Monday, 24 June 2013

(10.00 am)

(Delay in proceedings)

(10.15 am)

THE CHAIRMAN: Good morning.

MR WOLFE: The next witness is Mr Kevin Doherty, please.

MR KEVIN DOHERTY (called)

Questions from MR WOLFE

MR WOLFE: Good morning, Mr Doherty.

A. Good morning.

Q. You have so far provided the inquiry with one witness statement; it's dated 2 May 2013 and it's numbered 313/1.

A. Mm-hm.

Q. We ask all of our witnesses this: do you wish to adopt that witness statement as part of your overall evidence to be read in conjunction with your oral testimony today?

A. Yes.

Q. At the time we are most interested in, which is the period at or about 2000/2001, you were head of litigation services for Westcare?

A. I was litigation services manager attached to Westcare, yes.

Q. You're now head of litigation services; is that correct?

A. I'm still litigation services manager.

Q. Right. The title "head of litigation services", where does it emerge from?

A. I'm not quite sure. We maybe refer to it one day as litigation services manager and the next as head of litigation services. They're both the same role.

THE CHAIRMAN: There's no difference?

A. There's no difference.

MR WOLFE: Thank you. The job description which I was wishing to bring you to has "Head of litigation services" on it.

A. Sorry about that.

Q. That's your job description?

A. Yes.

THE CHAIRMAN: That's your job apparently?

A. That's my job apparently. I don't mind what I'm called as long as they're paying me!

MR WOLFE: Just looking at that briefly, please. You were appointed to this post on 1 May 1997.

A. Yes.

Q. And as I say, let's look at your job description briefly, 319-042a-013. Perhaps before we delve into the detail of that, Westcare Business Services, could you tell us something about that organisation and its interrelationship with the three trusts?

A. Yes. Westcare Business Services was a -- supplied a number of services to the three different trusts, including finance, litigation and various other ... We were a support services organisation.

THE CHAIRMAN: Before the trusts were established, did Westcare Business Services exist?

A. It did.

THE CHAIRMAN: Under the Western Board?

A. Sorry, it was a separate entity from the Western Board.

THE CHAIRMAN: Is it a company?

A. It was -- the idea behind it was to bring all the support services together and to share them out with the various trusts. It's not a company as such, no. We were still part of the Health Service.

THE CHAIRMAN: And you're a civil servant?

A. Yes.

THE CHAIRMAN: Right.

MR WOLFE: As we can see within the job description that's up in front of us, a little bit of detail there about the role of Westcare Business Services. As you've just said, it provides a range --

A. Sorry, it's not up in front of me.

MS SIMPSON: I think it isn't in front of the screen for the witness. If he could be shown that. (Pause).

MR WOLFE: What you should have in front of you is the job

description.

A. Yes.

Q. Where I'm bringing you to on this page is 013 of this series. If you can confirm you're on the right page.

A. Yes.

Q. I'm obliged. We're dealing with that section halfway down, which sets out the background to the organisation. It tells us that:

"Westcare Business Services provides a range of support services to the Western Board."

And then to the three trusts as they then were.

A. Yes.

Q. That is the Altnagelvin, the Foyle and the Sperrin Lakeland?

A. Yes.

Q. And then the background piece tells us a little bit about the litigation service --

A. Mm-hm.

Q. -- which you were to manage?

A. Yes.

Q. And it's described as:

"An important component of Westcare, providing specialist legal services to the trusts, the board and Westcare Business Services. It is owned by a consortium of the trusts and the board and is accountable to them."

A. Yes.
Q. Then just looking at the purpose of your job:
"The head of litigation services will be accountable to the general manager for the provision of quality services to the trusts and the board in accordance with the legal services service level agreement."
A. Yes.
Q. If we could go over the page, please, to 014, it says:
"The postholder will be responsible for the development and management of the required procedures and processes necessary to deal with all of the issues arising out of claims of medical negligence."
A. Yes.
Q. And then it sets out, under heading 1, your main responsibilities where there's a professional negligence claim being brought. There are other types of claims, as we can see at 3, and you had a role in public and employer liability type situations.
A. That's correct.
Q. Could I ask you this: you are not a solicitor; is that correct?
A. No. I'm an administrator and purely an administrator and I would not have taken any decisions in relation to the law. I'm purely an administrator.
Q. As we understand it then, the legal advice that was

received by the Sperrin Lakeland Trust in association with any matter arising out of Lucy Crawford's death was provided by the Directorate of Legal Services?
A. Yes, that's correct.
Q. And your role, as we will observe by reference to a number of specific episodes, was to provide a link between the trusts and the Directorate of Legal Services?
A. That's correct. Yes, mm-hm.
Q. Is that an accurate way to summarise it?
A. That's an accurate way to summarise it, yes indeed. We were a go-between.
Q. You tell us in your witness statement that you first became aware of the death of Lucy Crawford when a claim was received from Murnaghan & Fee.
A. That's correct, yes.
Q. And information around that would have been directed to your attention via the Trust?
A. That's correct, yes.
Q. I want to look briefly this morning at a number of the tasks that you had to undertake as part and parcel of your job. The first issue I want to look at is in relation to ascertaining whether there was to be an inquest in relation to Lucy's death. Could I ask you to look at a chronology, which you appear to have been the

author of, and I'll just ask you to establish that for me. It's 047-104-233.
This is a memorandum that you're sending to Ms O'Rawe in the Sperrin Lakeland Trust --
A. Yes.
Q. -- and it's dated 26 July 2004, which is about five or six months after Lucy's inquest.
A. Mm-hm.
Q. The subject matter is "LC case: RCA exercise."
That's the root-cause analysis exercise. Just to orientate you, and you may know this very well, there was to be a root-cause analysis carried out after the inquest; isn't that right?
A. That's correct, yes.
Q. And you say you're enclosing:
"... a chronology of key steps or actions and interactions from the litigation perspective."
A. Mm-hm.
Q. We'll look at the chronology now. How have you pulled that chronology together?
A. I would simply have gone through the files that we had and put it together from there, from correspondence or whatever in the files.
Q. So that's the litigation files?
A. Yes.

Q. And there is a note there: is that in your hand or is that in someone else's?
A. No, that's Bridget O'Rawe's hand.
Q. It says:
"Tie up with my RCA file on the Lucy Crawford case, along with ..."
THE CHAIRMAN: "Please receipt to Kevin".
A. Yes.
MR WOLFE: So in terms of the purpose of the document we're now going to look at, you've been asked to bring together a chronology of the main events as you can interpret them from the documents available to you?
A. Yes.
Q. And your primary source is the litigation file that you would have been managing?
A. Yes.
Q. And then if we could go over the page, please, to 234. We'll see reference to a scrutiny committee as we work through this. Help us please: what was the scrutiny committee?
A. The scrutiny committee was a committee made up by Trust personnel who basically would meet and decide how to take claims forward.
THE CHAIRMAN: Were you a member of the scrutiny committee?
A. I was, chair, yes. I would basically -- in an

administrative role again, a non-decision-making role.
THE CHAIRMAN: I think from some documents we've seen, DLS would be represented at those meetings?
A. Yes, they would. There would have been someone from DLS, there would have been the medical director, there would have been the director of corporate affairs, Bridget O'Rawe, and a finance representative from the Trust along with myself.
THE CHAIRMAN: Thank you.
MR WOLFE: Let's move away from this document for a moment and pull up 319-042a-005. This, sir, is the second page of a document which you supplied to us via the DLS. It's called "Claims management policy, September 2003", and this is version 3 of the policy.
A. Mm-hm.
Q. So there were a number of versions of this policy that pre-dated this version?
A. There would have been, yes.
Q. And I think you tell us through DLS that this is the only version that can now be found?
A. Yes.
Q. But help us with this: you can see at the bottom of the page a reference to "claims review", and then it sets out a reference to the claims scrutiny committee.
A. Yes.

Q. That's what we're talking about; isn't that right?
A. Yes.
Q. And then it tells us that the committee, I suppose, the purpose of it is to:
"Progress all the necessary tasks required to successfully defend and settle claims with an estimated value in excess of £25,000 or graded 'priority one'."
A. Mm-hm.
Q. So claims of reasonably high value or important claims for some other reason?
A. Yes.
Q. And then the composition of the committee is set out. "The chief executive", is that a reference to the chief executive of the Trust?
A. It could have been, yes.
Q. And then "medical director" and we know from what you've said in your witness statement that Dr Kelly was the medical director at the time and attended these meetings.
A. That's correct.
Q. It wouldn't appear that Mr Mills was in attendance.
A. He would not have attended every meeting, no. He would now and then have attended a meeting.
Q. Yes. Director of business services?
A. Which was director of corporate affairs, the same as,

I think, Bridget O'Rawe.
Q. That's Ms O'Rawe's role?
A. Yes.
Q. Director of personnel?
A. Not all the time, but would have been called in if her expertise would have been needed.
Q. So I suppose if it was not a medical negligence case, for example, if it was an employer's liability case, you might have had the director of personnel in attendance?
A. Mm-hm.
Q. And then director of finance, if appropriate, I suppose?
A. Well, no, director of finance would normally have attended most of them because there was a very big financial aspect to it.
Q. Legal representative and then litigation officer.
A. Yes.
Q. If we go back then to 047-104-234. I want to bring your attention to 12 October. Sorry, just before that, 25 June:
"Case discussed at Trust's scrutiny committee. Legal directorate to contact coroner's office to check details regarding inquest."
That implies that the DLS representative at the meeting is going to check with the coroner's office?
A. Yes, that would have been the case, yes.

Q. It would appear that by 12 October 2001, that check had been bottomed out?
A. Yes.
Q. And we are advised that a claim of privilege attaches to much of what we can discuss in this area, but that the DLS are happy to tell us that a letter was issued from Donna Scott, confirming what is said in front of us?
A. Yes.
Q. That is that there will not be an inquest?
A. Yes, according to that.
Q. And that is advice coming in to you, is it?
A. I would have got a copy of the letter, yes.
Q. Who else would have got a copy of the letter?
A. Copies -- as far as I can remember, I would have indicated that that letter be put in front of the next scrutiny committee that came up so that all those people would have got a copy of it.
Q. How do you remember that?
A. I've got a note on the file directing someone to bring it forward for the next scrutiny committee.
Q. I don't think we need to bring it up in front of us, but your witness statement, if I can quote verbatim:
"The file contains a written note from myself, advising it was to be included for the next scrutiny committee."

A. Yes.
Q. So this is a piece of relevant correspondence that has come in to you and the note is indicating that this is a relevant piece of information to share with the attendees at the scrutiny committee?
A. Yes.
Q. The next meeting is the November meeting; is that right?
A. 15 November 2001, yes.
Q. Yes. You tell us in your witness statement that there's no record on the file that the information that had been imparted to you by Donna Scott, I think it was, that there wasn't to be an inquest, there's no record on the file to indicate that you imparted this information.
A. Well, apart from the note that I had given to someone saying, "Bring this forward for the next scrutiny committee", and it would have been done then I think.
Q. Is it your belief that you did share the information at the November meeting?
A. As far as I can remember, yes, it would be.
Q. And can you help us with this, Mr Doherty? Up until the clarification had been obtained from the coroner's office via the DLS, was there an assumption that there was to be an inquest?
A. I don't really know. I mean I assume -- there probably was. There probably was, but not in the concrete sense

there was.
THE CHAIRMAN: Had you been involved in helping prepare for inquests before?
A. Before Lucy Crawford's inquest, yes. And really, my involvement would have been requesting reports from parties that the coroner would have identified, clinicians, et cetera. And that was it.
THE CHAIRMAN: Right. So if a person dies, whether a child or an adult, and there's to be an inquest, then the coroner's request for witness statements ends up with you; is that right?
A. Yes.
THE CHAIRMAN: And do you liaise or coordinate the gathering of those statements and the forwarding of those statements to the coroner's office?
A. Yes.
THE CHAIRMAN: So Lucy died in April 2000.
A. Mm-hm.
THE CHAIRMAN: From the evidence we have before the inquiry, the coroner wouldn't normally wait for a terribly long time to request witness statements; would that be your experience too?
A. It would, yes.
THE CHAIRMAN: Just for the record, in Adam's case the coroner asked for statements within one week of

Adam's death in November 1995. And when Raychel died in 2001, she died in June 2001, the coroner had asked Altnagelvin for their statements by October 2001, and he had asked the Royal for their statements by December 2001. So that would be in keeping with what you would expect?
A. Yes.
THE CHAIRMAN: You would have known, Mr Doherty, wouldn't you, that if Lucy had died in April 2000, that it would have been extraordinary that the coroner had not sent out a request for witness statements by the end of 2001?
A. Yes, I would think so, yes. I'd agree with that.
THE CHAIRMAN: And anybody who had any experience with inquests would know that too?
A. Mm-hm, mm-hm.
THE CHAIRMAN: Thank you.
MR WOLFE: Could we move on to the next page, please, 235? The position having been settled at the end of the year before, after a check had been made that there was to be no inquest, the issue appears to have come on the agenda again on 12 April 2002 meeting; do you see that?
A. Yes.
Q. It says:
"Dr Jenkins' report considered."
That was a report obtained by the Sperrin Lakeland

Trust in connection with the litigation?
A. The independent report, yes.
Q. And there's a message in your chronology that:
"Papers [would be] returned to counsel for further advices."
And then it says:
"DLS to confirm possibility of inquest being held."
A. Yes.
Q. Can you help us with that, Mr Doherty? There had been confirmation that there wasn't to be an inquest.
A. Mm-hm.
Q. What now changes is that in April 2002, a medico-legal reports comes in -- and we have that medico-legal report -- and it suggests that the fluid management of Lucy Crawford may well be implicated in her deterioration and death. I see you looking over the screen at somebody.
A. Sorry, yes, I was, sorry.
Q. Can I help you, Mr Doherty? Are you --
A. What I'm taking -- basing this on is basically from the notes that were taken at the scrutiny committee meeting, and that's what it was saying, and you may well have a copy of that document as well.
Q. But can you help us in terms of why this issue is back on the agenda?

A. I really am not quite sure why it came back on the agenda, apart from the fact that we had received the independent expert report and that brought it on it.
Q. The expectation then from that meeting was what, that somebody would speak again to the coroner's office?
A. I think so, yes. Uh-huh.
Q. And looking at the chronology that you have on paper here, 25 April 2003, over a year later, Mr Leckey writes to Dr Kelly to inform him that he would hold an inquest.
A. Yes.
Q. We know that the sequence of events that prompted Mr Leckey's intervention to decide to hold an inquest arose out of Mr Millar of the Western Health and Social Services Council contacting him after Raychel's inquest.
A. Mm-hm.
Q. Am I right in suggesting to you, Mr Doherty, that your review of the correspondence in order to compile this chronology did not indicate to you that DLS had achieved an answer in response to what was discussed in April 2002? In other words, there was no message back from the coroner --
A. No.
Q. -- to indicate that an inquest was to be held?
A. Yes.
Q. Was that the subject matter of any discussion?

A. I really can't remember. If it was, it would have been at scrutiny committee, but I'm sorry, I can't remember that.
Q. Because if DLS, as at 12 April 2002, were going back to the coroner, perhaps in light of Dr Jenkins' report, the scrutiny committee would be looking to see what had happened?
A. How they got on from it, yes.
THE CHAIRMAN: Mr Wolfe, 12 April 2002 doesn't say DLS are going back to the coroner. The entry says:
"DLS to confirm possibility of inquest being held."
It says nothing that DLS are going back to the coroner.
MR WOLFE: We'll need to check the transcript, but what was your understanding, Mr Doherty, of what was to happen in relation to confirming the possibility of an inquest being held? What steps were to be taken, if any?
A. Well, in that note I have:
"12 April 2002. Case discussed at the trust scrutiny committee. Dr Jenkins' report considered ... DLS to confirm possibility of inquest being held."
I think I would assume that maybe that meant they would be going back to the coroner's office, but it's not stated there. I think that's the only way they'd find out if an inquest was going to be held.

Q. That was your understanding?
A. Yes. Mm-hm.
THE CHAIRMAN: Sorry, if the coroner had already confirmed that there was to be no inquest --
A. I know, why would you go back again?
THE CHAIRMAN: Why would you go back and why would you go back two years after a child's death when nobody's bothered to collect a witness statement in between? There's no hint at all from the coroner that there's going to be an inquest for two years, sure there isn't.
A. No, there's not.
THE CHAIRMAN: In fact, there's no hint from the coroner for three years.
A. Yes, mm-hm.
THE CHAIRMAN: So what I'm wondering is how anybody in the Sperrin Lakeland Trust could have been under any misapprehension that there was going to be an inquest when it had been confirmed in October 2001, that's about 18 months later, that there was going to be no inquest and then for three years there was no witness statements gathered.
A. Yes.
THE CHAIRMAN: So who on earth could have been wondering round the Erne Hospital thinking, "I wonder what date the inquest is going to be on?"?

A. I agree, Mr Chairman.
THE CHAIRMAN: Thank you.
MR WOLFE: Well, the change in circumstances by April 2002 was the availability of Dr Jenkins' report.
A. Yes.
Q. And when I asked you about this earlier, I was enquiring with you as to whether you can help us in terms of whether the availability of that report, which raised some concerns about the fluid management of Lucy, could have been the prompt for further enquiries to be made. And as I understood your answer, by your speculating to some extent, you were agreeing with me that that might have been what was happening here?
A. That might have been the catalyst, yes. It may have been, but you know, again, I'm speculating.
Q. What you're telling us is that, from your drafting of this chronology, which is based on your interpretation of the notes and correspondence available on the files, there is no record of somebody having gone to the coroner and reported back to the scrutiny committee?
A. No.
Q. Could I ask you this: Dr Kelly, through his counsel, has suggested that in April 2002 he was not being told, if I put it in these negatives, that there wasn't going to be an inquest?

A. I can't answer that. I don't know. I mean, if Dr Kelly's saying that, then I have to go with that.
Q. Is your evidence that, so far as what your understanding was, the clear indication via the DLS in October 2001 was that there wasn't going to be an inquest and that position didn't change?
A. That's right and I think, at the time, that's why I've written the note saying, "Bring this forward to the next scrutiny committee", which would have been then shared with the members of that committee.
Q. Could we go back then and look at the claims management policy, which we had up on the screen earlier? 319-042a-004.
MR GREEN: Before we look at that, I wonder if we could just stick with the chronology for just one moment? There's a portion of the chronology which is incomplete. It's in relation to a meeting on 8 April 2003 at 4 pm in the Bar Library between Patrick Good, Donna Scott and Dr Kelly. I'm not going to ask that the reference be pulled up because claims of inadvertent disclosure and retrospective assertions of privilege have been asserted by DLS in respect of these documents, but if I may just raise three discrete points without having the document pulled up. It appears first --
MR WOLFE: What document are we referring to?

MR GREEN: I'm referring to a document, Mr Wolfe, for your own reference, 036c-043-101.
THE CHAIRMAN: And the date, Mr Green?
MR GREEN: The date of it is 8 April 2003.
THE CHAIRMAN: Thank you. And the three points?
MR GREEN: 1, Dr Kelly appears to have been getting a steer not to meet with or engage with Lucy Crawford's family whilst litigation was ongoing. 2, he was getting a steer that mediation wasn't a likely route to settlement. 3, he appears to have been expressing surprise that an inquest hadn't been arranged before now when informed in that meeting that an inquest was likely.
I'm happy for Mr Wolfe to check this note for himself, if Ms Simpson is happy with that, just to make sure that there has been no self-serving selectiveness in my approach to it. But perhaps that can be done at a break if he feels it fit to do so.
THE CHAIRMAN: And you're referring to this because the chronology, as prepared by Mr Doherty, doesn't include a reference to this 8 April 2003 meeting?
MR GREEN: It doesn't include a reference to that meeting which is why this whole area is a little bit volatile because we're been given a chronology based on documents over which privilege is asserted. One therefore has to

tread with some caution as to how far one can rely on it in terms of treating it as complete.
THE CHAIRMAN: Or what it actually means.
MR GREEN: Yes.
THE CHAIRMAN: Well, could we bring up the page from the chronology, Mr Wolfe, that had the April 2003 entry on it?
MR WOLFE: We're dealing with two different things.
THE CHAIRMAN: We are.
MR WOLFE: The note that my learned friend refers to is a consultation at the Bar Library, it's not a scrutiny committee meeting.
THE CHAIRMAN: I understand.
MR WOLFE: But so far as the April 2003 meeting in Mr Doherty's chronology, we'll find it at 047-104-235.
MR GREEN: And you will see, sir, that we jump from -- well, I'll not put it in the plural, I will express it in the third person. Mr Doherty jumps from 18 March 2003 to 25 April 2003, and of course there is this very significant meeting in the Bar Library on 8 April 2003.
THE CHAIRMAN: This was a meeting in the Bar Library, which was in essence to agree an approach to what should be done with the claim brought by Lucy's parents about her death; okay?
A. Mm-hm.

THE CHAIRMAN: Would we expect that to feature in your chronology or not?
A. I think it should do, yes. I think it should have.
THE CHAIRMAN: And that would then record that there was a meeting on 8 April, which is between the second and third last dates on this page?
A. Mm-hm.
THE CHAIRMAN: And the point which is being made by Mr Green is that at that meeting, apparently, Dr Kelly was recorded as being surprised that no inquest had been arranged, whereas the information which you've provided on this chronology is that for some considerable time before that it was clear that no inquest was to be arranged.
A. Yes.
MR WOLFE: No doubt you will consider all of the documentation and oral evidence to you in the round, but it's evident from the document that my learned friend refers to that it will have to be read with some care. It doesn't expressly refer to Dr Kelly in the context of indicating surprise that an inquest had not been arranged before now. Perhaps it's a matter for submissions by those concerned about it in due course.
The claims management policy, Mr Doherty, 319-042a-004. Could you help us with this? This

document, as we indicated earlier, is in its third version on the screen in front of us.

A. Yes, mm-hm.

Q. Was there such a policy in place when the litigation surrounding Lucy Crawford's case commenced in the spring of 2001?

A. I think there was a previous draft of that.

Q. The purpose of the document is what, to provide a road map through the litigation process?

A. Yes.

Q. This section in front of us, dealing with apologies and explanations, I want to ask you just about that. There is a statement of principle at 7.1 that:

"The Trust encourages staff to offer apologies and/or explanations as soon as an adverse outcome is discovered."

And those who are interested can read the rest of it, but from that statement of principle, is it proper for this inquiry to infer that the culture that the Trust is attempting to promote is one of openness and transparency?

A. Yes, I would agree with that.

Q. Just on this document, it does refer to "the Trust"; is this document the Sperrin Lakeland Trust's?

A. It is.

Q. This culture of openness and transparency appears to have encountered difficulty in the context of litigation. We have had evidence from Dr Kelly who has explained to us that, by the middle of 2002, he wanted to go to the family because he was concerned about the evidence that was accumulating. So by this point in time you had a report from Dr Moira Stewart of the Royal College of Paediatrics and Child Health, you had a report from Dr John Jenkins, and by August of that year you had a second report from the Royal College.

I wonder, can you help us with this? Dr Kelly, as I've described, wanted to go to the family with information but was held back from doing so; can you help us with that?

MS SIMPSON: Before the witness answers, I think it would be proper to find out if he was the person who made that decision or he had a part to play in that.

THE CHAIRMAN: Were you aware of that?

A. Sorry, of having a part to play in it or ...

THE CHAIRMAN: In light of the clear-ish reports which the Trust was receiving, were you aware that Dr Kelly wanted to speak to the family to express regret or an apology?

A. Well, not that I remember, chair, to be honest with you, no. But again, as counsel has pointed out, it would not have been my remit to make the decision whether or not

to go to the family; we would have got legal advice on that.

MR WOLFE: One of the things that was suggested on Dr Kelly's part is that this desire to be more open to the family is necessarily the subject of legal advice in the litigation context.

A. Well, the decision, as I say, was not mine, but it had been advised -- our legal people had advised that it would not be proper to go to the family, but that was taken out of my hands, unfortunately.

THE CHAIRMAN: When you say your legal people had advised that, is that in the context of Lucy's case?

A. Yes, yes.

THE CHAIRMAN: Beyond Lucy's case, was that pretty much a standard position, that if there was litigation going on, doctors or nurses or managers were discouraged from engaging with the families?

A. I'm not sure if -- I don't think I've ever come across one this bad(?) before Lucy's case, to be honest with you, Mr Chairman.

THE CHAIRMAN: What about since Lucy's case?

A. No.

THE CHAIRMAN: Okay.

MR WOLFE: One of the tasks that fell within your job description was to collate statements for the litigation

process.

A. That's correct.

Q. That also applied when an inquest was to be held.

A. Yes.

Q. Dr O'Donohoe provided Dr Kelly with a witness statement in August 2003, I believe.

A. Mm-hm.

Q. If I could just put it up on the screen, please. 047-038-118. I will put it in context for you. The statement comes to Dr Kelly and then he passes it on to you; is that right?

A. That's correct, yes.

Q. And this is Dr Kelly enclosing original statements as promised. He's indicating you were to access Dr Malik's statement. Dr Malik had, by this stage, left the Trust --

A. Yes.

Q. -- and they're to be forwarded to Donna Scott and then on to the coroner's office; is that the appropriate procedure?

A. Yes, and there is a note at the bottom from myself saying that they have been forwarded on to DLS.

Q. So that's, "Originals to Anne Cassidy", who's a solicitor in the DLS?

A. That's correct, "For the attention of Donna".

Q. And you've signed off on that then?
A. Yes.
Q. So the process seems to be that statements go to the medical director and then on to you --
A. Mm-hm.
Q. -- and then on to DLS for forwarding to the coroner's office; isn't that right?
A. Mm-hm. In this case that is correct, yes.
Q. And Dr Kelly received the following statement, if I can put it up on the screen. 047-053-148. You can see it's sent to Dr Kelly on 24 August 2003. Could we highlight the last paragraph, please? Dr O'Donohoe is saying:

"The only respect in which this report differs from the previous version ..."

By "the previous version", he means, he has told us in his witness statement, the version that he provided for the review back in the year 2000. He says:

"The only difference is in respect to the infusion of 500 ml of normal saline to which I did not refer in the version I sent to you previously. Since this is approximately 50 ml/kilogram, a much larger volume than I would use, I believe this had been started following the first episode of diarrhoea, i.e. before the convulsion."

And then if we can go over the page, please, to 149,

he then sets out a description of his understanding of the state of medical knowledge at or about the time of Lucy's death by reference to certain literature with which he has been provided.

That appears to have been the statement that you've passed on to DLS. Could we then have a look at the statement that was eventually sent? A second statement was sent to you directly by Dr O'Donohoe. If I could have that up on the screen, please; it's 047-158-334.

So this is sent to you on -- if the facsimile stamp on the top is right -- 12 December 2003, so it's about four or five months after the statement that's given to Dr Kelly.
A. Mm-hm.
Q. By the stage of this statement reaching you, there's one new entry. If you look at the second paragraph, there's a sentence which says:

"The intravenous fluid used was saline, 0.18 per cent."

And then the last paragraph, which I referred you to earlier, which contained the comment, the critical comment, in relation to the amount of normal saline that had been used, and then the analysis by reference to the medical literature, that drops out of this statement?
A. Mm-hm.

Q. And this is the statement that you send on to the coroner. I wonder, can you help us in relation to that? It does seem to be your role, Mr Doherty, to look at statements and provide comments before they go in to the coroner; isn't that right?
A. No, I wouldn't agree with that.
Q. Is that not right?
A. No, I wouldn't necessarily read every statement that comes in. I would have forwarded them on to my legal advisers for their attention.
Q. Could I ask you just to look at 047-035-114? This is you sending an e-mail in October 2003 back to the Trust. Jim Kelly is copied in to it.
A. Mm-hm.
Q. It's you making a number of suggestions to Esther -- that is Esther Millar -- making a number of suggestions to Trust witnesses in respect of the contents of their deposition or statement for the coroner; isn't that right?
A. That's correct, yes.
Q. You have the first statement from Dr O'Donohoe, the original of which you sent to the DLS --
A. Yes.
Q. -- with the expectation that that would go to the coroner?

A. Yes.
Q. You then have faxed to you on 12 January 2004 a further statement from Dr O'Donohoe that contains a number of changes.
A. Mm-hm.
Q. Can you help us, Mr Doherty, in terms of why certain content falls out of Dr O'Donohoe's statement and why --
MS SIMPSON: Sorry, sir. Firstly, if the content has changed, the witness has to be asked whether he noticed the content changed, that's the first question. And if those changes had been made, was it he who made those changes? Just for correctness.
THE CHAIRMAN: What we're getting to is a question of how those changes came about.

Just before we leave this, looking at the changes which are suggested by you on screen --
A. This is in the e-mail, chair, yes?
THE CHAIRMAN: On the e-mail, yes. Would you say that's correcting grammatical errors and --
A. I think that that information would have been given to me by DLS, having received the statements, to make amendments and ... But you are right, the majority of the errors are correcting grammatical errors.
THE CHAIRMAN: So when it says at the start:

"I would be obliged if you could bring the following

to the attention of the nurses involved?"

Do you think that what follows is pretty much a cut-and-paste job from DLS coming to you and you forwarding that to the Trust?

A. Yes.

THE CHAIRMAN: As opposed to you going through the witness statements of Jones, Swift, McManus and McCaffrey and correcting, for instance, "Should 'giving' be read as 'given'", and so on?

A. That's correct, yes.

THE CHAIRMAN: So you say this is all DLS?

A. Yes.

THE CHAIRMAN: Okay.

MR WOLFE: Just in response to my learned friend's intervention, let's take this process back a step. Could we put up on the screen, please, 047-160-336? Four/five months after having received a statement from Dr O'Donohoe, via Dr Kelly, you find yourself writing to the coroner on 11 December 2003, telling him that you are awaiting a statement from Dr O'Donohoe; do you see that?

A. Yes.

Q. Help us if you can: you are telling the coroner that, but you have already received a statement from Dr O'Donohoe and, as we can see from the compliments

slip that you signed off with Anne Cassidy, you anticipated that that statement would go to the coroner?

A. Yes.

Q. It clearly hasn't gone to the coroner.

A. Yes.

Q. There is a process afoot, is there, to examine Dr O'Donohoe's statement?

A. Well, I was certainly not examining Dr O'Donohoe's statement.

Q. Right. So what do you understand is the position on 11 December?

A. Well, I understand from that there that I -- obviously that Mr Leckey had been in touch with us looking for the statements and I was trying to bring him up-to-date with where we were at that time.

Q. You know that there is a statement because you've had it in your hands and you've given it to DLS?

A. Yes.

Q. So in terms of process, what is happening to that statement?

A. Well, I would imagine, if there were any amendments being made to it, they would have been made and Dr O'Donohoe advised, but I don't know.

Q. So your understanding of the process is that somebody is making amendments to it and then those proposed

amendments go back to Dr O'Donohoe?

A. Again, I couldn't say yes or no to that. I really don't know. I mean, I think that the time was that for all statements that came in that they would have been forwarded on. If there was something that was noticed by our legal people, then they would advise accordingly. I certainly wouldn't be taking any decisions as to what should stay in or come out.

Q. Did you appreciate that the statement that you ultimately sent on to the coroner in early January from Dr O'Donohoe was different to the statement that you had received four or five months earlier?

A. I would say no because, again, I don't read all the statements through, and that's as simple as that.

Q. And in terms of the changes that were made to the statement which I've pointed out to you now, is this morning the first time you've noticed them?

A. I have to say yes. Again, I would not have been involved in editing statements, advising on statements and that. Basically, I think what I would understand is we were basically a post-box that got the reports in and forwarded them on to the relevant people.

MR WOLFE: Very well. I'm obliged. I have no further questions.

MR GREEN: Can I help with a date? I think my learned

friend said twice that Dr O'Donohoe's final statement was sent to the coroner in January 2004. In fact, if we can pull up the chronology at 047-104-236 --

THE CHAIRMAN: 12 December?

MR GREEN: 12 December. And if one looks at the rest of the page and reads back down to that date, it might help the inquiry to some extent with what was going on because there seems to have been toing and froing about the litigation, and then a consultation on 9 December 2003, doctors O'Donohoe, Auterson, Mr Doherty, Donna Scott and Mr Good, senior counsel, in attendance. On 10 December, there seems to have been some robust analysis of where the Trust were with this. Then, on 11 December, "approval for settlement sought". 12 December, the claim is settled and, on that date, Dr O'Donohoe's statement is sent to the coroner.

So it may well be that DLS parked the sending of the statement to the coroner until they knew exactly where they stood with the litigation. But I just thought that it might assist if the correct date were brought to the inquiry's attention.

MR WOLFE: In fact, if we could have up on the screen, please, 047-157-333. There appears to be an inconsistency, perhaps, between the timeline produced by Mr Doherty and this letter, unless the coroner was sent

it on both dates.
MR GREEN: Perhaps the witness could be invited to deal with that apparent inconsistency.
THE CHAIRMAN: Can you help with us that? You've seen from the chronology a moment ago that it records that Dr O'Donohoe statement was finally sent to the coroner on 12 December, whereas what we have here is your letter enclosing the statement; should I go by your letter of 6 December?
A. I think, yes.
THE CHAIRMAN: Thank you.
MR WOLFE: I have no further questions.
THE CHAIRMAN: Any questions from the floor? Ms Simpson?
Thank you very much indeed for coming. You're now free to leave.
(The witness withdrew)
THE CHAIRMAN: We'll take a short break and then hear Mrs Dennison, who I expect to be finished by lunch.
This will have to be addressed in submissions by both the Sperrin Lakeland Trust, or the Western Trust as the successor, and those who represent the various doctors and others who were involved in the Sperrin Lakeland Trust, but I should just say I'm having the greatest possible difficulty accepting at the moment that anybody really believed there was going to be an

inquest. Thank you.
(11.18 am)
(A short break)
(11.35 am)
THE CHAIRMAN: Ms Anyadike-Danes?
MS ANYADIKE-DANES: Good morning. Can I call Mrs Dennison, please?
MRS MAUREEN DENNISON (called)
Questions from MS ANYADIKE-DANES
MS ANYADIKE-DANES: Good morning, Mrs Dennison.
I'm going to ask you if you wish to adopt the two previous statements that you've made, subject to anything that you might say now in your evidence. Let me just help you with that. You made a statement to the PSNI. It's 115-033-001, dated 7 December 2004.
A. Yes.
Q. And then you also made a statement for the inquiry. The reference for that is 276/1.
A. I don't have a copy of that statement, sorry.
Q. It will come up on the screen, the relevant parts of it. This is your PSNI one.
A. I've got that one, yes.
Q. Let's have this up. Would it assist you if you had a copy of it with you?
A. It might, if that's all right.

Q. We can get that arranged.
A. Thank you very much.
Q. As I say, subject to anything that you say now, do you wish to adopt those statements as your evidence?
A. Yes.
Q. Thank you.
THE CHAIRMAN: Do you understand what that means? What it means is that you don't want to correct or change anything in those statements and that when I'm considering your evidence, when I'm writing my report, I will take your evidence as being contained in the written statements, topped up by what you're going to say orally today.
A. Yes, that sounds fair, yes, thank you.
MS ANYADIKE-DANES: Thank you.
You said in your PSNI statement that you started work in the coroner's office in 1999; is that correct?
A. Correct.
Q. Can you remember roughly when in 1999 you started?
A. No.
Q. Would it have been the first part of the year or the latter part. Do you know?
A. No, I'm sorry.
Q. That's all right. When you started work in the coroner's office, had you done anything like that

before? Ever been required to look at medical documents?
A. No.
Q. Deal with medical information?
A. No.
Q. And then I think when you made your statement to the PSNI, you said that you were there until April 2004; is that correct?
A. Yes.
Q. And you were then making your statement to the PSNI in December 2004?
A. Yes.
Q. Did you return back at any time after April 2004 to work in the coroner's office?
A. Yes, I did.
Q. And when was that, roughly?
A. I returned ... I retired from the Court Service and I was there probably about a year before I retired, so maybe about 2010.
Q. 2010, roughly?
A. Yes, to 2011-ish.
Q. Thank you. And when did you go back, were you doing much the same job as you had been doing up until you left in April 2004?
A. The coroner's office had quite changed in that time.

When I went back, it was different type of work that I was doing then.

Q. Can you help us with the difference in work between what you were doing previously and what you did when you came back?

A. At the time of this death, I was working part-time and I was working 9 o'clock to 2 o'clock and that mainly -- in that time, that was taking deaths and when I went back the second time, I set up inquests for hearing.

Q. Did you take deaths when you returned?

A. No.

Q. Okay. We have a job description for you. I'm just going to pull up the first page of it and then, as I ask you some questions, we'll go through particular parts of it. But just so that you recognise it, it's witness statement 276/1, page 7.

A. This is -- I had a quick look at this this morning -- one of the girls gave it to me -- and as I understand it, this is a current --

Q. Yes.

A. This wouldn't have applied at the time of this.

Q. Ah. That's what I was going to ask you about.

A. Sorry.

Q. No, no, that's all right. Because on the very last page, if we go through to page 20 of this, there are

a number of postholders. We don't need to worry about those, we've redacted them. Unfortunately, in an excess of redaction, we've actually redacted your name, but your name would have been fifth down --

A. Okay.

Q. -- in fact, the longest line. That would have been your name.

What I wanted you to help me with is: if that has been agreed by you as being the job description, for what period did you say this reflected your job?

A. So Sharon, the staff officer, has dated this for November 2010, so this would have been at the second stage going back. This wasn't in place at the stage of the death of Lucy Crawford.

Q. So what, so far as you can help us with, was your job description at the time of Lucy Crawford's death?

A. At this stage, when this document was written, there was a coroner's service --

Q. Yes.

A. -- but in the days of Lucy Crawford, it was part of the Northern Ireland Court Service.

Q. I see.

A. And it was based in Newtownabbey and it was a small office. At that time, my role was to record deaths, set up inquests and just general running of the office.

Q. I'm going to help you by asking you a few more detailed questions about that, but that's in general terms what your job was?

A. Yes, and we mainly all did the same thing.

Q. How many were in that office at that time?

A. As I remember, four.

Q. At any given time there would be four, would there?

A. Yes, there were four members of staff. There was myself, and I worked in the morning. Then there was another EO, Mr Ian Maxwell, and then there was a personal secretary to Mr Leckey, but you also helped with office duties, Denise -- I've forgotten her other name -- and a clerk, Graham Kennedy. So that's four of us.

Q. In terms of those who were mainly concerned with receiving the reporting of deaths, who would they have been in the office?

A. We all did that.

Q. You all did that?

A. Everybody.

Q. If you had not done anything like that before, what sort of training did you have so that you could receive those reports of deaths and know what to do with them, if I can put it like that?

A. We just trained. It was a very small office, it wasn't

very big, and you just sat with somebody and you just learned hands-on, and you just -- it was a very comfortable office to work in, so if I took -- when you were learning, you just took a death and then you asked the person to hold and then you discussed it with your colleague, whoever was free. I just discussed it with one of them and they said, "Do this, this, and this", and you just -- that's how you actually learned to do the job.

Q. So there wasn't a sort of programme set out, if you're going to come in, "Now we'll start you with this and then we'll work through in that way and by the time you get to that you'll have reached the full range"? There wasn't a programme like that?

A. No, and reading this now, that you get medical terminology set out and all, which probably is very helpful to the people, whereas you kind of learn that, you learn a basic understanding and then you go for advice after that.

Q. In fact, we can pull that up just as you mention it because that was one of the things I was going to ask you about. If I can take you to two pages and put them side by side. So if you can put page 9 alongside page 10, if you look at that bullet which is one up from the bottom, starting:

"The postholder processes reports of deaths via telephone calls from the medical, legal and other professions on a daily basis to progress coroner's business in accordance with the coroner's service charter."

And if you ignore for a moment the "coroner's service charter" element of it, it goes on to say:

"This includes: recording the death on the coroner's database; making recommendations to the coroner if an autopsy is required and making arrangements for the autopsy to be carried out; also referring and discussing cases with the coroner's medical officer where appropriate. The postholder is required to undertake this duty without supervision during the weekend and bank holidays on a rota basis."

That is reflecting what you say was the position when you came back in 2010.

A. Yes.

Q. Did you do any of that in 2010?

A. Yes, there was no medical officer in our day, in the day of this. So the postholder --

Q. Let's start first with 2010. I didn't mean to confuse you. What I have just read out, did you do any of that in 2010 when you came back?

A. No.

Q. So you were entirely dealing with inquests and not this aspect of it?

A. Correct.

Q. Maybe you can help us as to what elements of this you did at the time of Lucy's death. So if we start with processing reports of deaths via telephone calls from -- let's keep it to the medical personnel; did you do that?

A. Yes.

Q. That was to progress the coroner's business, but in any event to carry out the coroner's work; that would be right, would it?

A. Yes.

Q. Then you say, "This includes recording the death". If you leave out the database part of it, you would have recorded the death?

A. Yes.

Q. Is that right?

A. Yes.

Q. It says:

"Make recommendations to the coroner if an autopsy is required."

Did you do any of that?

A. Not so much make a recommendation as to discuss --

Q. Whether one was required?

A. Yes, what I had taken down. And then the coroner to

guide me to where I was going with it and what he thought or what the doctor had thought. You would kind of like liaise between the two, collating the information.

Q. Would it be fair to describe it as you're a gatherer in of the information --

A. Very much so.

Q. -- which you then provide to the coroner or the coroner's deputy, a decision is going to be made, whenever that decision is going to be made, you then inform whoever it is that has reported the death?

A. Yes.

Q. Would that be a fair way of describing it?

A. That does, yes.

Q. I wonder if you can help with this point before we get into the specifics of Lucy's case: I know that, in total, you were dealing with these sorts of matters from 1999 to 2004, so it might not be long enough to express a view, but from your point of view, by the time you left, were there more or less reports of hospital deaths that you can recall?

A. I wouldn't ... I don't know.

Q. Did you have any sense that it was something that was increasing or did it all seem much the same to you?

A. I never thought of it in those terms. I never thought

of it --

THE CHAIRMAN: Okay, that's fine.

A. -- like that. I never thought of it.

MS ANYADIKE-DANES: That's all right. I'm really going to focus on that 1999 to 2000 period if I can put it that way. About how much of your time would you have spent, if you can even look at it in those terms, taking reports of deaths?

A. Because of the hours I worked, a lot of my time was taken with -- because you had a recording machine which was on all night, so doctors left messages on that throughout the night. So that had to be sorted as well as deaths that happened maybe in a hospital during the night. So those doctors were going to ring or accidents or bodies that had come to the mortuary. So the morning time in a coroner's office is a very busy time, so mainly most of my time was dealt dealing with deaths that had to be recorded.

Q. And just to go on to the point that you had made before when I was asking you, if we see over on page 10, nowadays, if one looks at the first bullet, it says:

"The postholder will undergo training in all tasks to ensure effective business disposal and teamwork."

But more to the point:

"This training will include medical terminology."

And then you will see, or at least you have seen, that earlier in this job description, you are required to be familiar with medical terminology. How did you gain that understanding in 1999?

A. By using -- just ... There was a certain amount of terminology that was familiar, you know, that was used over -- myocardial infarction, I'd never heard of that word until I went to coroner's, but became a familiar term. So terms like that. So that became ... So just by using some of the words.

Q. And then we also see from this that the first highlighted part, certainly in this, that you might be required to work unsupervised at times. I take it from what you have said in the 1999 phase when you were working there up to 2000, you were working 9 am to 2 pm only during the week; is that right?

A. No, I also worked at the weekend on the rota.

Q. You did?

A. Yes, I did.

Q. Did you also work unsupervised in the way that it is described here?

A. Yes. Probably, yes.

Q. So if you were doing that, if you were working at the weekend or on bank holidays, who else would be in the office at that time?

A. Some other person from the rota. There were always two of you.

Q. So two of you, but doing the same thing?

A. Yes.

Q. Manning the phones really?

A. Yes.

Q. I understand. I wonder now if we can come to the issue of the reporting of deaths to the coroner's office. This area is governed by legislation. There's the Coroner's Act and there's also the regulations. Were you introduced to that and helped to see what the obligations were on the part of those persons who were reporting?

A. No. I don't ...

Q. Were you told that there were certain circumstances in which -- let's keep it to medical practitioners or clinicians -- were required to report? Were you aware of that?

A. No, I didn't know that they were required by law. I can't say that I did know that, no.

Q. Or those specific circumstances in which they had to do so? Were you made aware of that?

A. Well, I knew that if it was an unnatural death that you would have to report it.

Q. Yes.

A. Yes.

Q. Would this be fair: that your knowledge of the circumstances in which clinicians reported was really gained by noting the occasions when they did report?

A. Yes, probably.

Q. Then can you help us with this? So far as you're concerned, what did it mean when we say "a clinician reports a death"? What did that mean to you?

A. That the death had happened unexpectedly or unnaturally.

Q. Was it also possible for clinicians to phone up and simply want some guidance?

A. Sometimes.

Q. Did that happen often?

A. Yes.

Q. How were you able to tell the difference between a clinician who wanted some guidance and a clinician who was actually reporting a death?

A. Because usually, they said they wanted guidance. They were just making sure they preceded their report.

Q. If they told you that they wanted guidance and explained the circumstances, would you make a record of that?

A. Yes.

Q. And where would you record that?

A. In the register. Well, in my shorthand notebook and then my register.

Q. If they wanted guidance, you put that in the register as well?

A. Mostly, yes. I would have recorded that "death certificate issued", yes.

Q. Well this, is where I wanted to be a little bit careful to make sure I'm clear. If a clinician was reporting a death, how did you record that that was the report of a death?

A. I'm sorry?

Q. In fairness, let me pull up this register, 013-053a-290. You have described this as the main register of deaths in your police statement.

A. Yes.

Q. And you can see there, at the top left, there's a space to identify the person who's reporting, then on the top right the name and the date of birth of the person whose death is being reported and then a place to include the circumstances.

A. Yes.

Q. Does this mean this is a report of a death?

A. Correct.

Q. And who advised you, guided you in where and how you actually record a death?

A. I would have sat with one of my colleagues when I came to the office and watched them do it and then I would

have just copied that, the way they did it.
Q. I wonder if I can show you this, and you may not have seen it, but this is an extract from the coroner's rules, the Coroner's Practice and Procedure Rules of 1963. If we can please pull up 170-001-037. There we are. About three-quarters of the way down, you can see, "Records, documents and exhibits".
A. Yes.
Q. And then at rule 34:
"A coroner shall keep an indexed register of all deaths reported to him or to his deputy, which shall contain the particulars specified in the second schedule."
Firstly, were you aware of that, that that's something that had to be done? That if a death was being reported, you had to record it?
A. I didn't know that; we just did it.
Q. You didn't know from here, but you knew you had to do it?
A. Correct, yes.
Q. If we just pull up 170-001-041, this is the second schedule that is being referred to. You can see that that is a register of deaths reported to the coroner.
A. Yes.
Q. Similar sort of information, although organised

differently to the one that you've got. Did you have anything other than what I had pulled up for you before, and which you described as the main register? Was there anything else in which you could record a report of a death?
A. At the stage of this, there was one register within the office and we took the -- so when somebody phoned up, we took the note, I took the note in a shorthand notebook and then transferred it at as soon as possible stage afterwards into the main register because there was one register between four of us.
Q. And the one we were looking at where you have entered Lucy Crawford's details, that was your main register?
A. Yes.
Q. So you would have your own little notebook where you take the details down from in your telephone conversation and then you would transcribe those into the main register when that became available to you?
A. Yes.
Q. And everybody else would do the same; is that right?
A. Yes. You'll probably find that on that page, maybe I have three or four deaths in my writing and then somebody else will have three or four in their writing.
Q. Yes, there's two others on that page, you're right. We've redacted them because we don't need to see their

details, but you're right. What I wanted to know is: is there any other place apart from your own notebook where you would record the note of a death?
A. No.
Q. Thank you. If we bring back your actual recording of it, 013-053a-290, it's got a tick on that. Did you put that tick there?
A. No.
Q. Do you know what that means?
A. Yes, I do. It's very complicated. It means it's gone on to the computer. So the clerk in the office -- so once they're on to the -- then somebody at a later stage, which may be not as urgent, so somebody has said that's gone on to the computer, and that's -- once it's ticked, then somebody knows that.
Q. This is your main register of deaths reported to you and at some point these details get put on to a database, computer database?
A. Yes.
Q. Thank you very much. In your PSNI statement and your witness statement for the inquiry, you've referred to this telephone call from Dr Hanrahan as a report of a death; that's correct, isn't it?
A. Correct.
Q. And you're quite clear that is what he was doing, he was

reporting a death?
A. Yes.
Q. Thank you. Do you actually remember the telephone conversation? I don't mean word for word, but do you remember the occurrence of it?
A. I'm sorry, I don't remember anything about it.
Q. That's all right. Nobody else does either. That's all right.
I then want to deal with what happens when a death is reported. So far as you're concerned, who guided you on what details you needed to gather in when the report was being made to you?
A. When I was training?
Q. At any time. How did you know what details you needed to request?
A. I probably initially learned from a colleague and then learned from, you know, having to go back and forward to a doctor and asking what information I needed, maybe going back several times, so then you learned fairly quickly what you needed to ask, so therefore you just built up a basic knowledge.
Q. Let me perhaps help you in this way. I'm going to pull an extract up from a document called "Working with the Coroner's Service of Northern Ireland". This is a more recent document; they didn't have a guide like

this when you were working, but it does have a list of details and perhaps you can help me whether these were the sorts of things you were expected to try and get. The reference is 315-025-028, and can you pull up 029 alongside it?

Just while that is coming up, I'll tell you what it's called. It's produced by the Coroner's Service for Northern Ireland, so you're right, it's at the later stage when it is a service, and it's called "Working with the Coroner's Service for Northern Ireland". There's a series of sections dealing with the GP or dealing with a doctor. This section is actually hospital doctors.

A. Okay.

Q. This is really a guide, actually, to what the hospital doctor ought to be doing before the report is made. Just before that series of bullets:

"Before reporting the death to the coroner, the doctor must become familiar with the patient's medical notes and records and be in a position to tell the coroner."

And then there's a whole list of things and it's that list of things that I'm going to ask you whether these were the things that you had been told or you'd observed ought really to be obtained. So:

"The patient's full name, address and date of birth."

You would agree, that is something you needed to get?

A. Yes.

Q. "Details of the patient's next of kin"?

A. Not necessarily.

Q. "Date and time of death"?

A. Yes, you need that.

Q. "Date and time of admission to the hospital"?

A. Date, not necessarily the time, but date.

Q. "Patient's medical history" or some elements of it?

A. Yes.

Q. Then, "Name and address of the patient's GP"?

A. Not necessarily at this stage, but maybe at a later stage you might need that.

Q. "The name of the consultant in charge of the patient's care and other medical staff involved if there were, for example, any surgical procedures"?

A. I wouldn't necessarily have asked for the consultant in charge, more really about the procedure. That is what I would have --

Q. Mrs Dennison, I'm dealing with it at the stage when the doctor is first reporting to you because I understand, from the way you answered one of those bullets, that you

might go back and be asking for further information later on in the process.

A. Yes.

Q. But just at the initial report, if you can help me with that. Any concerns expressed by family members; is that something at the initial report?

A. Yes.

Q. "Any concerns that the reporting doctor or the staff may have."

Do you want to know that at the initial report?

A. Yes.

Q. "Conclusions as to the cause of death"; do you want to know that?

A. Yes.

Q. We won't go into industrial disease because that's not something that we need to take cognisance of here. If the family had started legal proceedings, would you want to know that at this stage?

A. Yes. That would come under concerns, I would have said, yes.

THE CHAIRMAN: That's not a separate bullet point, that's somebody who dies of asbestosis and the family -- and the question is, "Have legal proceedings already been started?". It doesn't apply in anything like the scenario we're talking about today. So that's the same

bullet point as the industrial disease.

MS ANYADIKE-DANES: Thank you. Then:

"Final conclusions as to the cause of death."

Would you want to know that at this stage?

A. Yes. You would also want to know about any HIV or hepatitis or anything like that for the mortuary staff --

Q. I understand.

A. -- and a pacemaker.

Q. So those sorts of things you would want to know at this initial stage?

A. Yes.

Q. And if the reporting clinician doesn't give you that information at the initial stage, do you ask for it then and there?

A. Yes.

Q. Would you have had a sort of ready reckoner that you'd sort of tick off to make sure that you'd got all the information or had you done it so often that you knew exactly what you were looking for?

A. Yes, you knew what you needed to know. As well as the doctors were very good as well, they were able to tell you mostly too. They were very good at assisting you. Quite often, I explained at the beginning of a call that I wasn't a medical person and that therefore ...

Q. You would need their guidance --
A. I would, yes.
Q. -- on what was important?
A. Yes.
Q. Is that particularly when it came to -- if you see that bullet, the first up from the bottom:
"The conclusions as to the cause of death and the final conclusions as to cause of death."
That sort of thing, you're really relying on them, is that so?
A. Yes, and their terminology. I found the terminology sometimes difficult from a hospital death and found then I needed their help with that. But yes, I did rely on them.
Q. And once you have received the report and you have taken down your note of the details that you think are relevant, what then happens about a report?
A. Then I ask the doctor to hold and inform him that I'm going to speak to the coroner.
Q. Sorry, you ask the doctor?
A. To hold on the line.
Q. Literally hold on the line?
A. I do, yes. Then I go and speak to a coroner, the coroner, and I --
Q. If I pause there: why are you doing that?

A. Because I have to liaise [sic] the information -- I'm not in a position to make a decision, so -- the doctor has phoned us so that a decision can be made about the deceased person as to whether a post-mortem is required or on the way to proceed or he has a problem with the death and he needs to report it. So therefore, I go to report it to the coroner.
Q. So then is it because once the doctor has reported it, because as you say, he has a problem, he has a concern, so he's reported it, so the next thing that has to happen is that the coroner has to make a decision as to what he's going to do about that death; would that be fair?
A. Well, I give him the information and it's between the coroner and the ... He may suggest and the doctor may agree and between the two of them, they decide the best course of ... Of ... Best way to proceed.
Q. But is this an appropriate way to put it: at some stage the coroner needs to decide whether he's going to exercise any jurisdiction, if I can put it that way, over this death?
A. Yes.
Q. Is he going to have an inquest, is he going to order a post-mortem himself? He presumably needs to exercise some decision about what to do in relation to that

report.
A. Yes.
Q. Yes. So you've put the clinician on hold, you try and reach the coroner to see what has to happen next; would that be the correct way of putting it?
A. Yes.
Q. And what might happen next?
A. I would discuss it with the coroner and he would say, "Well, I think maybe this is the case for a post-mortem", and I'd say," Fine, thank you", and I'd go back and say, "I've discussed it with the coroner and he thinks this is a case for a post-mortem".
Q. If the coroner were to say that, "I think this is a case for a post-mortem", what sort of post-mortem does that mean? Does that mean, "I'll direct one, so the post-mortem is under my authority"?
A. Yes.
Q. Or is it suggesting, "You can do one if you like for your purposes, but I don't need it"?
A. If it was that case, the coroner would have made that clear. If it was a hospital post-mortem then the coroner would make that clear to me to say to the doctor.
Q. Does that happen often, that the coroner volunteers that the clinician might want to have a hospital post-mortem

or is he more usually telling you, "You can tell the clinician I'll want a post-mortem done"?
A. Yes, more that the coroner wants a post-mortem done, less likely that a hospital post-mortem event -- in my experience at that time.
Q. Because if there's a discussion about a hospital post-mortem, to be having a hospital post-mortem means that the coroner doesn't think it's one of those deaths that he himself needs to investigate, and therefore it becomes a matter for the family and the clinician whether they're going to have a post-mortem?
A. Yes.
Q. That would be correct?
A. Yes. I always found it very confusing.
Q. I understand. So that might be something that the coroner might tell you?
A. Yes.
Q. He might say that. Could he tell you that, "You can tell the clinician that I'll be holding an inquest into this particular death"?
A. Because once there was a post-mortem, then the inquest decision was after that.
Q. I see. So the result of the post-mortem would actually determine, in a way, whether the coroner is going to move on and have an inquest?

A. Correct.
Q. If the coroner didn't want a post-mortem himself, what was the direction you were told to give the clinician?
A. After that, if the coroner didn't direct a post-mortem, then he could have either accepted a death certificate unsigned with a covering letter from the doctor, explaining the circumstances, and that was called a pro forma letter, or he could have issued a death certificate.
Q. Who could issue the death certificate?
A. A doctor.
Q. Ah. So there were two -- if I pull this up -- and tell me if you think this is the sort of thing that you mentioned in pro forma. I hope I have got the page reference correct --
A. It's on the screen.
Q. Yes, there's a reference to it there. But 170-001-056, is that the sort of thing? It's called a form 14.
A. That would be -- that's what a GP would use --
Q. I see.
A. -- but hospitals didn't have access to that. So what we used in a hospital case was an unsigned death certificate and a letter giving the circumstances from admission through to death, a covering letter. So they

didn't have that, GPs did, but that's what we used instead.
Q. So that turned it into a form 14 effectively?
A. It did, yes.
Q. If we bring back the previous page because that might be assisting you to see that there. So that was the option, he could tell the clinician, "I'm going to order a post-mortem in this case"?
A. Mm-hm.
Q. Alternatively, "Tell he clinician we can proceed via a form 14", which would mean, for a hospital, they send in the death certificate with a covering letter and that will do. The other option is that the clinician is able to and does issue the death certificate himself in the normal way.
A. Yes.
Q. Is that right?
A. That's correct.
Q. But whichever way you go, once the report is in, the coroner really has to make a decision as to what is the appropriate course?
A. Yes, I suppose so, yes.
Q. Yes.
A. He agrees. He agrees -- you're making ... He kind of agrees it with the doctor, I suppose. It's like ...

Yes.
Q. But he's involved?
A. Oh definitely, yes. They're both involved, yes.
THE CHAIRMAN: It's more than he agrees with the doctor; it's ultimately the coroner's decision.
A. I suppose, yes.
THE CHAIRMAN: Most of the time I'm sure it is by agreement, but ultimately, if there is a disagreement, it's for the coroner to decide --
A. Yes. And he will, yes. I suppose that's right, yes. That's right.
MS ANYADIKE-DANES: If the report is made to you and you say, "Hang on, I will just get hold of the coroner", and then you can't get hold of the coroner, how do you get a decision on what to do then?
A. So if -- I'm only thinking of this case, but if the coroner was in a meeting or out in court or out of reach for some reason --
Q. Yes.
A. -- and I knew that I wasn't going to get in touch with him and, at the same time, I have a doctor on the line, then we contacted the State Pathology Department, who we worked very closely with, and who always took our calls and I would have explained that I had a doctor on the line and had a medical death and would somebody be

willing to talk to me.
Q. You're looking for assistance at that stage?
A. I definitely am, yes.
Q. You can't reach the coroner, who would otherwise be able to give the direction as to what happens, so you get hold of somebody in the State Pathology Department and once you have discussed it with that person, then do you have a way forward for the clinician? Let me put it this way: what's the result of that discussion, typically?
A. Yes, usually the pathologist has guided me in a direction that I can speak to the doctor and I have a decision then, yes.
Q. And so when that happens, you then go back to the clinician and tell the clinician whatever it is that you've received some guidance on, either this is going to be a post-mortem or you can issue your form 14 --
A. Yes.
Q. -- or go and issue your death certificate?
A. Yes.
Q. But one way or another, the result of all of that is to give the clinician the direction as to what's going to happen; is that correct?
A. That's correct.
Q. And you had learnt that on the job that that's what you

did in those occasions when you could not reach the coroner?
A. Yes.
Q. Did everybody do that so far as you were aware?
A. Yes. It didn't happen very often, it only happened really in sort of -- emergency is a bit strong a word, but in a situation where you definitely needed an answer and you needed something to happen and you couldn't get hold -- if you were really stuck and it didn't happen very often, but yes, everybody knew that was a situation, a door that was open for us, and we didn't abuse it, but we were very careful to use it carefully. But yes, that was a door we all knew that we could ...
THE CHAIRMAN: Can I ask you, Mrs Dennison, this is all at a time before the coronial service was reorganised --
A. That's correct.
THE CHAIRMAN: -- so Mr Leckey at that time was a full-time coroner?
A. He was.
THE CHAIRMAN: Was he the only full-time coroner in Northern Ireland?
A. You see, that's what I can't remember ...
THE CHAIRMAN: Mr Hunter at the back was effectively a full-time coroner for some time --
A. I think he came -- I think -- I was talking to Mr Hunter

and I think he came later. I can't remember. Ms Malcolm was there, but I can't remember when they came or if they were there. I can remember them coming, but I can't remember if they were there at that stage or not. I'm sorry, that just --
THE CHAIRMAN: But also at that time there were coroners in the different counties?
A. That's right, I forgot about that. That's right.
THE CHAIRMAN: So the service that you've been just answering questions to Ms Anyadike-Danes about, about doctors ringing in, would the doctors be ringing in from all over Northern Ireland?
A. No. Mainly from the Greater Belfast area.
THE CHAIRMAN: So what happened if a child or an adult, for that matter, died in Altnagelvin or Daisy Hill or Craigavon?
A. They contacted the coroner for their area.
THE CHAIRMAN: Right. And did the coroner in each area have a service like the one that you were providing for Mr Leckey.
A. No, they were part-time.
THE CHAIRMAN: Does that mean that outside Greater Belfast, the doctors would have to speak directly to the coroner for that area?
A. Yes.

THE CHAIRMAN: And the service you were providing was for Mr Leckey and whoever else assisted him in Greater Belfast?
A. That's correct.
THE CHAIRMAN: Thank you very much.
MS ANYADIKE-DANES: I know that you have said you can't actually remember Dr Hanrahan's call, but you also say that, in your view, you're quite clear that he was reporting a death and that is how you've recorded it and treated it as that.
A. Yes.
Q. If we go back to it, 013-053a-290, you can see there that you've recorded some details, the gastroenteritis, dehydrated, and brain swelling. At that time, would you have understood the implications of those things or would you just be recording what you had been told?
A. No, I wouldn't have understood the implications of those.
Q. You wouldn't have known, for example, or would you, whether gastroenteritis was likely to lead to dehydration or likely to lead to brain swelling? Were you just simply recording what you would have been told?
A. Yes.
Q. Maybe you can help us: did you take many deaths relating to gastroenteritis of children?

A. I don't think so. I don't know. I can't ... I just don't know. It doesn't stand out that I did. I don't think so.
Q. That's all right. Then you've included in there, "Spoken to D Curtis".
A. That's a "Dr".
Q. Sorry. Is that something that you would record to distinguish that from the fact that you would be normally speaking to the coroner?
A. Yes.
Q. So on the infrequent occasions when you had to do that, you would identify the person in the State Pathologist's Office that you had spoken to?
A. Because it was unusual, yes, just as you say.
Q. That would be the practice, would it? Others would do that as well or don't you know?
A. I think they would.
Q. And then after that, you've got "DC", correct me if I'm wrong, but I always interpreted that as "death certificate".
A. Correct.
Q. And "gastroenteritis", does that indicate what's going to go on the death certificate?
A. Yes.
Q. Is that what this means?

A. Yes, in that bottom right-hand corner, we would have put the cause of death quite commonly.
Q. Yes. And in the way that you had described to me the system on the not very frequent occasions when you had to use the State Pathologist's Department, and you contacted somebody and they gave you some guidance, a direction that you could give to the clinician, is this one of those instances where that happened?
A. Yes.
THE CHAIRMAN: Can I just check with you, when it says "Spoken to Dr Curtis", does that mean that you have spoken to Dr Curtis or that Dr Hanrahan has spoken to Dr Curtis, or can't you remember?
A. I can't remember.
MS ANYADIKE-DANES: Maybe I can ask you that. The scenario that you gave us is that you literally have a doctor on hold, you put the doctor on hold, and then you try and seek out the coroner and if you can't get the coroner, then, at the limit, you try for somebody in the State Pathologist's Office. How often would you put the clinician in direct contact with somebody from the State Pathologist's Office?
A. I don't know that I would. I don't know.
Q. Well, sorry, let me help you in this way: can you ever remember doing that?

A. No.
Q. And does that mean then -- and I know you can't directly remember it -- that that reference to "Spoken to Dr Curtis" is more likely to be a reference to you having spoken to Dr Curtis?
A. Yes, probably, yes.
Q. Dr Curtis, I think, had been in the State Pathologist's Department for about seven months before Lucy's death. Did you know him well? Had you been in communications with him before this occasion?
A. I may not have met any of the pathologists, I just probably had spoken to them.
Q. So if you were going to speak to somebody in State Pathology, was it that you spoke to State Pathology to see if they could find you somebody to speak to or did you ask for somebody in particular?
A. No, I would have phoned the mortuary maybe for whoever was carrying out post-mortems that day and either would have done that or I would have phoned the secretaries and asked was anybody available, that I had a death that I needed to speak -- and I can't remember which way that worked.
Q. That's all right. The practice that you've just described and which I know that you said didn't happen very often, is that something that the coroner knew

happened from time to time?
A. Um ... Yes, I think, yes. I think he did know.
Q. Did anybody ever tell you at any stage, whether then or afterwards, that those decisions are decisions that really the coroner ought to make?
A. I don't think so. I can't recall that anybody said that to me. What do you mean, going to speak to the pathologist?
Q. Sorry, I beg your pardon. I meant the direction that the pathologist has helped you make is actually a decision that the coroner ought to make; did anybody ever tell you that?
A. Um ... No. No, I can't remember anybody ever saying that.
THE CHAIRMAN: You know the point is that the fact that --
A. Yes.
THE CHAIRMAN: -- "death certificate" appears on this note means that a decision has been taken that there is to be no coroner's post-mortem; isn't that right?
A. That's right.
THE CHAIRMAN: I know it's difficult to try to reconstruct what happened when you don't really recall and Dr Curtis doesn't recall and Dr Hanrahan doesn't recall, but it seems that a decision was taken to issue a death certificate without the direct input of the coroner

himself.
A. Yes.
THE CHAIRMAN: And that is really what Ms Anyadike-Danes is asking you about. The system for you and your colleagues contacting the State Pathologist's Office, that must have been in place with Mr Leckey's knowledge. Mr Leckey must have known that from time to time, if he wasn't available, you might contact the State Pathologist's Office; would that be right? You were hardly going behind his back to contact --
A. That's what I mean, yes, he probably did know. I can't say I don't know if he knew or not. I don't know, I just can't remember what ...
THE CHAIRMAN: But that system was in place before you arrived, was it?
A. Yes, I think it was.
THE CHAIRMAN: So although it's a bit unusual, there's nothing irregular about speaking to the pathologist's office?
A. It was unusual, it didn't happen very often, but it did happen.
THE CHAIRMAN: Yes. And one thing Ms Anyadike-Danes was asking you about is whether, at some time after that, anybody had said to you, "What you're doing is very helpful, but there really shouldn't be a decision taken

that a death certificate is issued without the coroner being involved"?

A. No, I never remember a conversation like that.

MS ANYADIKE-DANES: And that's really why I was asking you at the beginning about your knowledge as to whether you were given any guidance as to the legal framework in which you were operating. I think the answer that you gave me was: no, not really, you just started the job and watched what other people did and picked up what they were doing and did similar; is that a fair way of characterising it?

A. I think so, yes.

Q. Were you, for example, even aware of whether there was a copy of the legislation there or the regulations or any guidance if you just wanted to check for yourself? Were you aware of that?

A. It was never something that came up in my mind to do that.

THE CHAIRMAN: If Mr Leckey was out, for instance in court, as he would often be, then it wouldn't have been that unusual for a call to come in in the morning that you couldn't speak to him about when the call came in; would that be right? Mr Leckey would have been sitting regularly in 2000 in court hearing inquests.

A. Mm-hm.

THE CHAIRMAN: And if you're busy time was the morning and you were getting through the messages left overnight and calls that were coming in in the morning, Mr Leckey would often be in court hearing inquests.

A. Yes. He was also very good at maybe phoning us from chambers or -- "What's happening," and keeping in touch with us --

THE CHAIRMAN: Right.

A. -- on an ongoing basis.

THE CHAIRMAN: So even if he wasn't there in the building with you, he would be regularly contactable?

A. He usually was, yes.

MS ANYADIKE-DANES: You had a mobile number for him too, didn't you, which you could use?

A. I'm sure we did. I don't remember. I'm sure we did, yes.

Q. We're spending a long time talking about it as if it's a normal occurrence. I recognise that you have said it's something that didn't happen very often at all, I recognise that. Unfortunately, it's just the one that we've got to focus on. If that had had to happen, you'd had to seek the assistance of somebody from the State Pathologist's Department, and then given a direction to the clinician and the clinician had, in this case, let's say, gone off to issue a death certificate, which is

something that wouldn't concern you at that stage because it wasn't going to be a coroner's matter any more, but if that had happened would you tell the coroner when you did get in touch with him, "We couldn't reach you, this is what we've done", just so he was in the loop, if I can put it that way?

A. Um ... I can't remember. Um ... Just, you know, it's so difficult. I can't remember this particular case. It depends -- Mr Leckey came back into the office and quite often when he was in the building -- we were in this small office and he was in our office. So if he was in the office and we were generally talking, we may have gone over what had happened, but if he came back and he was busy as well and because it was a death certificate, it wouldn't have been something to bring to his maybe immediate attention because it wasn't on top of the pile for the urgent things that needed dealt with.

Q. Because he wasn't actually going to have any more to do with it effectively?

A. Yes, but because I had spoken to Dr Curtis I may have -- if he had been in the office and generally about, I may have said, "We had Dr Hanrahan on from ICU", and just generally told him what had happened, but only -- I may not and I just can't remember, I'm so sorry.

Q. No, that's all right. Did Mr Leckey himself from time to time look at the main register of deaths?

A. Yes, he was always involved. He was in and out on a day-to-day basis and was in the office and worked with us. He was there and he was very approachable.

Q. So a benefit of you identifying when you had spoken to somebody from the State Pathologist's Office is, if he had wanted to follow that up, you've recorded who you spoke to?

A. I don't know. Yes. I just put it as a ... Because it wasn't dealt with by a coroner, I think. That's what -- I think that's what ...

Q. I understand. Can I ask you to comment on something that has been said? The coroner has described Dr Curtis as acting on his behalf. Have you seen the coroner's witness statements?

A. No.

Q. Ah. Then let me help you with this. Let's pull up the relevant thing so you see it in its context: 277/1, page 4. In answer to (g):

"On whose behalf was the pathologist acting?"

Mr Leckey, the coroner, is under the impression that Dr Curtis spoke directly with Dr Hanrahan, but leaving that aside, he's talking about the actions of Dr Curtis and we have asked him:

"On whose behalf was the pathologist acting?"

And you see his answer:

"The pathologist would have been acting on my behalf as HM Coroner for Greater Belfast."

Do you understand what that means?

A. That he would have been as if I was talking to Mr Leckey.

Q. Is that what you thought was happening?

A. Well, yes, I was regarding his advice the same as I would have regarded Mr Leckey's advice.

Q. So he was instead of the coroner?

A. Yes.

THE CHAIRMAN: Sorry, I think we need to be careful. I think the coroner himself can clarify that because the answer to the next question talks about Dr Curtis providing advice to his office.

MS ANYADIKE-DANES: I'm going to come to that part.

THE CHAIRMAN: I'm not sure how far Mrs Dennison can help us on the interpretation of Mr Leckey's witness statement.

MS ANYADIKE-DANES: I beg your pardon. I didn't mean to put you in the position of trying to interpret Mr Leckey; I was simply trying to know whether you had ever heard the expression or had ever understood the except that the pathologist would be acting on behalf of the coroner.

A. I never thought of it in those terms.

Q. We did ask you what role you thought Dr Curtis had. In fact, I can take you to where we ask you that. It's your witness statement 276/1, page 4. We ask you that question almost precisely. It's at (l) right down at the bottom:

"What was your understanding of the role or function of Dr Curtis in the coroner's absence?"

And you have answered:

"Dr Curtis had no role."

A. I was thinking of that in the running of the coroner's office, Dr Curtis had no role within our office.

Q. Yes.

A. It sounds all mixed up.

Q. No, no. So he generally didn't have a role?

A. He had no role within the office except in these unusual circumstances --

Q. I understand.

A. -- except as a pathologist when called as a witness, of course.

Q. The fact that you or your colleagues could, on the isolated occasions when you needed to, contact the State Pathologist's Office in the way that you had done, were you aware of whether you were able to do that because there was any kind of informal arrangement between the coroner's office and the State Pathologist's Office?

By that, I mean anything that might have been established by the coroner or perhaps maybe by a more senior person in the office. Were you aware of that?

A. No, I don't think so. It was just a good working relationship that we had with them.

Q. I understand. And on an occasion when the direction that you were communicating was effectively, "This is not a coroner's matter, you can issue your death certificate", that would really mean that the matter usually didn't come back at all to the coroner's office.

A. That's correct.

Q. I know it doesn't happen very often, so you might not be able to generalise, but when you were telling the clinician that a death certificate could issue, can you help as to why it seems you indicated what could go on that death certificate as opposed to simply leaving that to the clinician to sort that out themselves really?

A. I ... I'm only guessing, but I'd have said Dr Curtis maybe suggested to me that "1(a) gastroenteritis" could have been a cause of death. That's the only reason I would have got that or that the doctor -- I don't know.

Q. I'm wondering if it is this way: when you were answering me before about that line and you said, "That's where we put the cause of death", irrespective of whether it was

going to be a coroner's matter or whether you were going to give a direction that the clinician could issue a death certificate, were you required to try and insert a cause of death there?

A. No, not necessarily. But if somebody had given me a cause of death, I would have written it.

Q. I see. So you weren't obliged to do it, but if one was given to you, you would?

A. I would have written it there so that I knew if somebody asked me anything about it, I would have known what 1(a) should have been.

Q. Yes. Then I wonder if I can ask you about this, if you just give me one moment. (Pause).

You left the coroner's service after the period that we've just been talking about in April 2004. Were you aware then that an issue had arisen in relation to Lucy's death by the time you left?

A. Um ...

Q. Let me see if I can help you because it's a very long time ago to start thinking about that.

A. I think the cause -- if the cause of death of hyponatraemia -- had that come through?

Q. I'm going to help you with something. This is a letter that Mr Stanley Millar wrote to the coroner. He wrote it on 27 February 2003. It's 013-056-320. We maybe

need to pull up 321 so we get the two pages alongside each other. Before you left, were you aware that Mr Millar or anybody for that matter had contacted the coroner, the coroner's office, about Lucy's death?

A. I can't remember, but I can remember the discussion of hyponatraemia because we had never heard of -- at least I'd never heard of hyponatraemia before, and then the issue of that all arising from that.

Q. Was that before you left that that arose?

A. Yes. I can remember the discussion of hyponatraemia and that sort of, to us, being an unheard of thing that we had never come across before.

Q. Mr Millar, if you don't appreciate it, he was a chief officer for the Western Health and Social Services Council, and he was particularly assisting Lucy's parents --

A. Right.

Q. -- through the process of trying to find out what had happened to their daughter.

A. Right.

Q. So in the course of that, he learns about the circumstances of a death of another child, which is Raychel.

A. Right.

Q. And he puts two and two together effectively, and you

can see in the top of the second page:

"I am left with two questions which you may be able to answer."

The first is to do with whether the two deaths might be related in terms of cause and then:

"Would an inquest in 2000/2001 have led to the recommendations from Raychel Ferguson's inquest being shared at an earlier date with the consequent saving of her life?"

In other words, if they had had an inquest into Lucy's death reasonably shortly after she died, would they have learnt the lessons that may have been passed on and affected the treatment that Raychel had got? That is really the point he's getting at in that second question.

The coroner replies to Mr Millar on 3 March. We see it at 013-056a-322. It's a two-page letter and we don't need to get into the second page. On the bottom paragraph:

"At the time the death was reported to my office, a note was made to the effect that Michael Curtis of the State Pathologist's Department spoke to Dr Hanrahan of the Children's Hospital. He concluded that a post-mortem was not necessary."

So the coroner has got that the death has been

reported, the two clinicians, Dr Curtis from the State Pathologist's Office, have spoken -- that's Dr Hanrahan who reported -- and the upshot of it was that a post-mortem was not necessary. Were you ever asked about the entry that you had made or the circumstances of the phone calls or anything, do you remember that, before you left, really?

A. No.

Q. Apart from when you were asked to provide a statement to the PSNI, were you ever asked about the circumstances of Lucy's death, or rather the report to you of it?

A. No.

Q. Was that the first time then?

A. When the police officer came to make a statement? Yes, as far as I remember.

Q. And at that stage you were no longer working for the coroner?

A. Yes, but I was still part of the Court Service. I was in the Court Service and I was just across the road, I wasn't far away. I was in Laganside, you know, so it wasn't far away --

Q. But nobody asked you about that until that happened?

A. Not as far as I remember.

MS ANYADIKE-DANES: Thank you very much.

Mr Chairman, if you just give me one moment.

(Pause). I have no further questions.

THE CHAIRMAN: Any questions from the floor? No?

Mrs Dennison, thank you very much for coming. Your evidence is complete so you're free to leave now.

A. Thank you very much indeed.

THE CHAIRMAN: Mr Quinn, that brings an end to today's evidence. I think there are a couple of bits and pieces to be tidied up before we leave.

MR QUINN: There may well be.

THE CHAIRMAN: I'll rise for five minutes to deal with those points. Tomorrow morning, Dr Curtis is giving evidence first, but he is not available quite as early as other witnesses have been, so we will not sit tomorrow until 10.30. I'll come back out in five minutes.

(12.58 pm)

(A short break)

(1.08 pm)

MS ANYADIKE-DANES: There are just a couple of questions and I've indicated that to Mrs Dennison.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: The first question, Mrs Dennison, is: were there ever any circumstances where, in relation to the same death, you could get a report from more than one doctor?

A. A report?

Q. Let me give you an example and it's this example: a child is treated in one hospital and that's where they get their all treatment from really and they are transferred to the Children's Hospital and that is where they carry out the brainstem death tests and they are certified as brainstem dead there. Did you ever have a situation where the doctor from -- let's call it the treating hospital -- reports in when they hear the child has been certified dead as well as a doctor from the Children's Hospital who is actually there when the child is certified dead?
A. No, that never happened to me.
THE CHAIRMAN: Or did you ever get two doctors, say from the Royal, reporting the same death?
A. That never happened to me.
THE CHAIRMAN: So there was always one death, one report?
A. Yes.
MS ANYADIKE-DANES: You say it didn't happen to you. Is it something that you were even aware of having happened to any of your colleagues?
A. No, I can never remember that happening.
Q. Were you ever aware of a member of a board contacting you, having carried out investigations and perhaps having formed the view that the death of this child really ought to be reported; did you ever have

a situation like that?
A. Not that I can remember.
Q. Or director of public health?
A. No.
Q. As you know, one of the things that can happen -- and in fact did happen with Lucy -- was that there was a hospital post-mortem, and that was something that you knew did happen from time to time.
A. Yes.
Q. Did you ever get a report from the pathologist as a result of that hospital post-mortem, realising that this is a matter that ought to be referred or reported to the coroner; did that ever happen?
A. I can't remember. Sorry.
Q. No, no. Only two more questions. One of them is this: in the main register for deaths, you put in gastroenteritis.
A. Yes.
Q. You have also said, in your view, you spoke to Dr Hanrahan, you would have got certain details from Dr Hanrahan and you also spoke to Dr Curtis. The reference to the death certificate having gastroenteritis, do you know or are you in a position to help us with whether that suggestion for how to complete the death certificate came from Dr Curtis or from

Dr Hanrahan?
A. Sorry, I can't remember.
Q. That's all right. And then this is the final question.
If a doctor contacts you and says, "I actually don't know what the cause of death is" --
A. Sorry?
Q. If the death or the clinician who is making the report says, "I don't know what the cause of death is, this is something, it's most unusual, I think it needs further investigation, I just don't know what the cause of death is", do you know what the procedure is then?
A. It would mean then that the doctor would be unable to write the death certificate.
Q. Yes.
A. So then a post-mortem would have to take place because he's really saying, "I don't know what the cause of death is".
Q. And if that happened, would you need to get any advice or do you know what the upshot of that is? If you can't write a death certificate, then we're going to have to engage in some further investigation; would you know that?
A. Yes. You would know that that was a post-mortem, that the doctor is unwilling to write anything in the death certificate and unhappy to write after discussion and

discussion with the coroner, and he says, "I am unhappy". He can't write anything then -- a post-mortem ...
Q. Would have to happen?
A. Would have to happen because he was refusing to write --
THE CHAIRMAN: And you mean by that a coroner's post-mortem would have to happen?
A. Yes.
MS ANYADIKE-DANES: And I think you have almost answered it, but just to be clear because I have been asked to raise it with you: if, when you'd gone to speak to the coroner or Dr Curtis, as you did in this situation, and had gone back and said, "Well, the direction is you can just issue a death certificate", if the doctor had said, "I can't, I don't know what to put on it for the cause of death", what's the procedure then? I think you have answered it, but just for clarity.
A. I would go back to Dr Curtis and talk to Dr Curtis again and discuss it with him and then go back to the doctor and if the doctor still said he couldn't issue, I'd go back to Dr Curtis then so we got a resolution. But it doesn't go on like what you're saying now. It doesn't go on like that forever.
Q. No.
A. That's not ... Maybe one or two times if something is

severely wrong or there's a misinterpretation or just ...

Q. But ultimately, if that was the case, then as you have indicated, there would have to be --

A. A post-mortem.

Q. -- a post-mortem and --

A. If there was no resolution to it, yes, a post-mortem would happen.

The other thing is, sorry, if another doctor phoned in about Lucy Crawford, say in this case from the Erne Hospital, and somebody in the office, because there are only four of us and we sit as closely as this (indicating), and say just for example a doctor phoned in and said, "I'm phoning in to record the death of a child, Lucy Crawford, she's been transferred to the Royal", and somebody would just say -- I would just say, "Has anybody taken the death of Lucy Crawford?", just as simply as that in the office to my colleagues, and they would say -- because maybe I'd taken it and it wasn't in the register, and I'd say," Yes, I've got that death, that has been reported by a Dr Hanrahan". That's sometimes -- so, you know, that may happen if that's --

Q. Then of course you wouldn't be recording that other doctor's communication, if I can put it that way?

A. No, the one record of the -- that would stand then. You

know, that's what sometimes -- sometimes that has happened, you know. I didn't mean to mislead you, but that's --

Q. Just something that I should have asked you before. When you said it was a small office when you were there, 1999 to 2004, and you all pitched in more or less, did you also work on inquests yourself then or was it really just the reporting of deaths?

A. No, I also worked on inquests, but that was really after deaths were dealt with. If they were dealt with, if it was a quiet morning, then that's when -- yes, other things were required in the office.

Q. If the coroner had decided, or at least the guidance you got from Dr Curtis was, "This is something that the coroner needs to take on", and that's what the coroner was going to do, can you help us with typically what happens then and how long does it take before there's any contact with the hospitals that have been involved with the child?

A. What happens, they await the results of the -- await the result of the post-mortem --

Q. Yes.

A. -- and then the coroner makes a decision.

Q. So let's assume the coroner has seen the result of the post-mortem and says, "Yes, this is an inquest case".

A. Then it starts immediately and you start -- you contact the police officer and there's a central liaison department for the hospitals and you contact them and they start getting statements from everybody concerned.

Q. Remember the scenario I gave you, which is the one we have here, which is the child's treatment really was mainly in one hospital and then the child was transferred to the Children's Hospital, where brainstem death was determined. In a case like that, where would the coroner be seeking statements from?

A. He would seek statements from everybody who has had any part in her care at any stage.

Q. So that would be from both hospitals?

A. Correct.

Q. And once the post-mortem result or report has come through and the coroner's made his decision, you say you then immediately are contacting the police and effectively the procedure is underway to gather in the evidence, if I can put it like that?

A. Correct.

Q. Would it be common or unusual for a hospital involved to not appreciate for over a year that the coroner has decided that there should be an inquest?

A. Sorry?

Q. I didn't phrase that very well for you.

THE CHAIRMAN: We don't need to get into that because the point is that there's a liaison department which represents the hospitals to help you get statements in.

A. Correct.

THE CHAIRMAN: For instance, Mr Doherty, who gave evidence earlier this morning, said he worked for -- I think it's Westcare Business Services, is it? Yes, he worked for Westcare Business Services. His office would be contacted by the coroner's office to get statements.

A. Right.

THE CHAIRMAN: Does that ring a bell?

A. It does not. That's maybe a new system now.

THE CHAIRMAN: When you talk about a liaison department, where would that -- of course, that would be from the west. The liaison department for the Belfast hospitals, where would that be?

A. In the Royal somewhere, I would have -- if I can remember rightly, it was in the Royal somewhere.

THE CHAIRMAN: Was there a separate one for each hospital?

A. Yes, as far as I remember we had a separate person that we contacted for each sort of ... I'm guessing now.

THE CHAIRMAN: Okay, thank you.

MS ANYADIKE-DANES: That contact would be made reasonably speedily after the coroner had made his decision?

A. Yes. I think there was a standard letter that was sent

out and that then initiated proceedings.
MS ANYADIKE-DANES: Thank you.
THE CHAIRMAN: Thank you, Mrs Dennison. I think you'd better escape before anyone else thinks of any more questions to ask you.
(The witness withdrew)
Mr Quinn, I have received two notes this morning about Claire's case. One is about W2.
MR QUINN: Patient W2, sir.
THE CHAIRMAN: Yes, midazolam. And the other one is a query which has been raised about whether we should seek a forensic analysis of Dr Sands' entry in Claire's medical records.
MR QUINN: Yes.
THE CHAIRMAN: What I intend to do is we're going to paginate and circulate these documents in the next few minutes and then what I would like to do is for the Trust to give me its views on -- Wednesday is a fairly short day in the sense that we have Dr Carson being recalled, he's the only witness, so we'll take a bit of time on Wednesday to look at this and I'll hear any views from the Trust and I'll also invite views from the representatives of, I think, Dr Stevenson and Dr Webb might have something to say about midazolam.
MR QUINN: Sir, may I just add this one point? When

I circulated this this morning, I didn't include Mr and Mrs Roberts. I did show this to Mr Roberts during the first break and Mr Roberts has come back with another issue, that he did inform me about last week, which due to my omission, that I didn't put into the analysis that I prepared in relation to the forensic analysis of the notes. What it is is that Mr Roberts would also like --
THE CHAIRMAN: Sorry, which one is it?
MR QUINN: This is the issue of the forensic analysis of the notes and I will date the papers and number the papers. Really, what he's saying -- and I think this actually bears some strength of argument -- is that he also would like the tribunal of inquiry to consider investigating Dr Webb's entry of 4 pm, which appears in the same page as the "encephalitis/encephalopathy". If one were going to investigate that entry, one may as well investigate the entry made by Dr Webb. If I can bring the page up and demonstrate it --
THE CHAIRMAN: I'll tell you what to do, Mr Quinn, in the next half hour, we'll provide the facility for this to be amended and circulated rather than discuss now how it might be done. This paper will be circulated, finalised in the next half hour and be circulated to everybody by e-mail after that and we'll pick up the discussion after Dr Carson finishes his evidence by Wednesday.

By that time, the Trust will have had it today, and the Trust has a general idea of what we're saying today, but we will also forward the papers to the other parties, but specifically for the attention of Dr Stevenson and Dr Webb.
MR QUINN: Thank you, sir.
THE CHAIRMAN: So unless there's anything further today, ladies and gentlemen, I will adjourn until 10.30 tomorrow morning. Thank you.
(1.22 pm)
(The hearing adjourned until 10.30 am the following day)

I N D E X