing
22 staff present for an update. I cannot now recall if
23 I got a clear answer. I believed at that time that Lucy
24 had been receiving the fluids I had earlier requested.
25 I discussed the matter with Dr Kelly after Lucy had been

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1 might have said:

2 "To the best of my knowledge and recollection,
3 Dr O'Donohoe did not mention fluids or make any other
4 comments in relation to Lucy's case to me."

5 But she goes on to say that she informed Ms Millar
6 of her conversation with you and she says:

7 "[She] expressed concern to Ms Millar [this is at
8 (viii)] and awaited her response and direction."

9 Can you recall any better what was discussed during
10 that meeting, that discussion?

11 A. No, I don't recall that, any detail of that.

12 Q. She says that you asked this open question, "What
13 happened here last night?"

14 A. I don't remember asking that question, but if I was to
15 say -- an alternative version of the question was if
16 I went in and said, "I wonder can I talk to you about
17 what happened here last night?" I may have done so. If
18 that was after when Dr Crean had contacted me, then the
19 meeting with her may have been in the same spirit as the
20 meeting with Dr Malik, which was to say, "Listen, I have
21 been told this has happened, Dr Crean has rung me to say
22 he thinks there was some discrepancy in the fluids.
23 Therefore my intention would be that I would notify this
24 to Dr Kelly as a critical incident". I don't recall
25 that conversation, but that's my best guess as to what

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1 the conversation would have been. It would have been
2 along those lines. Sister Traynor then did go and talk
3 to Mrs Millar and did notify in the same that I had
4 notified Dr Kelly.

5 Q. It would seem logical that you would want to speak to
6 somebody, perhaps on the nursing side, about what had
7 happened.

8 A. Yes, that would seem logical, yes.

9 Q. Could I bring you to another account, which
10 Sister Traynor has apparently provided, and if I could
11 have up on the screen, please, witness statement 298/3,
12 at page 12? It's a summary of the account which
13 Sister Traynor appears to have provided to the
14 Royal College team that were examining Lucy's case
15 in the context of this external review in 2002.

16 They say that although Sister Traynor was not on
17 call when the child was admitted, she was on call the
18 following morning:

19 "The nurses who had been looking after Lucy had not
20 expressed any concern."

21 She reported a conversation with you, Dr O'Donohoe:

22 "[He] said to Sister Traynor, 'What are you going to
23 do with the IV fluids your staff got wrong?' In
24 response, Sister Traynor said, 'Who prescribed the
25 IV fluids?' Sister Traynor admitted [that is admitted

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1 the fourth last line, it says:

2 "Sister Traynor admitted there had been a nursing
3 error in totalling the fluids."

4 If that is meant to indicate that was part of the
5 conversation with me, that can't relate to what happened
6 that morning because I wasn't aware and I don't think
7 she had any basis for being aware, unless some of her
8 nursing staff had told her that there had been an error
9 in totalling the fluids.

10 Q. Well, we will hear from her tomorrow. I can't help you
11 with that.

12 A. I understand. I haven't talked to her about that, but
13 I don't believe that error that she was referring to was
14 recognised or known about. Certainly not by me on the
15 morning in question.

16 Q. Well, let's feed into this the conversation with
17 Dr Crean. Perhaps a useful starting point would be to
18 look at the note that you have written in respect of
19 that conversation. We can find that at 027-010-024.
20 Perhaps we could have alongside it 025 as well.

21 You're writing a note into Lucy's medical notes;
22 isn't that right?

23 A. That's right, yes.

24 Q. You're writing it retrospectively on 14 April, following
25 a conversation with Dr Crean on 13 April?

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1 to the authors of this report] that there had been
2 a nursing error in totalling the fluids. Sister Traynor
3 felt that Dr O'Donohoe was trying to instil a blame
4 culture relating to the particular case."

5 So you said something a moment ago, doctor: you
6 can't recall, but you wouldn't be surprised if
7 a conversation happened after your conversation with
8 Dr Crean?

9 A. No, I wouldn't be surprised, no.

10 Q. And Dr Crean -- we'll move on and look at his
11 conversation with you in a moment -- but in broad terms,
12 he was bringing to your attention the fact that Lucy had
13 received a fluid regime which was inconsistent with what
14 you thought she should have received. In other words,
15 the fluids were wrong.

16 A. Yes, that's right. That's the substance of the
17 conversation, yes.

18 Q. Do you think it likely, doctor, that having been
19 apprised of that information, that you would be seeking
20 an account from the ward sister? As I understand it
21 Sister Traynor was the senior nurse on paediatrics.

22 A. That's right, she was, yes.

23 Q. So she would be an appropriate person to approach?

24 A. It would certainly be appropriate for me to approach
25 her. If I may draw your attention to the fact that on

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1 A. That's right, yes.

2 Q. Dr Crean, as appears from your note, rang to enquire
3 about the fluid regime Lucy had been on.

4 A. Yes.

5 Q. Plainly, he was in possession of her notes at this point
6 in time.

7 A. Her Erne Hospital notes?

8 Q. Yes.

9 A. I don't know, I can't say for sure, I can't recall that
10 being discussed. And if he did have them, either the
11 originals had been left with him or the originals had
12 been photocopied. As I think I've said, I don't
13 remember that happening.

14 Q. He's querying with you what fluid regime Lucy had been
15 on. You told him a bolus of 100 ml over one hour,
16 followed by Solution No. 18 --

17 A. Yes.

18 Q. -- at 30 ml per hour.

19 A. Yes.

20 Q. And he replied, if we follow the sequence of your note,
21 that he thought it had been Solution No. 18 at 100 ml
22 per hour.

23 A. That's correct, yes.

24 Q. Which was factually absolutely correct?

25 A. That's right, yes.

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1 Q. So he must have derived that from the fact that the
2 notes --
3 A. Either from the notes or the account given by the nurse
4 who came with me to the nurse in paediatric intensive
5 care. I can't say which it was.
6 Q. If the nurse had possibly given that account, why
7 weren't you aware of it?
8 A. All I'm saying is I can't say from where that
9 information came. That's all I'm saying. I'm not
10 saying that I know she was aware of that information.
11 Q. And you then say to Dr Crean that you thought it had
12 been 0.18 -- sorry, you thought that it had been --
13 A. My recollection is that -- can I help you with my
14 handwriting?
15 Q. Yes. I can see now:
16 "A bolus over one hour and 30 ml as above."
17 A. Yes.
18 Q. And of course, factually, that was incorrect?
19 A. Yes. He was right.
20 Q. Yes. And you would say that at that point you didn't
21 know what she had received?
22 A. No, I didn't. He asked me what had happened, I told him
23 what I thought had happened, and then he told me what he
24 believed had happened.
25 Q. The General Medical Council characterised your note as

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1 Q. And you can't remember whether you obtained that
2 information that day or the following day?
3 A. No, I can't.
4 Q. Was this not something that was of the utmost urgency?
5 A. Urgency doesn't mean I could necessarily lay my hands on
6 the notes. As I've said, I had to leave to go and do
7 a clinic at another site during the course of the day.
8 I can't remember at what point I got my hands on the
9 notes. Even if it is urgent, it doesn't mean that I can
10 necessarily tell you I'd be able to get the notes as
11 rapidly as I would wish.
12 Q. I'm conscious that Sister Traynor has, on the face of
13 it, provided accounts which appear to be inconsistent,
14 one with the other, but on the account that she's given
15 the Royal College, it would appear, as we've discussed,
16 that you approached her in a tone which she interpreted
17 as blaming of someone and asked who had caused this
18 problem with the fluids.
19 A. That's my understanding of what you have read out. When
20 I read her witness statement for the inquiry, there was
21 a different content and a different tone and I think she
22 was saying she hadn't seen the records of that meeting
23 and she doesn't believe them to be accurate. That was
24 my understanding of what I read.
25 Q. I think that's fair. We'll ask her about that. You

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1 misleading and inaccurate.
2 A. I don't remember that, but they may have done. I don't
3 remember the exact words.
4 Q. That was their finding.
5 A. I'm not disputing it, but I don't remember the words.
6 Q. You had it within your power to go and check what she
7 had received; isn't that right?
8 A. To look at the fluid sheets?
9 Q. Yes.
10 A. Yes. I did -- my recollection was that I faxed fluid
11 sheets -- and my recollection is that before talking to
12 Dr Kelly I had seen the fluid sheets that were within
13 the Erne Hospital, but I can't remember whether that was
14 the following morning or whether that was the morning he
15 rang.
16 Q. Well, your recollection of the sequence is that having
17 been told this information, you did what?
18 A. I went to try and find the notes to look at what had
19 been written. But I can't remember at what time I was
20 able to access the notes.
21 Q. Well, this then, upon obtaining the notes, became your
22 first sight of the fact that a fluid regime had been
23 delivered which you had not prescribed and, in fact, was
24 inconsistent with what you had prescribed.
25 A. Yes.

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1 approached her, if her account is accepted, to --
2 A. Just to be clear, which account are we accepting?
3 Q. On that Royal College account.
4 A. If we accept the Royal College account? I'm not
5 terribly keen to accept an account which is contradicted
6 by another account in writing.
7 THE CHAIRMAN: We have to go on an either/or basis.
8 Sister Traynor is going to give evidence tomorrow.
9 Don't assume that this is the account that's going to be
10 accepted ultimately --
11 A. Okay.
12 THE CHAIRMAN: -- but since Sister Traynor hasn't given
13 evidence, Mr Wolfe may want to ask you some questions as
14 against both accounts, not just one.
15 MR WOLFE: Let me perhaps think about that, but in the
16 meantime approach it in another way.
17 Dr Crean has given you information which, to say the
18 least, must have come as a surprise.
19 A. Yes.
20 Q. You had authorised a fluid regime which, after the
21 administration of a bolus of normal saline, would have
22 meant that Lucy would receive Solution No. 18 at a rate
23 of 30 ml per hour; isn't that right?
24 A. Sorry, I lost track. I beg your pardon.
25 Q. After the administration of the bolus that you intended,

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1 you anticipated that Lucy would receive 30 ml per hour
2 of Solution No. 18.
3 A. Yes.
4 Q. And Dr Crean was telling you that not only did Lucy not
5 have a bolus of normal saline, but in fact, in terms of
6 the Solution No. 18 that she received, she was receiving
7 100 ml per hour?
8 A. That's right, yes.
9 Q. That's 70 ml in excess per hour of what you intended --
10 A. That's right.
11 Q. -- and no normal saline?
12 A. That's my recollection of the conversation, yes.
13 Q. At that point then, doctor, did you give any
14 consideration to whether that fluid error was implicated
15 in this child's deterioration?
16 A. I certainly don't recall reaching any conclusion. In
17 one previous account I think I've said something like
18 the sodium was 127, but I didn't think that was low
19 enough to produce hyponatraemic convulsion. So in terms
20 of following it through further to the cerebral oedema
21 and so on, the sequence we've talked about, no. This
22 was after quite a long night and I'm not sure that
23 I would necessarily have been at my sharpest at the
24 time. So again, maybe I should have, but I don't think
25 I reached that conclusion at that time. It was a matter

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1 hospital with gastroenteritis, but in terms of the
2 health standards of the western world, she was not
3 severely ill; is that right?
4 A. That's correct, yes.
5 Q. The only thing that you or any other doctor had directed
6 to go into her was fluids by the time of the seizure?
7 A. That's correct, yes.
8 Q. There's no other drug going in?
9 A. No, no.
10 Q. In terms of your view of the appropriate fluids compared
11 with the fluids that she actually received, there was
12 day and night; isn't that right?
13 A. Yes, that's a reasonable summary of the situation, yes.
14 Q. We know, as you've indicated, that excess amounts of
15 hypotonic fluid have the potential -- and I put it no
16 higher than that -- to cause an electrolyte derangement
17 to the extent that a cerebral oedema could occur.
18 A. Yes. If you're to ask me that as a multiple choice
19 question, I'm sure I would have ticked that box, if
20 I can put it like that. That's not the same thing as
21 being able to say I could access that information in
22 that particular context, which is a slightly different
23 question, and to join up the dots as the --
24 Q. I realise I'm putting these points to you in fairly
25 simple and in-the-round kind of terms, but it's to lead

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1 of great concern in a child who's deteriorated so
2 markedly in a way that you don't understand when any
3 discrepancy is pointed out. But I hadn't joined the
4 dots in the way that I would now accept is correct.
5 Q. Why didn't you join the dots?
6 A. It wasn't that I set out to not join the dots. It
7 wasn't a conscious decision, if I can put it like that.
8 I can't now explain in detail, but when I looked at
9 that sodium of 127 at that time, that -- and for quite
10 a long time afterwards, that seemed very
11 disproportionate to the severity of what I had seen in
12 front of me. It was at -- a level, 127 is not
13 a terribly uncommon level of sodium to see in children,
14 either well or unwell, when you take blood specimens.
15 And it is very unusual for it to be associated with that
16 sort of situation. This is the only situation that
17 I can think of where I've seen such a deterioration
18 where the sodium measurement was 127. I accept the
19 point that it may have been lower at that point, but
20 that had not occurred to me. So it may seem very
21 obvious that I should have said: 127, serious
22 deterioration, therefore cerebral oedema -- or whatever
23 sequence in the middle. All I can say is that I didn't.
24 Q. Can we look at the following factors, doctor? This
25 child came into hospital dehydrated. She came into

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1 to an in-the-round kind of conclusion, doctor. Are you
2 telling this inquiry that, on the basis of the
3 information now supplied to you by Dr Crean and taking
4 all of these other factors into account, you weren't
5 even suspicious that the fluids were the trigger for
6 this deterioration?
7 A. I couldn't grasp and I couldn't understand that a sodium
8 of 127 could be associated with such a profound
9 catastrophic outcome. I had a conversation with
10 Dr Kelly and I think there's somewhere a record saying
11 there could have been a misdiagnosis. I don't remember,
12 but it was clearly a very vague conversation, if I can
13 put it like that. I think that was the hallmark of
14 somebody who was struggling to understand what had gone
15 on.
16 MR WOLFE: Perhaps that would be an appropriate moment, sir.
17 THE CHAIRMAN: Doctor, we'll break until 2 o'clock, but
18 we will get through your evidence this afternoon.
19 (1.05 pm)
20 (The Short Adjournment)
21 (2.00 pm)
22 MR WOLFE: Sir, I understand Ms Simpson wants to make
23 a point about this morning's documents.
24 MS SIMPSON: If I could clarify one point that you raised at
25 the outset of this morning. The file in question was a

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1 DLS file, not a Western Trust file.
2 THE CHAIRMAN: So I point the finger at somebody else? You
3 say it's a DLS file, but it's the DLS that holds files
4 on behalf of which trust?
5 MS SIMPSON: I think it's a file that was held by DLS
6 in relation to the investigation of matters on behalf of
7 the trust, but it's a DLS file rather than
8 a Western Trust file. Secondly, can I simply say that
9 we understand practically all of the information ought
10 to have been with the inquiry, so while it seems to be
11 voluminous, hopefully you should find that there is
12 nothing that should cause an embarrassment at a later
13 stage.
14 THE CHAIRMAN: We're hoping too that -- I think it was said
15 to us before -- I think by you, Ms Simpson -- that a lot
16 of this documentation might appear elsewhere and I hope
17 that is the case. Thank you.
18 MR WOLFE: Doctor, if you can come back to the witness
19 chair, please.
20 Can we just finish off our discussion about your
21 interaction with Dr Crean and can I draw your attention
22 to something Dr Crean said in evidence the day before
23 last? While he has no recollection of your discussion,
24 he did express the view that the fluid regime that you
25 say you rehearsed to him, which was 100 ml as a bolus

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1 aware that Lucy had received 500 ml of normal saline?
2 A. Yes, I think so.
3 Q. That doesn't appear to have been part of your
4 contribution to the conversation. In other words,
5 you haven't indicated in the note that you made
6 thereafter that that was part of the exchange or the
7 information sharing.
8 A. I don't think it was. I think he rang to raise a very
9 specific point, which I was -- I think I have said I was
10 very surprised to hear. So I don't think the
11 conversation went on to issues of what was the rest of
12 the fluid and what was happening beyond that. My
13 recollection is he was notifying me of something that he
14 thought was noteworthy or he was asking me about
15 something that he had noted.
16 Q. But of course, you would have known, would you not, that
17 the very significant infusion of normal saline would
18 have had the potential to exacerbate any cerebral
19 oedema?
20 A. I think you're making the assumption that I was
21 approaching this as somebody who understood what was
22 going on, who had an understanding of the basic problem,
23 and my difficulty at that time was that the sequence
24 we've talked about, the fluid, hyponatraemia, cerebral
25 oedema, was not what I was thinking.

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1 and then 30 ml of Solution No. 18, he has commented that
2 that regime for a dehydrated child makes absolutely no
3 sense at all. Is it your position -- and it appears to
4 be your position from the note -- that that is what you
5 said to him?
6 A. That relates to the intravenous fluids.
7 Q. Yes.
8 A. Dr Crean did also, I think, go on to say something to
9 the effect that it wasn't an area of treatment that he
10 was usually involved in, so the fact that the question
11 of oral rehydration fluid as an extra source of fluid
12 didn't come up, didn't occur to him or he wasn't in
13 a position to make a comment on it is what he's
14 referring to in that context, I think. He rang about
15 the intravenous fluids.
16 THE CHAIRMAN: So are you saying that your fluid
17 prescription was to be 30 ml an hour plus oral
18 rehydration?
19 A. Yes, oral rehydration is a route -- a universal part of
20 the treatment of gastroenteritis, and depending on how
21 much was taken, then you would adjust accordingly as
22 time went by.
23 MR WOLFE: The second point arising out of that
24 conversation, which I want to ask you about is this: by
25 the time you're having the conversation with him, you're

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1 And in light of that sequence of events which I've
2 had -- which as I said, Dr Sumner and so on have
3 delineated very clearly, I take the point you're making,
4 but on the other hand that was not the position I was in
5 at the time. I was informed of something which took me
6 rather by surprise in the situation of a child who had
7 had a catastrophic deterioration that I didn't
8 understand.
9 Q. Yes. You commented upon your state of mind upon
10 receiving this information from Dr Crean when you gave
11 evidence before the General Medical Council. If I could
12 have up on the screen, please, 163-001-021. At the
13 bottom of the page, you are asked a question about the
14 note that you then made retrospectively on the 14th.
15 THE CHAIRMAN: Is that at letter F?
16 MR WOLFE: Yes.
17 A. I can see that, yes.
18 Q. You're asked:
19 "What effect did reading the notes ..."
20 That is the notes in the file which established for
21 you that Dr Crean was right that it was 100 ml per hour
22 of Solution No. 18. You say:
23 "I was very surprised and it precipitated the note
24 recording. I cannot necessarily say it was the calmest,
25 most collected and thoughtful note I have ever made. If

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1 I was to say that it was an upsetting and even
2 distressing thing to think that in a child who had
3 deteriorated so markedly from although what was
4 a potentially dangerous illness was the sort of thing
5 we would expect to deal with normally and to have
6 something like that pointed out to me was, it would not
7 be unreasonable to say, a distressing experience."

8 So I'm anxious to explore with you, doctor, in light
9 of that answer, that seems to suggest that Dr Crean's
10 revelation, as confirmed by you when you went to the
11 notes, seemed to trigger in you a sense of, if you like,
12 as you suggest there, a sense of upset in relation to
13 the fluid regime and what had gone wrong.

14 A. I was trying to choose my words very carefully under
15 these circumstances because I don't want to give anybody
16 the impression that I'm in any way, shape or form
17 suggesting that any upset I may have suffered on any
18 occasion to do with this is comparable to what the
19 family has experienced. So if I could make that clear
20 from the outset, I can then address your question.

21 This was a child who had been admitted, as I've said
22 there, with a relatively normal illness that I would
23 expect to be home within a day or two at most. The
24 child had deteriorated catastrophically. That in
25 itself -- and I appreciate that as a professional person

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1 might be. It doesn't have to necessarily follow -- and
2 I come back to the point that a sodium of 127, even with
3 that information, would not -- it did not allow me to
4 reach the conclusions which have subsequently been
5 reached.

6 Q. The sodium of 127 seems to have triggered the conclusion
7 reached by, for example, Dr Dewi Evans in his
8 medico-legal report for the family, prepared in or
9 about February 2001. He seems to have based his
10 conclusions that the fluid caused the cerebral oedema on
11 the basis of a 127 finding.

12 A. I don't remember the details. I have seen his report,
13 but I can't remember the details.

14 Q. I was going to add to that. Dr Asghar, who was
15 a colleague of yours working at the time, he wrote, as
16 you will recall, to Mr Mills, saying:

17 "It appears this child had 100 ml running through
18 the night. It appears she had too much fluid and now
19 the post-mortem has found a cerebral oedema."

20 So he seems to be linking all of these points
21 together.

22 A. May I try and -- I think there are two things you have
23 referred to. The first was Dr Dewi Evans.

24 Q. If I could focus that into a question perhaps, it might
25 be easier. There does seem to have been an ability on

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1 working in this area, one should be detached and one
2 should not have any emotional response -- be able to
3 contain all emotional responses. That sort of situation
4 is not one that does not have an emotional impact on me
5 and, I suspect, quite a number of my colleagues. The
6 very fact of something having gone wrong to that extent
7 in such an unexpected fashion.

8 If I may just finish, the suggestion then that there
9 was something untoward in the recording of the fluids,
10 that didn't have to trigger any association with what
11 had happened to me to be a further upsetting issue. And
12 you will recall the conversation I had with Dr Kelly was
13 rather vague and I suspect -- I'm sure he'll give his
14 own account of it -- was possibly rather unfocused and
15 somewhat rambling ... And I don't think that I knew
16 what the significance of his phone call was. If there
17 was one thing wrong, what else might there have been
18 happening that I wasn't aware of might be ...

19 Q. Why would you characterise the discovery of the fluid
20 error as a distressing experience unless it was
21 indicating to you some problem in terms of causation
22 in relation to the deterioration?

23 A. It doesn't necessarily have to be a sign of causation.
24 It's a problem, and if there is a discrepancy then
25 I have no way of knowing what other discrepancies there

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1 the part of, for example, Evans and, for example, Asghar
2 to reach a view that the fluids were indicative of
3 a problem or were causative of a problem.

4 A. If I can take Dr Evans --

5 Q. Why couldn't you do that?

6 A. If I can take Dr Evans first. He specifically refers to
7 the level of 127 and says he believes that was enough to
8 cause the episode in question. Even at that stage when
9 I saw his report -- although I think Dr Sumner's report
10 put it differently, and I thought it was a very clear
11 exposition of the issue. The best information that I'd
12 come across in the intervening years about the levels of
13 sodium at which you're likely to get cerebral oedema --
14 I think was there was an article from, I think it was
15 the Sick Children's Hospital in Toronto, and if you look
16 at the general run of levels at which you get cerebral
17 oedema, they're considerably -- sorry, maybe not
18 considerably, but certainly significantly lower than
19 127.

20 Dr Asghar's involvement was slightly different in
21 the sense that, to the best of my knowledge, he didn't
22 present any particular coherent pathway. I think he
23 said something about the amount of fluid; I don't know
24 that he said hyponatraemia.

25 Q. That's entirely right. In fact we can put up on the

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1 screen what he said. 036A-099-212 and have alongside
2 that 213. We've had to redact, sir, because of
3 irrelevancies contained within the letter. This is
4 a letter written to Mr Mills on 5 June 2000. What he
5 says at the top of the right-hand page is:
6 "A PM revealed cerebral oedema. This child might
7 have been given excess of fluids. All through the
8 night, fluids were running at 100 ml per hour."
9 And there are other aspects of that that don't
10 trouble us. The point I'm making, doctor, is that
11 no one is necessarily expecting you to make a finite
12 finding in relation to all of this, but at the very
13 least should you not have had a suspicion, perhaps
14 a strong suspicion, that the fluid error here was
15 causative of Lucy's deterioration?
16 A. All I can say is that I didn't. I think in retrospect,
17 the reason was the catastrophic nature of the
18 deterioration. If she had been unwell, but not so
19 catastrophically unwell, or for example she would had
20 a convulsion, one of the other more minor manifestations
21 of cerebral oedema, it might have seemed proportionate.
22 But with a sodium of 127 and the disastrous
23 deterioration, those two did not line up in my mind.
24 THE CHAIRMAN: Let me ask you two points about that. Does
25 that mean that you considered whether excess fluid had

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1 deterioration was something I couldn't get a handle on.
2 There are very few situations where I find myself at
3 least unable to get a lead into it. I accept the point
4 you're making that maybe I should have.
5 THE CHAIRMAN: I'm not making the point with the benefit of
6 hindsight; I'm saying, at that time, you say that
7 although you try to remain professional and that
8 involves an element of detachment, people are inevitably
9 upset about the loss of a child who was previously well.
10 A. Yes, I've said that.
11 THE CHAIRMAN: Okay. That being the case, you're even more
12 curious about why a previously well child has
13 deteriorated and died in such a short period of time.
14 A. Yes.
15 THE CHAIRMAN: You have no lead other than an issue about
16 the fluids.
17 A. And I approached Dr Kelly as the medical director.
18 I couldn't see how I could tackle this issue and reach
19 any conclusion myself. That was the basis -- I didn't
20 know that they were related, but I couldn't see how
21 I could approach the issue and tackle it satisfactorily
22 myself.
23 THE CHAIRMAN: I'm not criticising you for going to
24 Dr Kelly -- and that will be explored in the next few
25 minutes -- but having gone to Dr Kelly, would you

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1 brought about Lucy's death and then discounted it
2 because the reading was 127?
3 A. I think the latter is closer in that I think I've said
4 somewhere that I was aware of 127 and I thought this was
5 inadequately reduced to explain a hyponatraemic
6 convulsion, or words to that effect.
7 THE CHAIRMAN: Are you telling me that you remember
8 consciously exploring the issue and saying: Lucy got far
9 too much fluid, she got far too much Solution No. 18,
10 then she got far too much normal saline, but I discount
11 the fluids as causing her death?
12 A. No, I didn't.
13 THE CHAIRMAN: Did you have a better lead than that?
14 A. No, I didn't.
15 THE CHAIRMAN: Did you have any other lead?
16 A. No.
17 THE CHAIRMAN: So in the absence of any other lead, why not
18 explore the single lead that you did have about excess
19 fluid, the rate of her fall from 137 to 127, and then
20 possibly the effect of giving her a free run of normal
21 saline from about 2.30 or 3 o'clock?
22 A. I didn't explore it. I didn't explore those issues.
23 That was not a sequence that occurred to me.
24 THE CHAIRMAN: Why not if you had no other lead, doctor?
25 A. What I was trying to say was the degree of this

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1 yourself not have at least a professional interest in
2 exploring the issue of whether or to what extent the
3 fluids contributed to Lucy's death?
4 A. She had been transferred to Belfast and I think it was
5 the following --
6 THE CHAIRMAN: In effect, she was transferred to Belfast to
7 die.
8 A. But that's -- what I'm saying is I had a conversation
9 with Dr Hanrahan, the paediatric neurologist, who told
10 me he had undertaken a number of investigations and
11 subsequently told me that a post-mortem was to be done.
12 As it happens, I didn't get an awful lot of information
13 back about those. But the point to those investigations
14 would be that presumably he wasn't clear what other
15 possibilities there were and the post-mortem results,
16 similarly, would be exploring what the possibilities
17 were.
18 THE CHAIRMAN: Okay, thank you.
19 MR WOLFE: Doctor, when you discovered that the fluids were
20 not as you had directed or prescribed, did you reach the
21 conclusion that the fluids were therefore inappropriate,
22 it was an inappropriate fluid regime?
23 A. It wasn't the regime I had prescribed, and in that sense
24 it was inappropriate, yes, I would say.
25 Q. But inappropriate both in terms of the rate or the

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1 volume of fluid that Lucy had got before her collapse?
2 A. I'm accepting the inappropriateness, yes.
3 Q. And inappropriate in type?
4 A. I'm accepting the inappropriateness in the broad sense.
5 It was not what I had intended. That does not
6 necessarily mean that it allowed me to make the leap
7 from that to the cerebral oedema.
8 Q. Well, did you give any consideration to whether those
9 fluids could have caused any harm to this child?
10 A. I've spoken about the sodium of the 127 as the
11 intervening step. The earliest recollection of what
12 I have written and said is that I considered the
13 possibility of a hyponatraemic convulsion, the
14 convulsion associated with low sodium, but that I felt
15 the 127 was not low enough for this to be a real
16 possibility. So my recollection and my understanding of
17 my thought process is that a sodium level of 127 didn't
18 allow me to identify what the cause of the cerebral
19 oedema was.
20 Q. Let me move on to your discussions with Dr Kelly. It
21 appears, doctor, that you obtained the notes in relation
22 to Lucy and made your entry on 14 April.
23 A. That seems to be the case, yes.
24 Q. It does appear that you made a report to Dr Kelly on
25 that day; is that fair?

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1 with Dr Crean.
2 A. Yes.
3 Q. What did you tell him about that conversation?
4 A. I don't remember the discussions in any great detail.
5 I certainly believe that I attempted to indicate what
6 had drawn this issue to my attention. I'm sure I told
7 him that it was a disastrous outcome, unanticipated, but
8 I don't have an immediate recollection of the details of
9 the conversation.
10 Q. Just to be clear, I've been advised by Dr Kelly's
11 counsel that the conversation that you had with Dr Kelly
12 did not involve reference to Dr Crean. But you seem
13 quite confident that you did bring that --
14 A. I can't remember whether I used Dr Crean's name, but the
15 start of the episode, the start of the notification
16 episode, was "somebody in the Royal", if I could put it
17 like that. I had written Dr Crean's name in the notes
18 and I think I had physically brought the notes to that
19 meeting with Dr Kelly. Whether I used Dr Crean's name
20 or not, I honestly can't remember. When I referred to
21 notifying back to Dr Crean, I don't know that
22 I necessarily meant that I could remember using
23 Dr Crean's name, for example.
24 THE CHAIRMAN: Does that mean but for the phone call from
25 Dr Crean you might not have gone to Dr Kelly at all?

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1 A. I don't remember when I first contacted him. I may have
2 spoken to him on the phone on the Thursday. I believe
3 that I spoke to him face-to-face on the Friday.
4 Q. And had you ascertained, by the time you spoke to him,
5 that Dr Crean's concern was accurate?
6 A. I believe so, yes.
7 Q. Had Dr Crean said anything to you about his concern
8 other than just expressing the view that he thought she
9 had had 100 ml an hour of Solution No. 18?
10 A. No, he didn't suggest to me the possibility that the
11 cerebral oedema was related to hyponatraemia, the
12 sequence that we've talked about. He didn't raise that
13 in the discussion.
14 Q. Did you get any sense of why this was at all
15 significant? 100 ml an hour is what she got; why did he
16 see that as significant?
17 A. I think in the same conversation he also referred to the
18 fact that he had referred her on to Dr Hanrahan, the
19 paediatric neurologist. My understanding from that --
20 and I didn't chase this through specifically -- was that
21 he hadn't reached a specific conclusion.
22 Q. So he was simply wanting confirmation --
23 A. More information, I think. More information in general.
24 Q. And you have told us in your witness statement that you
25 spoke to Dr Kelly and notified him of your conversation

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1 A. There was no increased clarity about what had happened.
2 Dr Hanrahan rang, had done some investigations,
3 a post-mortem was happening. If I had received
4 a discharge summary letter which had said there was some
5 rare neurological disorder that I'd never heard of and
6 which we hadn't identified, that would have been one
7 issue. If there had been information that all of the
8 investigations were normal and the following were the
9 conclusions, that might have been another circumstance
10 that would have led me to notify Dr Kelly.
11 THE CHAIRMAN: In this case the starting point for going to
12 Dr Kelly was Dr Crean's phone call.
13 A. That's right.
14 THE CHAIRMAN: But for Dr Crean's phone call or any
15 subsequent information, you would not have gone to
16 Dr Kelly to say, "I think you should know there has been
17 a disaster on the children's ward, I don't know why it
18 happened, but a little girl came in here yesterday
19 evening to be rehydrated, she had moderate dehydration,
20 apparently had gastroenteritis, and she coned at
21 3 o'clock this morning"? That information would not
22 have been provided to Dr Kelly but for information
23 coming from the Royal?
24 A. I can't say that is necessarily the case. It wasn't
25 long after I got back from the Royal that Dr Crean was

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1 in touch. There wouldn't have been enough time to have
2 done anything before, much before, Dr Crean was in
3 touch. I can only hypothesize. I believe that it was
4 such a disastrous outcome that unless I heard
5 a satisfactory explanation for it, it would have been
6 something that I would have wanted to enquire into
7 further.

8 MR WOLFE: So in terms of raising with Dr Kelly the input of
9 Dr Crean, you are saying you may not have used his name
10 specifically, you may instead simply have said, "I have
11 been in touch with the Royal", or, "The Royal has been
12 in touch with me"?

13 A. I could have done. That's possible.

14 Q. Very well. You have told the inquiry in your witness
15 statement that you believe that you discussed the repeat
16 electrolyte results with Dr Kelly when you notified him
17 about the case.

18 A. Yes, I believe I did. But again, I don't have a vivid
19 recall of that discussion.

20 Q. What is your process of reasoning for thinking that you
21 did, for believing that you did?

22 A. I don't have any specific reason behind that. I was
23 asked a question and provided the answer that seemed to
24 me to be a true response to that. I don't have any
25 particular recollection to say that I remembered the

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1 ask you to look at. That looks like a rogue reference.

2 THE CHAIRMAN: Is this the conversation between Dr Kelly and
3 Dr O'Donohoe?

4 MR WOLFE: Yes.

5 THE CHAIRMAN: It started at the bottom of the previous page
6 and continued into this page.

7 MR WOLFE: Maybe if I have 002 alongside it, please.

8 THE CHAIRMAN: It's the last five or six lines.

9 MR WOLFE: If we could start with:

10 "Dr O'Donohoe outlined that he was raising this
11 under critical incident reporting."

12 What's that? What is critical incident reporting?

13 A. Where a person deteriorates, I was using it in the -- my
14 understanding of the term where a person deteriorates
15 unexpectedly.

16 Q. And for which you haven't got an explanation?

17 A. Yes, for which you don't have an explanation, yes.

18 Q. He recalls that you informed him that the child had been
19 admitted with diarrhoea and vomiting and had
20 subsequently suffered an unexplained collapse, requiring
21 resuscitation, and -- I think that should say
22 "intubation".

23 A. Yes, that's correct.

24 Q. He explained that he had transferred the child to PICU
25 at the Royal, you advised him that the child was on

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1 flow of the conversation and it came up at this point or
2 at that point in that context. I don't.

3 Q. Did you answer yes to that question because you think it
4 reasonable that you would impart such information?

5 A. I think that probably was -- yes, rather than
6 specifically remembering it.

7 Q. Again, I'm advised that Dr Kelly would say that he does
8 not accept that you discussed the repeat electrolyte
9 results with him.

10 A. He may be correct. I don't have a specific
11 recollection.

12 Q. In terms of the description of Lucy's fluid regime, did
13 you discuss with him that there had been a significant
14 error in terms of the fluids that she had received?

15 A. I believe I drew his attention to the conversation, the
16 phone conversation, which had drawn this to my
17 attention, which was, as I have said, a significant
18 discrepancy.

19 Q. Do you think you discussed the specific fluid regime
20 that was intended and compared it with the fluid regime
21 that she had received?

22 A. I don't remember going over the calculations, the
23 numbers, and I doubt if that happened.

24 Q. He has set out in his account to the PSNI, when
25 interviewed, an account at 116-043-003, which I would

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1 a ventilator at the Royal, but her prognosis appeared
2 poor, brainstem tests were planned. You said that you
3 weren't sure what was happening:

4 "[You] stated that there may have been
5 a misdiagnosis, the wrong drug had been prescribed, or
6 the child had an adverse drug reaction."

7 What drugs had been prescribed that might have given
8 rise to that thought?

9 A. I don't know that that was a specific suggestion.

10 I think that was -- that's a manifestation of the fact
11 that I didn't understand what was going on. I think it
12 was in terms of, "What else might there be? What might
13 you not have thought of?"

14 Q. I should have said that is Dr Kelly's recollection.

15 A. I understand that and I'm not disputing it. It's not my
16 recollection, but I'm not disputing that that could have
17 happened and all I can do is speculate about the
18 possible context in which I might have said that.

19 I don't remember those specific words. I'm not
20 disputing his recollection in that regard. I can easily
21 understand if I didn't know what had happened and that
22 the question would be, "What could have --"

23 Q. Are you surmising then that although no drugs had been
24 prescribed for this child pre-collapse, that somehow or
25 other a drug might have got into her system?

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1 A. It wouldn't be outside the realms of possibility. It
2 wasn't something I was suggesting as an active
3 possibility, but if you don't know what has happened and
4 if you don't understand what has happened and if you're
5 scratching your head trying to think of what might be
6 relevant, I don't think that's an unreasonable
7 suggestion to raise. It wasn't one I was pushing
8 forward in any sense. It was just a thought.
9 Q. Of course, this may not have all happened in the order
10 that he recites it to the police. He then says you
11 explained that there had been some confusion over
12 fluids.
13 A. Yes.
14 Q. Which in terms of how it's described there seems
15 rather -- a rather modest way to describe what was
16 clearly a fairly significant departure from your fluid
17 prescription, about which you knew.
18 A. I don't remember the words that were used in that
19 context. I don't believe that I'd been able to satisfy
20 myself that I was sure what fluids had been given. In
21 order to do that, I think it would have involved
22 identifying which nurses had recorded what and so on and
23 trying to confirm what had been given. So I don't think
24 I was in a position to be any stronger than that,
25 although I don't remember that those were the actual

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1 normal saline?
2 A. I don't remember the detail, I am sure I brought the
3 records with me. I don't think Dr Kelly particularly
4 wanted to go over the written records that there were.
5 I think my visit there was to tell him there was
6 a serious episode. He, as he's indicated -- and
7 I understood there was going to be an investigation, an
8 examination of the issues, undertaken fairly promptly.
9 Q. Did you express any view as to what might have happened
10 to cause this child's deterioration?
11 A. No, I don't think I did.
12 Q. At or around this time -- and I mean the days after
13 Lucy's transfer to the Royal -- you spoke to Dr Hanrahan
14 at the Royal.
15 A. That's correct, yes.
16 Q. Dr Hanrahan was the neurologist who was, in part,
17 treating Lucy.
18 A. So I believe, yes.
19 Q. There's a note written into the Erne notes for 18 April,
20 which records that:
21 "A verbal report of a post-mortem had indicated rota
22 gastroenteritis and cerebral oedema."
23 A. Yes, I remember that, and it's not on the screen, but
24 I do believe I wrote that.
25 Q. Did you receive that report from --

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1 words that I used.
2 Q. But you were satisfied on the basis of your
3 consideration of the notes that 100 ml of
4 Solution No. 18 had been given every hour from 10.30 --
5 A. No, I was satisfied on looking at the notes that what
6 Dr Crean had told me was what was recorded in the notes.
7 That's not necessarily the same thing as what actually
8 would have happened.
9 Q. So you were inviting Dr Kelly to investigate all of
10 this?
11 A. Yes, I wasn't trying to -- I don't recall trying to
12 point him in any particular direction.
13 Q. If at that stage you had obtained information from the
14 notes that there had been this difficulty, to put it at
15 its mildest, over fluid administration, is that not
16 something that you should have been shouting loud and
17 clearly about?
18 A. I don't remember the full details of the conversation
19 and Dr Kelly will undoubtedly be spoken to as well.
20 I do recall having seen a written account of the
21 conversation with him, in which I may have been somewhat
22 shouting, if I can put it like that, not necessarily in
23 a particularly clear-minded fashion. I think agitated
24 might be the word.
25 Q. Did you tell Dr Kelly about the input of 500 ml of

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1 A. I received the report, but I can't remember whether
2 I received it first-hand or whether that was relayed to
3 me by somebody else. If I'd received it directly from
4 the Royal, I would normally -- as I did, for example,
5 with Dr Crean -- have written who it came from. But
6 I can't remember specifically whether it was directly to
7 me or via somebody else.
8 Q. You were also told on 14 April that there wasn't to be
9 an inquest, isn't that right, there wasn't to be
10 a coroner's post-mortem?
11 A. I believe that Dr Hanrahan told me that on the 14th. I
12 think it was the 14th, yes.
13 Q. And did Dr Hanrahan convey that information to you?
14 A. I believe so, yes.
15 Q. When he was conveying the information to you about the
16 fact that the case had been reported to the coroner's
17 office and there wasn't to be a post-mortem, did you get
18 into a discussion about his understanding of that and
19 why that was the conclusion?
20 A. Why there wasn't to be a
21 Q. A coroner-led post-mortem?
22 A. No, I don't think he gave me any indication as to --
23 reasons were given. I don't recall there being any
24 reasons given.
25 THE CHAIRMAN: Were you surprised?

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1 A. In one sense I was, but on the other hand, not having
2 any previous experience of the Coroner's Service of
3 Northern Ireland, I didn't know if that was common
4 practice or not. I had anticipated there would be
5 a post-mortem.

6 THE CHAIRMAN: Had you any previous from your time in
7 Roehampton of the Coroner's Service?

8 A. Yes, I had been in touch, dealing with the coroner, on
9 a number of occasions.

10 THE CHAIRMAN: By this time you'd been a consultant for
11 eight years.

12 A. Yes.

13 THE CHAIRMAN: Did it not strike you that, under UK law --
14 and accepting that English law is not identical to
15 Northern Irish law -- that this was apparently a very
16 clear case for a coroner's post-mortem and inquest?

17 A. I couldn't have quoted the legislation, but I didn't
18 understand the connection between the cerebral oedema,
19 which had happened, and the antecedents. If I'd
20 understood that, from what I now know of the
21 legislation, it would have been a clear indication to
22 report. If I'd contacted the coroner, I would have
23 said: a child has died of unexplained cerebral oedema,
24 there's some discrepancy in the notes. That's as much
25 as I would have been able to report.

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1 A. Yes.
2 Q. You had worked out that there had been, at best, an
3 inconsistency in the documentation of the fluids and, at
4 its worst -- and as we now know factually -- a clear
5 departure from your fluid regime. Was that latter
6 factor not the kind of thing you were sharing with
7 Dr Hanrahan?

8 A. Most of the conversations I recall about possible causes
9 were to do with neurological disorders. He had
10 undertaken a number of investigations to do with unusual
11 possibilities that had occurred to him about cerebral
12 oedema. My understanding was that that was the line of
13 enquiry he was pursuing.

14 Q. But you had information which perhaps he didn't have,
15 that there had been a fluid error, or at least
16 a suspicion of a fluid error?

17 A. That had been drawn to my attention by Dr Crean in the
18 Children's Hospital.

19 Q. Yes.

20 A. I don't remember asking was he aware of that, but that
21 information was within the Children's Hospital, so
22 I imagine he must have known.

23 Q. But is it not surprising that that didn't emerge as
24 a topic of conversation between you two?

25 A. I didn't find myself surprised because he was talking

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1 THE CHAIRMAN: You would have been able to say much more
2 than that. You would have been able to say that: a
3 previously healthy 17-month-old girl came in with
4 a comparatively minor illness and, within a few hours,
5 she was dead, she received excess fluid, she died as
6 a result of cerebral oedema, I don't understand what
7 happened, nobody I know can understand what happened,
8 this is an unexplained, unexpected death of a previously
9 healthy child, I'm reporting it to you because I believe
10 there should be an inquest.

11 A. I didn't -- that line of thought did not occur to me.
12 Dr Hanrahan informed me he had discussed the situation
13 with the coroner. I suppose ...

14 THE CHAIRMAN: If you don't have a coroner's inquest into
15 Lucy's case, when do you have a coroner's inquest?

16 A. That's not entirely for me to answer because this was
17 a discussion between Dr Hanrahan and the coroner's
18 office. That information was relayed to me as
19 a fait accompli, I suppose ...

20 THE CHAIRMAN: I'm sorry, I think Mr Wolfe is about to take
21 you on to the point that it's not a matter for you.

22 MR WOLFE: By this stage, the afternoon of 14 April, Lucy is
23 now dead.

24 A. Yes, that's right.

25 Q. You have had a conversation with Dr Kelly.

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1 about neurological disorders, rather rare disorders, and
2 many of the things he was talking about were conditions
3 that I would have very little knowledge of.

4 Q. Well, you have said quite often today that you didn't
5 draw the connection between the fluid mismanagement,
6 doctor, and the cerebral oedema. But presumably you did
7 draw a connection between the fluid mismanagement and
8 the hyponatraemia.

9 A. I don't remember looking at it specifically in that
10 sense. The hyponatraemia was not -- and this was my --
11 I accept this was my limitation and a defect. The
12 hyponatraemia was not proportionate to what I'd seen in
13 terms of the catastrophic deterioration.

14 Q. The coroner has spoken publicly about his disappointment
15 that the death of Lucy Crawford didn't make it to his
16 attention. And what he says is that in terms of the
17 legal obligation to report Lucy's death into his office,
18 not only did it rest with Dr Hanrahan and the Royal, but
19 it also rested with the clinicians in the Erne Hospital
20 who were aware of Lucy's moribund condition as they
21 transferred her to the Royal. Have you seen that
22 comment by him?

23 A. I have seen comments to that effect, yes.

24 Q. Bearing in mind section 7 of the Coroner's Act, do you
25 now see his point that there was an obligation on any or

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1 every medical practitioner who had the requisite
2 knowledge to make a report to his office?
3 A. I'm sorry, can you repeat the question?
4 Q. Do you see his point under section 7?
5 A. Yes. I couldn't have quoted the words to analyse it
6 in the terms you're talking about, I couldn't have done
7 that at the time. I didn't identify a legal obligation.
8 And in no subsequent conversations did anyone say to
9 me -- no people with greater familiarity maybe with
10 Northern Ireland procedure have raised it with me. So
11 it wasn't a matter of me saying to myself, "I have
12 a legal obligation here, but I will not discharge my
13 legal obligation". Is that the question ... Is that
14 what we're ...
15 Q. What are the obligations in the Republic of Ireland?
16 A. I have spent most of my career working in England.
17 I have never been able to quote, wouldn't be able to
18 quote, the obligations. There have been a list of
19 conventions, circumstances, under which, in individual
20 departments, things would be notified. Most of these
21 tended, as far as my recollection over the years, to
22 emanate from the individual coroners in the individual
23 areas, who would disseminate -- I suppose, "This is
24 particularly important, we've had problems in this area,
25 so these are the situations". I couldn't have quoted

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1 I didn't realise at that time I could be seen to be
2 under a legal obligation to report something that had
3 already been notified to the coroner.
4 THE CHAIRMAN: Does that mean that in the eight years that
5 you'd worked in the Erne that you had not received any
6 instruction on the circumstances in which doctors are
7 obliged to report a death to the coroner?
8 A. One of the coroners has, over the last two or three
9 years, done an annual training session, which I have
10 attended over the last three years. Prior to that, no.
11 THE CHAIRMAN: You joined the Erne in 1992.
12 A. I'm sorry, I'd have to look. 1997.
13 THE CHAIRMAN: Sorry, 1997. So from 1997 to 2000, you had
14 received no training in the Erne about your obligation
15 to report a death to the coroner. And had you been
16 trained or been given instruction in Roehampton between
17 1992 and 1997?
18 A. Not that I recall. Again, I'm not sure that I can
19 actually recall when I last had any specific training on
20 those issues, even going back further than that.
21 MR WOLFE: I realise this is hypothetical, but in terms of
22 what the coroner should have been told, if you were
23 reporting the death, would it have been a matter of
24 significance to note the fluid errors and report them?
25 A. I think it would have been important to try and gather

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1 the specific obligation, I'll have to be honest.
2 Q. Would you have seen yourself as having had a similar
3 obligation in England when you worked there?
4 A. I don't recall a situation which was in any way parallel
5 to this, but I have no recollection of hearing of more
6 than one person notifying the same issue to the coroner.
7 It was not something that I'd ever come across. I'm not
8 saying that means it couldn't happen, I'm just saying
9 I've never heard of it.
10 Q. You say you were surprised that this wasn't going down
11 the coroner's route.
12 A. Yes.
13 Q. But you didn't, it appears, check to ascertain from
14 Dr Hanrahan just why it wasn't going down the --
15 A. I don't remember exactly what the conversation, how it
16 flowed, so I can't say whether I said to him
17 specifically, "But surely they must have given you
18 a reason". I don't think I asked him for a specific
19 reason. He didn't volunteer a reason and I suppose
20 I got the impression that the coroner had said no, so we
21 do what the coroner says, and that was the end of it
22 from the coroner's aspect.
23 Q. Why didn't you make a report yourself?
24 A. I didn't make the requisite association. You've drawn
25 my attention, as the coroner has, to legal obligations.

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1 all of the information together, what Dr Crean thought,
2 for example, or any of the other people in the intensive
3 care unit, what Dr Hanrahan thought, and submit as much
4 of that as was available. That would include the fluid
5 issues if they were believed to have a connection to the
6 deterioration.
7 Q. Was it a matter that you reported back to your
8 colleagues in the Erne that the coroner was not pursuing
9 this matter?
10 A. I can't remember who I told and at what point I told
11 people. My recollection is that that phone call came
12 through late on the Friday afternoon.
13 Q. Yes.
14 A. So I don't remember chasing anyone, Dr Kelly, for
15 example. I don't remember talking to him subsequently
16 that day. So I don't know if I did tell him, when
17 I told him. I don't recall.
18 Q. Do you think it likely you told him?
19 A. I have no recollection. I certainly think it's
20 possible, but I don't recall any conversation in which
21 it did happen.
22 Q. It was obviously of significance that there wasn't to be
23 a coroner's led post-mortem.
24 A. Yes. Dr Hanrahan did tell me at the same time that
25 he was pursuing, I suppose, what would be known as

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1 a hospital post-mortem.
2 Q. As I've said, at or around this time, you're having
3 a number of conversations with different people. You
4 spoke to Dr Malik at or around this time about the death
5 and its potential implications.
6 A. I did speak to him, yes.
7 Q. Dr Malik met with Dr Kelly some months later
8 in November 2000 to discuss the complaint that had been
9 made by Dr Asghar in relation to you.
10 A. That's correct, yes.
11 Q. And if I could have up on the screen, please,
12 036c-011-034. The second entry from the top, Dr Malik
13 in this interview with Dr Kelly, which is taking place
14 several months later on 7 November, but he's saying by
15 reference to the Monday -- that's presumably the Monday
16 after Lucy's death -- that he was explaining how he had
17 been called by Dr O'Donohoe to discuss the Lucy Crawford
18 case. It was clear to Dr Malik that Dr O'Donohoe was
19 upset by the death:
20 "Dr O'Donohoe explained that there would be an
21 enquiry into the circumstances surrounding the death.
22 This might lead to outside review of the case by the
23 College of Paediatricians and may even lead to a court
24 case. [Dr Malik] was advised that as the SHO directly
25 involved, he may need to contact the BMA and should

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1 should seek support from organisations like the BMA or
2 the Medical Defence Union --
3 Q. Sorry, just to cut across you --
4 THE CHAIRMAN: That's not the point you're being asked.
5 MR WOLFE: The point I'm asking you, doctor, is this: you
6 said you outlined to him the various ways in which he
7 could be criticised.
8 A. Yes, his --
9 Q. What were those ways? What were those things?
10 A. I think the way it worked was that he explained to me
11 what his worries were and I told him the only ways in
12 which you can be dealt with here would be the following
13 mechanisms, that if somebody wanted to take you to
14 court, it would be in this context, and your protection
15 is that you would do X, Y or Z --
16 THE CHAIRMAN: Doctor, I'm afraid we're missing the point.
17 It's not whether you can be sued or reported to the GMC
18 or whatever; it's what you were being reported or sued
19 for. What criticisms did you suggest he might be
20 vulnerable to?
21 A. Oh, I see. I didn't suggest any particular criticisms
22 he might be vulnerable to. I think I was trying to do
23 the opposite, in fact.
24 THE CHAIRMAN: What, suggesting that he wasn't vulnerable to
25 criticism?

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1 consider seeking support from colleagues. Dr Malik was
2 asked had he any close friends among the doctors
3 connected talk with and, in particular, if anyone from
4 the same cultural or national background would be
5 available to provide support."
6 So the nature of that conversation, do you agree
7 with that account?
8 A. I approached Dr Malik to let him know that I'd informed
9 Dr Kelly. Dr Malik was very concerned. My
10 understanding of what he was telling me was that in
11 Pakistan, if such a thing happened, he would be
12 concerned that he as the lowest member of the -- the
13 least grade would be singled out to be criticised, to be
14 blamed for everything that happened. I was trying to
15 explain to him that I did not believe that that would be
16 the case here, and I did go over the various ways in
17 which people might be criticised. And I did suggest to
18 him that he take whatever support he felt would be
19 appropriate. I didn't necessarily expect him to believe
20 my version of how things would work.
21 Q. What were the various ways which you explained in which
22 people could be criticised?
23 A. He did, I think, talk about various forms of legal
24 action in the Pakistani context, and I did tell him if
25 he was concerned about possibilities like that, then he

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1 A. No, I think I was trying to be supportive to somebody
2 who was extremely nervous in the context of not having
3 been working in the UK a very long time and considering
4 himself very vulnerable to mistreatment, if I may use
5 that phrase.
6 MR WOLFE: Why did he think that? Was he concerned that
7 something had gone wrong?
8 A. I told him that I had notified Dr Kelly. His
9 experience -- as I understood what he was telling me,
10 his experience of seniors investigating in the Pakistani
11 context is, as I've indicated, that somebody could very
12 well find themselves picked on and ganged up on, shall
13 we say.
14 Q. Yes, but let's reduce this to the facts of the case.
15 Dr Malik has sought you out, has he, or have you sought
16 him out?
17 A. I think I sought him out. We may have just come across
18 each other, but I think maybe I had seen him and I asked
19 him if I could have a --
20 Q. And you're telling him that you've had to report this
21 matter to Dr Kelly?
22 A. That's right, yes.
23 Q. And you have told him that there might be certain kinds
24 of investigations?
25 A. That wasn't my initial approach to it. When he told me

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1 what his concerns were, I told him that the ways in
2 which you might have difficulties would be the
3 following, and each difficulty -- for example, I don't
4 know whether he said, "I might be taken to court", or,
5 "Somebody might be taken to court", in which case my
6 response would have been, you want to make sure you have
7 your membership of the Medical Defence Union up-to-date.
8 Q. Why did he think he might be taken to court?
9 A. I don't think he had a very specific fear. He wasn't
10 all that long in the UK from Pakistan and I think he
11 felt that he, as a fairly recently arrived immigrant,
12 would be seen as an obvious scapegoat, if I may use that
13 word.
14 Q. A day or so earlier, you had told Dr Kelly, if his
15 recollection is correct, that there may well have been
16 a misdiagnosis, there could possibly have been a drug
17 overdose or misprescription of drugs, and you alluded to
18 the error with regard to fluids. In this context with
19 Dr Malik, did you discuss any of those matters?
20 A. No, I don't believe I did.
21 Q. Why not?
22 A. The nature of the conversation is that I approached him
23 to tell him what I had done. He was, I think, very
24 upset and frightened by the possibility of him, if I can
25 say, as the recently arrived immigrant, being badly

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1 I'm asking questions which are testing your recollection
2 of this meeting, Dr Malik says complimentary things of
3 you in this report, including, in terms, that you didn't
4 put him under any pressure or cause him distress.
5 I want to put that in the balance.
6 At the bottom of the page, Dr Malik recalls that:
7 "[You] told him that people might say the
8 responsibility lies with [him]. Dr O'Donohoe explained
9 that he would not let that happen."
10 A. I was saying that I would not let him be, if I can use
11 the colloquial expression, dropped in it.
12 Q. He says that you said to him the ultimate responsibility
13 lies with the consultant.
14 A. That is true, yes. I believe I said that. I believe
15 I may have said that to him.
16 Q. He goes on to say that:
17 "Dr O'Donohoe did not tell me to write anything or
18 indicate any specific changes to make. He did, however,
19 offer the notes if I wanted to add any new comments."
20 Do you see that?
21 A. I see that, yes.
22 Q. Can you remember the context in which you made that
23 suggestion?
24 A. I can't, no.
25 Q. Do you remember making that suggestion?

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1 treated. And I tried to tell him that that is not
2 generally how things would be done. I didn't pursue the
3 issue of what had happened on the night in question.
4 I didn't say to him, "You have made a wrong diagnosis",
5 or, "You did anything wrong". I didn't make any
6 accusations to him.
7 Q. Tell me, doctor, was there a general awkwardness about
8 talking out loud about this?
9 A. In what sense?
10 Q. Here you have the --
11 THE CHAIRMAN: Facing up to it.
12 MR WOLFE: Here you have the doctor who was on duty during
13 the relevant period of time and --
14 A. I told him I thought it was highly likely somebody would
15 come and talk to him -- would ask for reports and come
16 and talk to him about the night in question. I didn't
17 know at that time who it would be.
18 Q. Could I just move on down towards the bottom --
19 A. If I just might -- what I didn't want to happen was for
20 him to be approached, let's say, for example, by the
21 medical director of the Trust to say, "Dr O'Donohoe says
22 you were here and that something terrible happened".
23 That is what I was trying to protect him -- guard him
24 against.
25 Q. I should say in fairness to you, doctor, that although

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1 A. I don't particularly remember making that suggestion,
2 no.
3 Q. Would it be an appropriate suggestion to make?
4 A. I had written -- you would not want anything written
5 in the notes that would suggest it had been written
6 other than when it was written or in what context it was
7 written. So for example, I had recorded Dr Crean's name
8 as having contacted me. And I tried to indicate when it
9 had happened. I wasn't trying to indicate -- and
10 I believed I dated it accurately. If something is
11 written and dated accurately, then I don't see that
12 it would necessarily be a problem.
13 Q. The impression I gain from your evidence, doctor,
14 is that in this discussion with Dr Malik there was
15 a refusal to become engaged in a discussion about the
16 substance of Lucy's treatment and what might have led to
17 her deterioration and death.
18 A. We didn't discuss the substance of it to any extent.
19 I can't say that there was no allusion, no reference to
20 any aspects of the treatment, but it was not
21 a discussion about the substance of the matter. It
22 was -- the meeting, from my point of view, was to let
23 him know that I had notified Dr Kelly so that he
24 wouldn't find himself cornered -- not cornered,
25 approached -- without warning by somebody to say,

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1 "Dr O'Donohoe has notified us of an episode".
2 Q. But what would be the substantive basis, doctor, for
3 suggesting that if he wanted to add anything to the
4 notes, any new comment, as it's referred to here, what
5 would be the substantive basis for doing that? Why
6 would you suggest that?
7 A. I don't know for sure if I did suggest that or not.
8 I thought what you were asking me was: would it be
9 appropriate for somebody to add such information? If it
10 was dated and timed appropriately I don't believe that
11 would be misleading anybody. It would be wrong to
12 change something retrospectively. It would certainly be
13 wrong to write in that I had done X, Y or Z two days
14 ago. I certainly did not do that. That would not have
15 been something -- even in my own note, which has been
16 written, which has been criticised, I did not do that.
17 Q. By that stage in the piece, had it got round to Dr Malik
18 that there had been this error with regard to fluid
19 management?
20 A. I don't know. I don't recall it being raised. I don't
21 know whether he had been around in the hospital over the
22 weekend, for example. And I don't recall it featuring
23 in our conversation.
24 Q. So although this was an issue that had perturbed you to
25 the extent that you went and wrote this note and it

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1 A. I had asked for a review from Dr Kelly.
2 Q. You were approached by Dr Anderson to provide a report.
3 A. Yes. Can I just to be clear? There is a note which
4 says that Mr Fee and Dr Anderson discussed the review
5 with myself and a number of other people --
6 Q. Yes.
7 A. -- roughly, I think, a week after the episode happened.
8 I have no recollection of that meeting. I don't believe
9 that meeting ever happened. I don't believe I was ever
10 formally informed as to who was conducting the review.
11 Q. In terms of who asked you to provide a report or
12 a statement for the review, was that Dr Anderson?
13 A. He was the only person who approached me to provide
14 a statement. I don't think I was aware -- I'm sure
15 I wasn't aware at the time that he was part of the
16 review. He hadn't told me and I don't believe anyone
17 else had told me.
18 Q. And how did he approach you?
19 A. By letter, I believe.
20 Q. And I think we've asked you about this. You haven't
21 retained the letter?
22 A. I have looked at home and I can't find the original
23 letter.
24 Q. And the Trust has been asked in relation to that letter
25 and hasn't been able to provide it. Having said that,

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1 seemed to be at least part of the trigger, if not all of
2 the trigger, for contacting Dr Kelly, this error
3 in relation to fluid prescription wasn't something you
4 were bringing to Dr Malik's attention?
5 A. I don't think I drew -- I can't remember specifically
6 drawing it to his attention. What I was trying to draw
7 to his attention was that he was likely to be asked for
8 reports about what he had done. He may very well find
9 himself being asked to attend to discuss issues with
10 somebody who might be considerably higher in the
11 hierarchy than he was. That was the extent -- I didn't
12 discuss the substantive issues.
13 Q. But it seems surprising, doctor, that you wouldn't want
14 to have his take on it, wouldn't want to have his view
15 on it?
16 A. I don't think that it is surprising in the sense that
17 I had notified Dr Kelly. If I had continued to discuss
18 with everybody, I guess I would have been afraid of the
19 interpretation: here he is trying to persuade or cajole
20 people into saying things that he wants said. I tried
21 to refrain from, in any way, trying to influence what
22 people might say.
23 Q. You were informed shortly after the death, doctor, that
24 there was to be a review into the treatment of Lucy;
25 isn't that right?

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1 it has provided the correspondence that was issued to
2 nursing staff.
3 A. Yes.
4 Q. And what did the letter to the best of your recollection
5 ask you to do?
6 A. It was something like "a factual account of your
7 involvement on that night" or words to that effect.
8 Q. And did it draw any attention to the fluid issue?
9 A. Not that I recall particularly, I don't recall it
10 looking for a lot of details. When I previously
11 discussed issues within the paediatric department with
12 Dr Anderson, he tended to be fairly keen on a brief
13 summary. In retrospect, it might have been better if
14 I had told him everything including things that I didn't
15 think he wanted to know and let him filter it through
16 them himself. If I had been informed that he was the
17 Trust inquiry, then my attitude would have been
18 different.
19 THE CHAIRMAN: Sorry:
20 "If I'd been informed he was the Trust inquiry then
21 my attitude would have been different."
22 What did you think he was?
23 A. He was the clinical director.
24 THE CHAIRMAN: Yes. You have reported an event to Dr Kelly,
25 you have asked for a critical incident review to take

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1 place, Dr Anderson asks you for a statement setting out
2 the facts, but you didn't know that he was the Trust
3 inquiry?
4 A. No.
5 THE CHAIRMAN: How could you not?
6 A. I'm not sure that I understand. Dr Anderson was the
7 clinical director.
8 THE CHAIRMAN: Yes.
9 A. At best, he was uninvolved in the paediatric department.
10 When I had, in general, tried to raise issues of concern
11 when I'd first -- when he was first appointed, he had --
12 I won't say dismissed the possibility of any
13 involvement, but he didn't wish to be overly involved in
14 the paediatric section of the directorate. It was very
15 much, as far as I was concerned, a nominal role that he
16 played. And in that context --
17 THE CHAIRMAN: So he was the clinical director for -- is it
18 mothers and childcare?
19 A. Women and children.
20 THE CHAIRMAN: Thank you.
21 MR WOLFE: If we could have up on the screen the report that
22 you submitted to the review. 033-102-293. This is
23 preceded by a covering letter, which we don't need to
24 look at.
25 As we've established already, doctor, by the time

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1 A. Yes.
2 Q. -- and an explanation for that. It doesn't go on to
3 explain to the reader that there was now some
4 considerable doubt that she had ever received those
5 fluids.
6 A. It doesn't, no. I was writing a report in the terms
7 that normally Dr Anderson liked, as concise. I didn't
8 get any further requests from him to --
9 THE CHAIRMAN: Sorry, doctor, could you bring up beside that
10 on the screen the doctor's witness statement, 278/1,
11 page 8? You have just given me the reason why you
12 didn't include any more detail, which is that
13 Dr Anderson liked short factual reports: isn't that
14 right?
15 A. That was my recollection of the terms in which --
16 THE CHAIRMAN: Look at page 8. This is your written
17 response to the inquiry in January 2013 when these
18 questions were asked. Paragraph (d):
19 "If you knew at the time of writing your report for
20 Dr Anderson that Lucy hadn't received the fluid regime,
21 why did you omit to mention it? I cannot remember why."
22 A. Yes.
23 THE CHAIRMAN: "Why did you omit to state in your report for
24 Dr Anderson the fluids that Lucy actually received?
25 I cannot now remember why."

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1 you came to write this report in early May 2000, you
2 knew that Lucy had not received the fluid regime that
3 you had intended for her.
4 A. I had been informed by Dr Crean. I hadn't gone to
5 examine the issue in any detail. I hadn't spoken to any
6 of the nurses, for example, to try and find out who had
7 recorded what. So I don't know that I was in a position
8 to have reached a definitive conclusion about the fluids
9 by that stage. I hadn't heard about what enquiries had
10 been made.
11 Q. Did anybody tell you in advance of providing your report
12 that fluids were an issue that the review was going to
13 be examining?
14 A. I had recorded in the notes that Dr Crean had contacted
15 me.
16 Q. No, no. You missed my point. The review was focusing
17 on the issue of fluids and the fluid management of Lucy.
18 That was one of its primary considerations.
19 A. I'm sure it was. I wasn't informed as to the details of
20 the remit of the review. I had written Dr Crean's name
21 and an outline of the conversation, so the review could
22 not help looking at the fluid issue, I don't think.
23 Q. Yes. So we have your report. It tells the reader the
24 fluids that you had described or prescribed for Lucy,
25 isn't that right --

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1 Today you remember. Today you tell me it's
2 because: Dr Anderson liked short factual statements and
3 I didn't know he was doing the Trust report. So why did
4 you not give that information in the answers to the
5 inquiry in January this year?
6 A. I didn't know he wasn't doing the Trust inquiry.
7 I didn't connect that with the question that was being
8 asked.
9 THE CHAIRMAN: You're being asked specifically why you left
10 certain information out of the statement which is on the
11 left side of the screen.
12 A. Yes.
13 THE CHAIRMAN: Today you've given me two reasons for
14 that: one is that you didn't know that Dr Anderson was
15 doing the Trust inquiry, and the second is that in any
16 event Dr Anderson liked short factual reports. Those
17 are your reasons.
18 A. Yes.
19 THE CHAIRMAN: Those are precisely the questions that you
20 were asked in January and you couldn't remember why you
21 left out the information. When did you come up with
22 today's answers?
23 A. I can't remember what the ... what I was referring to.
24 There was never any --
25 THE CHAIRMAN: Do you agree that the questions on the

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1 right-hand side of the screen are entirely unambiguous?
2 Question (d) and (e), (f) and, for that matter, (g).
3 A. Yes, I think they're very clear questions.
4 THE CHAIRMAN: Thank you. We can move on, Mr Wolfe.
5 MR WOLFE: If you were seeking to write a statement in
6 accordance with the directions to you, which was to
7 provide a factual account, you could have provided much
8 more information about the fluid regime.
9 A. I could have provided him with much more information and
10 I should have provided him with much more information.
11 Q. So you could have provided information about your
12 suspicions that the child didn't get what you had
13 prescribed?
14 A. I could have drawn his attention specifically to that
15 conversation with Dr Crean. I don't know -- the screen
16 has gone blank -- I don't think I referred to the
17 discussions with Dr Kelly, for example. I don't think
18 I referred to any of the discussions with Dr Malik and
19 a number of other things. There was a lot of other
20 information I could have made available to him.
21 I did go to the -- I did write in there that the
22 sodium of 127 was not a level at which I thought
23 a hyponatraemic convulsion was very likely.
24 Q. I saw that, which indicates, doctor, that you were
25 giving some consideration to the role played by fluids.

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1 I would have anticipated as being an appropriate person,
2 a person who could see it through in great detail.
3 He had very little experience of paediatrics. He had
4 worked for most of his career in South Africa, only
5 having returned to Northern Ireland fairly recently, and
6 he had worked in private practice. I wouldn't -- if you
7 would ask me to pick somebody from the hospital who
8 might look into it, I don't think he would come anywhere
9 near the top of the list, to be honest.
10 Q. What did you think the purpose of your report was for?
11 A. For his own information --
12 Q. Right.
13 A. -- as clinical director in the sense of "things are
14 happening in my directorate".
15 Q. That went in and you thought it was for his benefit, for
16 his information?
17 A. Yes.
18 Q. You must have been curious as to when this investigation
19 was going to start.
20 A. Yes.
21 Q. Did you ask any questions about that?
22 A. Of Dr Anderson?
23 Q. Of Dr Kelly or Dr Anderson?
24 A. I spoke to Dr Kelly, I think, on three separate
25 occasions. The first one was when I notified him. The

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1 A. I was giving some consideration to the issue of the
2 sodium -- this is referring to the night in question.
3 Q. Yes.
4 A. You see any abnormal result, you're trying to figure out
5 what's the likely significance of that.
6 Q. Yes.
7 A. And I didn't attribute the significance that this
8 profound deterioration was related to this sodium level.
9 Q. And nor, for that matter, did you make any reference to
10 the fluids that you absolutely knew that she had
11 received after the collapse.
12 A. No, I didn't, no.
13 Q. Nor did you allude to in any sense at all the sequence
14 leading up to the bloods that were taken.
15 A. No. I had notified Dr Kelly and I understood those
16 issues were to be investigated.
17 Q. Well, what was the point of gathering a statement from
18 you for the purposes of an investigation if you're not
19 going to put the material down on paper?
20 A. I wasn't aware that this statement was for the purposes
21 of the investigation.
22 Q. Well, he --
23 A. I was never told he was part of the investigation.
24 Personally -- and I mean no criticism of Dr Anderson
25 when I say this -- I don't think he is somebody that

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1 second one, he informed me that Dr Quinn had been
2 approached.
3 Q. Yes.
4 A. And the third one was when he told me that Dr Quinn had
5 issued a report. No copy of the report was available to
6 me at that stage.
7 Q. And you didn't connect up the dots to realise that you
8 were contributing to a review, part of which was being
9 assisted by Dr Quinn's input?
10 A. I'm sorry, which dots are we ...
11 Q. You were asked by letter to provide a report.
12 A. By Dr Anderson, yes.
13 Q. Dr Quinn was on the other side of the review, carrying
14 out --
15 A. A review of the notes.
16 Q. -- some analysis of the notes?
17 A. Yes.
18 Q. Did you at any time join up the dots in order to
19 conclude that the statement that you provided was being
20 used as part of that review?
21 A. That was being sent to Dr Quinn, for example?
22 Q. Not sent to Dr Quinn necessarily, but was
23 a contribution -- your statement was a contribution to
24 the review.
25 A. No, I don't believe I was told that it was.

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1 Q. When it came to providing a statement for the purposes
2 of the coronial process in 2003, as we saw this morning,
3 you provided a statement to Dr Kelly, which referred to
4 the fluids that were given post-collapse, and you
5 provided a critique of that; do you remember that?
6 A. I do remember that, yes.
7 Q. We needn't bring it up on the screen. That was the kind
8 of information that you could have easily brought to the
9 attention of the review at the time in May 2000.
10 A. I could have, if I had been approached by -- first of
11 all, my recollection is that I had one letter from
12 Dr Anderson. I replied in the terms you have seen.
13 I wasn't approached further by him, neither by letter,
14 nor to discuss the issues further. If I had been asked
15 at the time, "How successful was your letter to
16 Dr Anderson?", I think not having had any further
17 enquiries, I would have thought I have judged what he
18 wants correctly and I have given him the information he
19 wants. He did not speak to me subsequently about the
20 matter, nor did he write to me subsequently about the
21 matter.
22 Q. Just so we're clear, because those who coordinated the
23 review have yet to give evidence: you didn't understand
24 that the report that you provided was a contribution to
25 the review?

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1 circumstances of, the deaths to those with parental
2 responsibility."
3 And we'll go on presently just to look at your
4 interaction with Mr and Mrs Crawford. But in this
5 context as well, if we could look at 19:
6 "Subject to your right not to provide evidence which
7 may lead to criminal proceedings being taken against
8 you, you must cooperate fully with any formal inquiry
9 into the treatment of a patient. You should not
10 withhold relevant information. Similarly, you must
11 assist the coroner or procurator fiscal when an inquest
12 or inquiry is held into a patient's death."
13 Could we skip to paragraph 23, two pages further
14 on?:
15 "Your duty to protect all patients. You must
16 protect patients when you believe that a doctor's or
17 other colleague's health, conduct or performance is
18 a threat to them.
19 "Before taking action, you should do your best to
20 find out the facts. Then, if necessary, you must follow
21 your employer's procedures or tell an appropriate person
22 from the employing authority, such as the director of
23 public health ..."
24 All of these principles, doctor, if I could take
25 them in the round, impose upon a doctor an obligation to

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1 A. I wasn't told who was doing the review. I would have
2 had no objection to the report being made available to
3 whoever wished to see it. It wasn't in any sense
4 reserved.
5 Q. You weren't directed to give information specifically
6 around the fluid regime.
7 A. Not that I remember, but I'll have to confess I haven't
8 seen the letter for many years now. I hadn't looked
9 into the fluids, I hadn't gone over the charts, for
10 example, with the nursing staff to try to identify who
11 had written what. It subsequently turns out that there
12 are various misprints and miscalculations and so on.
13 I didn't identify those; those were identified by other
14 people.
15 Q. And you weren't followed up on your report after
16 submitting it by Dr Anderson or anybody else?
17 A. No.
18 Q. The GMC have a guide called Good Medical Practice, which
19 discusses obligations of the medical profession in terms
20 of disseminating or disclosing relevant information.
21 Can I draw some of those paragraphs to your attention?
22 If we could have up on the screen, please, 315-002-009.
23 Under the heading, "If things go wrong", it says:
24 "If a patient under 16 died, you must explain, to
25 the best of your knowledge, the reasons for, and the

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1 disclose as much as possible about the cause of the
2 deterioration or the death of a patient; do you accept
3 that?
4 A. I do.
5 Q. And you had a lot more information that you could have
6 given --
7 A. To Dr Anderson.
8 Q. To Dr Anderson.
9 A. If I could say that I had notified Dr Kelly. I had not
10 had any approach -- Mr Fee and Dr Anderson may have --
11 they support that suggestion that they had talked to me
12 and others to tell us what was happening. Dr Anderson
13 approached me by letter, I believe, subsequently. There
14 was no announcement, "I am now the official -- or,
15 "Myself and Mr Fee -- who, I believe, were central to
16 this investigation -- were relevant. I had spoken to
17 Dr Kelly three times, and while I have no reason to
18 believe he had hidden this from me, I don't think that
19 Dr Anderson's name came up in the conversation at any
20 stage.
21 Q. You were subsequently shown a copy of the review and
22 Dr Quinn's report; is that correct?
23 A. I was, yes. That I think was probably in 2004.
24 Q. Was it not much sooner than that? You met with Dr Kelly
25 on 28 June 2000 to discuss Dr Quinn's report.

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1 A. Yes, he told me about the report. He didn't give me
2 a copy of it. I did ask if I could have a copy.
3 I think he told me he didn't have a copy available to
4 give me and I did ask to have a copy. I didn't see the
5 actual report until, I think, 2004.
6 Q. Could I have up on the screen, please, 033-102-271? If
7 we could highlight the bottom section.
8 This is Dr Quinn's report for the Trust, which you
9 say you didn't see until 2004.
10 A. That's my recollection, yes.
11 Q. As I say, Dr Kelly would say that he met you on
12 28 June 2000 to discuss Dr Quinn's report.
13 A. He did, yes.
14 Q. And --
15 A. I can't say the exact date, but I do recall meeting.
16 Q. Dr Quinn has recorded in his report that:
17 "Lucy was treated with Solution No. 18, which would
18 be appropriate."
19 Was that view shared with you by Dr Kelly?
20 A. I can't remember the words. It was words to the effect
21 that Dr Quinn has looked at the papers. I think the
22 fluids were referred to as -- fluids were not the issue
23 or were not the problem. Words to that effect. I did
24 ask to see the report so I could look at the analysis to
25 see if I could understand and clarify things in my mind.

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1 A. I don't think I saw it for some years. I think what he
2 probably said was "I'll let you have one when it becomes
3 available to me", or words to that effect. So I don't
4 know when he might have had the actual official
5 documents, for example.
6 THE CHAIRMAN: I'm sorry. If it wasn't even available to
7 Dr Kelly, what sort of discussion could Dr Kelly
8 possibly have had with you about the report?
9 A. It was a very brief and, I think, superficial
10 discussion, which is why I asked to see the written
11 document.
12 THE CHAIRMAN: Thank you.
13 MR WOLFE: If you'd been shown the report, which indicated
14 that Solution No. 18 was the appropriate fluid and that
15 the volume of Solution No. 18 was expressed as being
16 appropriate as well, you would have had problems with
17 that, would you?
18 A. It's not a very clear -- the paragraph you're showing
19 me -- and I may have forgotten other parts of the
20 report -- it says:
21 "She was treated with Solution No. 18, which would
22 be appropriate."
23 That would not be appropriate for all of the
24 treatments. It would not be the only treatment. If he
25 is saying that Solution No. 18 as a maintenance fluid

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1 But like I say, it was certainly some years before I saw
2 the report.
3 THE CHAIRMAN: Sorry, just pause there. You're saying that
4 on some date that you're not sure of, but Dr Kelly seems
5 to put in June 2000, Dr Kelly spoke to you about
6 Dr Quinn's report?
7 A. That's right, yes.
8 THE CHAIRMAN: And he told you in terms fluids aren't the
9 issue?
10 A. Yes. I'm not quoting verbatim, but --
11 THE CHAIRMAN: And you asked to see Dr Quinn's report?
12 A. That's right, yes.
13 THE CHAIRMAN: Did he refuse to give it to you?
14 A. No, my recollection is that he told me he didn't have
15 a copy of the report. Again, I don't think he said
16 this, but I think the sequence was that the
17 chief executive officer had contacted Dr Quinn. My
18 recollection -- and this is a rather dim recollection --
19 is that the report had come back to the chief executive.
20 Certainly Dr Kelly, I don't think, had a copy in his
21 hand when we were talking, for example, and I did ask to
22 have a copy of it.
23 THE CHAIRMAN: Did he say he would get one to you?
24 A. Yes, he did.
25 THE CHAIRMAN: And did he?

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1 for the maintenance part of the treatment was
2 reasonable, I would accept that. I saw this report
3 after having seen Dr Sumner's -- I believe I first saw
4 it after Dr Sumner's report and I think Dr Sumner's
5 analysis is very convincing and persuasive, so I've read
6 this report in the light --
7 Q. Dr Quinn is not saying that. He's been made aware that
8 the child received Solution No. 18 exclusively. By
9 contrast, you were aware that that wasn't the regime
10 that you had prescribed. You wouldn't have regarded
11 Solution No. 18 --
12 A. Not for a bolus, for the first section. The first hour
13 I'm referring to, I mean the bolus. Thereafter
14 Solution No. 18 would have been used by a lot of people
15 and I would have wished to see oral rehydration fluid as
16 well.
17 Q. Of course, but in your terms, doctor, Lucy had received
18 four boluses of Solution No. 18: 100 ml an hour running
19 from 10.30 until shortly after 3 o'clock.
20 A. I am sorry, yes. I see the point. No, that was not
21 what I intended. I don't think that was appropriate.
22 Q. And therefore, if you had seen this report -- and you
23 say you didn't see the report until probably 2004 --
24 upon reading it, you would have said, "This doesn't seem
25 appropriate to me"; is that fair?

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1 A. There are a number of respects in which -- if I'd seen
2 the report, I would have gone through it and would have
3 approached Dr Quinn to clarify. He seems to be willing,
4 for example, to accept the idea of cerebral oedema
5 without any underlying cause, without further
6 exploration with experts who might have some knowledge
7 of that. I'm sure he has seen relatively little
8 cerebral oedema, as I have, and has relatively little
9 knowledge of the topic.
10 Q. That's my point, doctor: that there doesn't appear to
11 have been interaction with you with regards to the
12 detail of this report.
13 A. No, no, there wasn't, no. Not at that stage.
14 Q. You had contact with Dr Hanrahan of the Royal in or
15 about 16 June.
16 A. I have seen reference to that. I have no recollection
17 of that meeting. I think it's very unlikely, I have to
18 say, but I don't know who -- I think I've said I had
19 such a meeting. I don't know where that idea came from.
20 Q. Could I have up on the screen, please, 030-007-012?
21 This is an extract from Mr Mills, chief executive of the
22 Sperrin Lakeland Trust, his file, 16 June 2000,
23 according to this key date timeline:
24 "JOD had informal meeting with Dr Hanrahan,
25 paediatrician in Belfast, and discussed the PM report."

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1 Q. Do you know why he wanted you to see them again?
2 A. No, I don't think he gave me any specific indication.
3 Q. You explained to him that you'd rather await the receipt
4 of the post-mortem report?
5 A. Yes. I hadn't seen a discharge summary, for example,
6 and I don't think I'd seen the post-mortem report at
7 that stage. So in reality, I would have heard about
8 Dr Quinn's -- I think the meeting ... I think the
9 meeting with Dr Kelly would probably have preceded that
10 meeting with the parents. I'm not 100 per cent sure.
11 Q. No, no, the meeting with Dr Kelly happened towards the
12 end of the month.
13 A. Did it? Okay, there may have been --
14 Q. There were other meetings with Dr Kelly, which we'll
15 briefly turn to.
16 A. I'm sorry, what was the ...
17 Q. The follow-up question was: it doesn't appear that you
18 had a second meeting with the parents --
19 A. I didn't, no.
20 Q. -- upon receipt of the post-mortem report? Why not?
21 A. I don't know when I received the post-mortem report.
22 I've been slightly confused by the fact that there are
23 a number of post-mortem reports referred to and addenda
24 to them, and certainly none were sent to me. I think
25 I may have acquired a copy of a post-mortem report,

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1 A. I don't recall any such meeting, and I -- this is what
2 I was referring to.
3 Q. In fairness, I think Dr Hanrahan has expressed the same
4 view; he doesn't know anything about this.
5 A. I would agree with that. I can't say how this came to
6 be.
7 Q. Is there any -- did you give anybody any basis for
8 thinking you did ever meet him in Belfast?
9 A. Not in this context. If somebody had said, "Have you
10 met Dr Hanrahan?", clearly I might have met him on
11 occasion, but I have no recollection of that issue being
12 raised in this context.
13 Q. In the PICU notes for Lucy for 14 June, in other words
14 two days previously, Dr Hanrahan recorded that he
15 contacted you and that you would see Lucy's parents
16 again, but you would rather await the post-mortem
17 report. So you had already seen Lucy's parents
18 in May --
19 A. That's correct.
20 Q. -- and Dr Hanrahan was contacting you again to ask if
21 you would see the parents again?
22 A. Yes.
23 Q. Do you remember that?
24 A. I do remember that conversation as having happened.
25 I can't date it very precisely.

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1 possibly from the GP, but I don't believe one had been
2 sent to me directly, and I don't know which one -- when
3 I did see it, I don't know which of the versions of the
4 post-mortem I've seen referred to would have been
5 involved.
6 Q. You wrote to Dr Kelly upon receiving the post-mortem
7 report; isn't that right?
8 A. I may very well have done. I don't remember that
9 particular letter.
10 Q. I will bring the reference up when I find it, but it
11 seemed to be -- you wrote into that note to Dr Kelly
12 that:
13 "The post-mortem report had emphasised the
14 importance or significance of bronchopneumonia."
15 A. I remember now, yes.
16 Q. And you had difficulty understanding or following
17 that --
18 A. That's right.
19 Q. -- because the suggestion was that the bronchopneumonia
20 was of some duration?
21 A. That's right, yes.
22 Q. Do you remember that?
23 A. I do, yes.
24 Q. And why did that surprise you? Why did it surprise you
25 that the post-mortem report was focusing on that issue

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1 and suggesting that it was of some duration?
2 A. The fact that there were findings of pneumonia on the
3 post-mortem report didn't surprise me very greatly. As
4 I understand it, that's not an uncommon occurrence in
5 people who have been intubated and ventilated. I wasn't
6 aware that you could date the duration of those changes
7 in any way from the changes on the -- that the
8 pathologist would have seen. I didn't know it was
9 possible to do that.
10 Q. Well, it was your understanding that clinically there
11 was no evidence of pneumonia.
12 A. That's right.
13 Q. In fact, chest X-rays and --
14 A. Was clear, as I recall.
15 Q. Yes.
16 A. So I couldn't ... I think I used a phrase -- I didn't
17 know what to make of that, and that's literally --
18 I couldn't figure out how to address that issue.
19 Q. Upon receipt of the post-mortem report, which you
20 obviously received in June in order to write to Dr Kelly
21 in those terms, why didn't you then meet the parents?
22 A. I don't remember to be honest about it. I think I may
23 have had a subsequent meeting with Dr Kelly later on.
24 I don't know whether I was looking for further
25 information, whether I was hoping I would have

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1 version that's been given to me.
2 You arrange to meet them in May. That meeting is
3 entirely unsatisfactory because you don't have the
4 hospital notes with you. You're asked by Dr Hanrahan to
5 meet them again, you said you will do that, but will get
6 the post-mortem report first. You get the post-mortem
7 report and then you don't meet Mr and Mrs Crawford.
8 What is complicated about that scenario?
9 A. There's nothing complicated about it. I should have met
10 with them again and I can't explain why I didn't.
11 MR WOLFE: You see, what Mrs Crawford explains in her police
12 statement is that the meeting with you in May 2000 was
13 arranged with one week's notice.
14 A. That's correct.
15 Q. They asked you for the meeting rather than you seeking
16 them out and arranging a meeting.
17 A. That's correct, I believe, yes.
18 Q. And notwithstanding the facility of one week's notice
19 before the meeting took place, you still arrived without
20 the notes, which seems rather surprising in all of the
21 circumstances.
22 A. I'm not sure that I would have seen it as an omission as
23 the parents did in the sense that I wasn't aware that
24 anything very much would have changed with the notes.
25 But it wasn't a question of making that decision; it was

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1 a discharge summary of investigations and so on.
2 I don't remember.
3 Q. You see, doctor, the impression to be formed from the
4 first meeting with the parents in May 2000 was that that
5 was, from the parents' perspective, a rather unhappy
6 event in that you presented yourself at the meeting
7 without Lucy's notes --
8 A. Yes, that's correct.
9 Q. -- and were unable to answer any of their questions,
10 it seems --
11 A. It was a very unsatisfactory meeting from their point of
12 view. I have no doubt about that whatsoever.
13 Q. But what you --
14 THE CHAIRMAN: Does that not make it all the more important
15 that you meet the parents in a more satisfactory manner
16 after you've received the post-mortem report, which you
17 said you were waiting for before you would see them?
18 A. I honestly can't remember making a decision one way or
19 the other. I just don't know what my thought processes
20 were at that stage.
21 THE CHAIRMAN: I'm sorry, doctor, but it seems to me the
22 thought processes can't really be that complicated.
23 These are parents who have lost a child who was
24 previously healthy in circumstances which are rather
25 difficult to understand or explain, if I take the

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1 a question of not being able to find the notes on the
2 day, as I recall. When I went looking for them --
3 I don't remember when I started looking for them. I may
4 not have responded as quickly as I should have.
5 Q. But it seems, on the account that they provide, that
6 your answer to their various queries was rebuffed on the
7 basis that you couldn't provide an explanation because
8 you didn't have the notes.
9 A. I don't think I said I couldn't explain because I didn't
10 have the notes. They may have understood I couldn't,
11 they may have concluded I couldn't understand them
12 because I hadn't the notes, and if I had the notes I
13 would have had answers. I don't actually believe that
14 I would have been able to be any great deal clearer with
15 them if I had had the notes in my hand. I did tell them
16 that I had asked Dr Kelly, as the medical director, to
17 look into the matter at the first meeting, and that was
18 my attempt -- and clearly a very feeble and
19 unsatisfactory attempt -- to say that this is not
20 a matter which I would regard as something that can just
21 be forgotten.
22 Q. The thing that you could have told them is that there is
23 now a review under way and one of the things that the
24 review might be looking at is the error that has
25 occurred in relation to fluid management.

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1 A. When I was referring it to Dr Kelly, what I was alluding
2 to was the fact that the circumstances were going to be
3 reviewed. I didn't, as far as I remember, refer to
4 Dr Crean's conversation with me, and I should have done
5 so so that they would be aware that this was not just an
6 undirected -- that there was a beginning to it, as it
7 were, and that there was a process, even if I didn't
8 know what that process was.
9 Q. Do you know or can you recall why you didn't tell the
10 parents about the fluid problem as you then understood
11 it?
12 A. No, I don't remember. I don't remember making
13 a decision not to tell them. The message that I was
14 trying to impart was that this was a circumstance I did
15 not understand. I had asked Dr Kelly to examine the
16 issue. I don't know if I used the word "review". And I
17 think when the parents subsequently heard that a review
18 had been undertaken, they were very surprised, so my
19 choice of words may also have been very unhelpful to
20 them in that regard.
21 THE CHAIRMAN: Their surprise was that the review was
22 carried out without their input.
23 A. Yes, but that was not my doing. I think they were
24 surprised that there had been a review. I don't know
25 that they had realised when I had used the phrase that I

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1 duration, did you speak to him about that conclusion?
2 A. About which conclusion?
3 Q. The conclusion in relation to the bronchopneumonia or
4 the finding in relation to the bronchopneumonia.
5 A. I'm sorry, I'm not understanding the question.
6 Q. You wrote to Dr Kelly in relation to the
7 bronchopneumonia.
8 A. Yes. That's right.
9 Q. Did you speak to him about it?
10 A. Um ... I don't recall speaking to him about it, no.
11 Q. In September 2001, Dr Kelly recalls that you met with
12 him to discuss the Royal College report that had been
13 conducted by Dr Stewart; do you remember that?
14 A. I do. I don't remember it in great detail, but I do
15 remember the meeting, having a meeting with him.
16 Q. Were you provided with a copy of that report?
17 A. I think I was provided with a copy of a summary report.
18 I don't think I was provided with the documents on which
19 it was based. I think I was provided with the report
20 about that issue, yes.
21 THE CHAIRMAN: That means you saw the report, but not the
22 attached statements and so on?
23 A. That's what I'm trying to get at, yes.
24 THE CHAIRMAN: Okay.
25 MR WOLFE: Could I have up on the screen, please,

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1 had notified Dr Kelly or I had asked Dr Kelly to look
2 into it that that's what I was alluding to. I can
3 understand why that would be the case that would be my
4 fault for not being clear enough that that was a review.
5 MR WOLFE: Could I touch upon a number of other discussions
6 briefly that you had with Dr Kelly?
7 Just for the avoidance of doubt, it was 26 June 2000
8 that you wrote to Dr Kelly in relation to the
9 post-mortem report. When you received the post-mortem
10 report, you would have observed that hyponatraemia was
11 referred to as part of the background or the history,
12 the clinical history. What did you make of the report
13 in that it didn't reach any definitive conclusions
14 in relation to the death?
15 A. It left it as an unexplained cerebral oedema of
16 unexplained cause. Hyponatraemia can just be used to
17 mean a sodium outside the normal range. So I didn't
18 think that it -- to quote the phrase we've used before,
19 I don't think that that joined up the dots for me
20 either. I don't think that was explicit in saying this
21 is the sequence of events from the documents, from my
22 recollection of reading it.
23 Q. Apart from explaining to Dr Kelly that you didn't know
24 quite what to make of the bronchopneumonia and the
25 reference to it, the suggestion that it was of some

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1 036A-025-056 and, alongside that then, 057? Within her
2 report Dr Stewart is looking at several possible
3 explanations for Lucy's deterioration. At (ii) on the
4 left-hand side she says:
5 "Lucy had a seizure-like episode due to underlying
6 biochemical abnormality. Initial sodium was 137,
7 potassium 4.1, at 10.30. At 3 am, after administration
8 of Solution No. 18, the repeat sodium was 127, and
9 potassium 2.5."
10 She has left out of the equation the administration
11 of the normal saline:
12 "Biochemical changes are often well-tolerated and
13 easily corrected with appropriate fluid replacement,
14 although these results do show a change over
15 a relatively short period of time."
16 Was that particular conclusion or any of the
17 conclusions set out in this page discussed with you?
18 A. It depends on how you read that, I suppose. What
19 I would read that to say is biochemical changes are
20 often well-tolerated and easily corrected. The
21 implication that I would have read from that -- and this
22 may not be what she intended -- was that she was not
23 looking at the sodium of 127 as being profoundly
24 important; she was drawing attention to the fact that it
25 could cause a seizure, but on the other hand saying it

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1 could be well-tolerated. So in terms of a child that
2 had deteriorated that catastrophically, that's not what
3 I see her saying.
4 Q. My question to you was: was that discussed with you?
5 Did you discuss it?
6 A. I can't remember the discussion in detail. I don't know
7 what points were gone over. No, I don't remember.
8 Q. In her witness statement to this inquiry, doctor,
9 Dr Stewart has said that in a subsequent conversation
10 with Dr Kelly in relation to this report, she made it
11 plain to him that the change in electrolytes resulted
12 from administration of Solution No. 18. She says
13 that is her recollection, that she conveyed that to
14 Dr Kelly. Have you any recollection of that being
15 conveyed to you at your meeting with Dr Kelly?
16 A. No.
17 Q. Could I move you forward a year to September 2002 and at
18 that time, according to Dr Kelly, you met with him to
19 discuss the second Royal College report? If I could
20 have up on the screen, please, 036A-150-312. Under
21 the heading "Poor documentation" -- the other pieces of
22 the document are redacted for issues of relevancy:
23 "The prescription for the fluid therapy for
24 Lucy Crawford was very poorly documented and it was not
25 at all clear what fluid regime was being requested for

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1 Q. And the implication of this report is that this was
2 triggered by hyponatraemia; is that not fair?
3 A. I would agree, reading that now, knowing what I do.
4 I can't remember reading it as clearly as that at the
5 time or it being drawn to my attention in those
6 black-and-white terms.
7 Q. That's the point I wanted to get to. Was this drawn to
8 your attention?
9 A. I don't recall it being drawn to my attention in
10 black-and-white terms, nor do I remember recognising
11 that in such stark terms.
12 THE CHAIRMAN: Were you given a copy of this document?
13 A. I don't remember being given a copy of it. I'm saying
14 I don't remember that being drawn to my attention
15 verbally or by documentation being sent for my review.
16 I may have been given a copy of it, but I don't remember
17 and I haven't been -- I don't have a copy at home is all
18 I can say.
19 MR WOLFE: We had a discussion this morning about when you
20 saw the Ted Sumner report, the Dr Ted Sumner report.
21 A. Yes.
22 Q. It would appear that you were shown that report, doctor,
23 before you composed your letter to Dr Kelly
24 in August 2003.
25 A. Remind me which that is to Dr Kelly.

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1 this girl."
2 That's a criticism of the prescription procedures --
3 A. And I accept that criticism, yes.
4 Q. And going into the substance of it:
5 "With the benefit of hindsight, there seems to be
6 little doubt that this girl died from unrecognised
7 hyponatraemia, although at that time this was not so
8 well-recognised as at present."
9 Leaving aside the "unrecognised" bit and "with the
10 benefit of hindsight", just on that issue of the
11 conclusion that it was hyponatraemia that was the cause
12 here, was that discussed with you in 2002?
13 A. I don't remember it being discussed in detail. What
14 strikes me about reading that now -- and I don't know
15 whether it struck me at the time -- is that that talks
16 about hyponatraemia and doesn't refer to the cerebral
17 oedema as being due to the hyponatraemia. So it's
18 not --
19 Q. Is the link not implicit?
20 A. The link may be implicit if you know what link you're
21 intending to make, but in a report of that sort I'm not
22 sure implicit links are what's being looked for.
23 Q. Well, we know that cerebral oedema led to coning and
24 brainstem death.
25 A. That's correct, yes.

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1 MR GREEN: 047-053-148. That's the first page of the
2 letter. If we could pull that up, please. You see on
3 the screen that that is dated 21 August 2003, and it's
4 directed to Dr Kelly. If we go on to the second page,
5 which is 149, at the top it reads:
6 "You have supplied me recently with a copy of
7 Dr Sumner's report. I would remind you of the
8 article ..."
9 And then it's signed off "Dr JM O'Donohoe". The
10 point is that this appears to suggest that Dr O'Donohoe
11 must have seen Dr Sumner's report before the inquest.
12 THE CHAIRMAN: Thank you.
13 MR WOLFE: You see that, doctor?
14 A. I do.
15 Q. And you accept it?
16 A. I accept it is my letter. I have written that, yes.
17 Q. And you accept that you must have seen Dr Sumner's
18 report?
19 A. That is the inevitable logic of what I have written,
20 yes.
21 Q. Of course. And just to tidy up this for us, I have
22 taken you through a number of reports, the two Royal
23 College reports, and you, if I may say so, demonstrated
24 a vagueness in terms of your memory of whether you saw
25 either of those reports or whether you heard about the

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1 conclusion contained in them in relation to the cause or
2 the potential cause of this child's death; is that
3 a fair synopsis?
4 A. Yes, I think so, yes.
5 Q. In the points I have put to you arising out of the Royal
6 College reports, they seem to point the finger at fluid
7 management as being part and parcel of the deterioration
8 in Lucy's condition --
9 A. The second report particularly.
10 Q. Yes. And if Dr Stewart is right in her witness
11 statement about what she said to Dr Kelly and if that
12 had been reported to you, can I suggest to you that that
13 might have stood out in your mind or should have stood
14 out in your mind?
15 A. It should have stood out in my mind. I have to say it
16 doesn't stand out in my mind. I don't recall that
17 sequence of events you have described.
18 Q. Were you ever shown a report produced by Dr Jenkins that
19 raised a suggestion --
20 A. I have seen his report, but I can't remember at what
21 stage I saw that report.
22 Q. When do you think the conclusion was reached by you that
23 fluids were the cause here?
24 A. I have made reference -- and I think Dr Hanrahan has
25 made reference -- to a discussion I tried to initiate

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1 a residual doubt in your mind about the --
2 A. It wasn't doubt in the sense of trying to argue or say
3 that everybody's wrong except me; what I was trying to
4 do is understand what this meant. For example in terms
5 of a sodium of 127, the next time I saw it, how do
6 I understand it, do I take a sodium of 127 to be
7 a galloping emergency every time I see it or is it
8 something that one can -- how to -- to try and put the
9 whole picture together. I hadn't a chance, as far as I
10 recall, to discuss this with anybody else who might be
11 able to clarify those sorts of --
12 Q. Of course, the findings of the learned coroner didn't
13 depend upon reaching a conclusion on whether the serum
14 sodium was much lower than 127.
15 A. I don't remember the conclusions well enough to make any
16 comment on that. I'm not sure that I quite understand
17 the point you're making.
18 Q. The point I'm making is that you seem to be saying that,
19 in December 2004, based upon your consideration of all
20 the materials that were available to the coroner and
21 researches you might have done yourself, that you
22 reached a view that the fluids could have been much
23 lower or at least somewhat lower than 127 --
24 A. Yes.
25 Q. -- and that caused the penny to drop, if you'll forgive

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1 with him, in -- I think it's December 2004 -- in which
2 I wanted to try to discuss with him the issues of
3 hyponatraemia and cerebral oedema and so on.
4 Q. Yes. He touched on this in his evidence yesterday, and
5 he said that you were at a study day in December 2004 --
6 A. That sounds right, yes.
7 Q. -- some months after the inquest verdict had --
8 A. That's right, yes.
9 Q. -- identified dilutional hyponatraemia as the cause.
10 A. That's right, yes.
11 Q. And are you saying it was only in that meeting
12 in December 2004 that you reached the view?
13 A. I was trying to understand what impelled me to talk to
14 him. It was trying to initiate a discussion. I was
15 still trying to understand the 127 sodium and the very
16 profound deterioration. I thought Dr Hanrahan, as
17 a paediatric neurologist, would be able to say to me
18 "127 actually, it turns out, is enough to cause that
19 profound a degree of cerebral oedema", or not, that he
20 might have been able to bring some clarity. So there
21 must have been residual questions in my mind to have
22 even raised that topic with him.
23 Q. So even though you had seen Dr Sumner in 2003, you had
24 heard the inquest verdict, which pointed the finger very
25 sharply at the fluid mismanagement, there was still

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1 the euphemism, with you?
2 A. That's right, yes.
3 Q. And what I'm saying to you is that the report submitted
4 by Dr Sumner, who was the coroner's expert, raised
5 a lower serum sodium as a possibility, but that wasn't
6 the cornerstone of his report.
7 A. I don't think I said I thought it was the cornerstone of
8 his report. I'm saying that's the impact it had on me;
9 not that that was what Dr Sumner -- I'm sorry.
10 Dr Sumner's analysis I found was very clear and what he
11 had said -- and he just dropped in the suggestion of the
12 lower sodium because there was no lower measurement.
13 But in terms of a very severe cerebral oedema, if it is
14 possible that the sodium was much lower, then it starts
15 to make sense that such a catastrophic deterioration
16 would -- I could understand as against a sodium of 127.
17 Q. Yes. But the import of the coroner's findings is that
18 even on the basis of a 127, you could still have
19 a cerebral oedema sufficient to cause brainstem death.
20 A. I don't remember that shape to it, if I can put it like
21 that, and if I had, that may have very well been what
22 precipitated the conversation with Dr Hanrahan. Trying
23 to understand 127 is not a terribly rare sodium, one
24 does see it from time to time. Does that mean every
25 time that happens -- what is the implication of that?

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1 Should that child be taken for an immediate CT scan, and
2 ventilated and mannitol and hypertonic saline
3 administered?
4 Q. In any event, at this meeting with Dr Hanrahan, you seem
5 to indicate that he was not convinced that the sodium
6 was any lower.
7 A. I don't think he gave a clear yes or no. That
8 question -- we didn't reach a -- there wasn't
9 a conclusion reached, as far as I recall.
10 MR WOLFE: Doctor, I have finished my questions. I look
11 round the room to see if --
12 MR QUINN: There's a matter I want to raise. There was
13 a reference earlier in the day, and I will just find it
14 for the inquiry. It's at page 34 of the [draft]
15 transcript into page 35 at line 22 to line 3 on page 35.
16 The witness said that he didn't see Dr Sumner's
17 report until after the inquest, but there was a Trust
18 meeting with senior counsel and there was a two-page
19 summary of what the Trust had done in terms of Trust
20 enquiries.
21 That strikes me as to be an issue directly
22 concerning governance because, according to the
23 witness -- I don't know what this document is -- it
24 relates to the Trust enquiries and he has received the
25 document. So therefore, I would assume that it would be

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1 want. I have to say to you, as I do to others, you
2 don't have to. You've explained your position with all
3 your strengths and weaknesses since about 10 o'clock
4 this morning. So if there's nothing you want to add,
5 don't feel obliged to add anything, but if you do want
6 to add anything more, you're free to do so.
7 A. May I take this opportunity to officially record my
8 apologies to all of those whose lives have been
9 adversely affected by what I have done when I shouldn't
10 have done it or what I haven't done when I should have
11 done.
12 THE CHAIRMAN: Thank you very much indeed. You are free to
13 step back.
14 (The witness withdrew)
15 Ladies and gentlemen, that brings an end to today.
16 Just to give you one piece of information. Tomorrow on
17 the witness schedule we have Dr Hicks, who will be here,
18 Sister Traynor, who will be here, and Dr Malik.
19 Dr Malik won't be here. Dr Malik is living and working
20 in Pakistan. We asked him in December last year to give
21 the inquiry a witness statement and all the parties have
22 the witness statement which was received from him on
23 2 May.
24 In between that time, Dr Malik confirmed to the
25 inquiry, by phoning us on 3 January, that he had

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1 in general circulation among those who attended that
2 meeting when senior counsel --
3 A. If I could clarify, I am not sure if I was physically
4 given a copy of it or whether I saw that such a document
5 existed.
6 THE CHAIRMAN: That's okay. If we go back to today at
7 page 34 [draft]. The witness said:
8 "My recollection is the Trust held a meeting with
9 senior counsel and invited a number of members of staff
10 who were to attend the inquest to attend and then gave
11 us a copy of, I think, a two-page statement, a two-page
12 summary of what the Trust had done in terms of the
13 Trust's enquiries."
14 Okay. We'll pick up the point and see if that's
15 in the --
16 MR QUINN: I'm only putting the point out there. I think
17 it's appropriate at this stage to raise the issue.
18 THE CHAIRMAN: Can we look at that overnight, Ms Simpson?
19 I'm sure it's in that file that we already had before.
20 If we could look at that overnight.
21 Is there anything else before I come to Mr Hayton?
22 MR HAYTON: No questions.
23 THE CHAIRMAN: Doctor, thank you. That brings an end to
24 your evidence. I have developed a habit of inviting
25 people at the end of their evidence to add anything they

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1 received the request for a witness statement. Despite
2 that confirmation and despite further reminders from us,
3 he did not provide any witness statement until 2 May.
4 He was then asked for some follow-up questions in
5 a further statement, which was issued on 8 May, and
6 he was written to again on 20 May, but he has failed to
7 respond to any further contact, whether by phone call at
8 the number that we previously had for him, or by e-mail.
9 I'm afraid in those circumstances he will not be here
10 tomorrow. I cannot compel anyone in Pakistan to respond
11 to calls or e-mails, but I will be taking this further
12 and reporting this to as many governing bodies as I can
13 because, in light of what he has previously said,
14 I regard it at least as hugely unhelpful to this inquiry
15 for him to engage belatedly and in part and then to
16 withdraw his support for the inquiry.
17 Unless there's anything further, we'll adjourn until
18 tomorrow morning at 10 o'clock. Tomorrow we will deal
19 with the issue about Professor Kirkham and the extent of
20 any further use of Professor Kirkham, and, Mr Quinn, if
21 it's convenient, I will also deal with a couple of
22 issues which have been raised on behalf of Mr and
23 Mrs Roberts about outstanding points and we'll try and
24 tidy that up tomorrow. Thank you very much.
25 (4.13 pm)

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1 (The hearing adjourned until 10.00 am the following day)
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1 I N D E X
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3 DR JARLATH O'DONOHUE (called)3
4 Questions from MR WOLFE3
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