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2 (10.00 am)
3 (Delay in proceedings)
4 (10.15 am)
5 THE CHAIRMAN: Good morning.
6 MR WOLFE: The next witness is Mr Kevin Doherty, please.
7 MR KEVIN DOHERTY (called)
8 Questions from MR WOLFE
9 MR WOLFE: Good morning, Mr Doherty.
10 A. Good morning.
11 Q. You have so far provided the inquiry with one witness
12 statement; it's dated 2 May 2013 and it's numbered
13 313/1.
14 A. Mm-hm.
15 Q. We ask all of our witnesses this: do you wish to adopt
16 that witness statement as part of your overall evidence
17 to be read in conjunction with your oral testimony
18 today?
19 A. Yes.
20 Q. At the time we are most interested in, which is the
21 period at or about 2000/2001, you were head of
22 litigation services for Westcare?
23 A. I was litigation services manager attached to Westcare,
24 yes.
25 Q. You're now head of litigation services; is that correct?

1 A. Yes. Westcare Business Services was a -- supplied
2 a number of services to the three different trusts,
3 including finance, litigation and various other ... We
4 were a support services organisation.
5 THE CHAIRMAN: Before the trusts were established, did
6 Westcare Business Services exist?
7 A. It did.
8 THE CHAIRMAN: Under the Western Board?
9 A. Sorry, it was a separate entity from the Western Board.
10 THE CHAIRMAN: Is it a company?
11 A. It was -- the idea behind it was to bring all the
12 support services together and to share them out with the
13 various trusts. It's not a company as such, no.
14 We were still part of the Health Service.
15 THE CHAIRMAN: And you're a civil servant?
16 A. Yes.
17 THE CHAIRMAN: Right.
18 MR WOLFE: As we can see within the job description that's
19 up in front of us, a little bit of detail there about
20 the role of Westcare Business Services. As you've just
21 said, it provides a range --
22 A. Sorry, it's not up in front of me.
23 MS SIMPSON: I think it isn't in front of the screen for the
24 witness. If he could be shown that. (Pause).
25 MR WOLFE: What you should have in front of you is the job

1 A. I'm still litigation services manager.
2 Q. Right. The title "head of litigation services", where
3 does it emerge from?
4 A. I'm not quite sure. We maybe refer to it one day as
5 litigation services manager and the next as head of
6 litigation services. They're both the same role.
7 THE CHAIRMAN: There's no difference?
8 A. There's no difference.
9 MR WOLFE: Thank you. The job description which I was
10 wishing to bring you to has "Head of litigation
11 services" on it.
12 A. Sorry about that.
13 Q. That's your job description?
14 A. Yes.
15 THE CHAIRMAN: That's your job apparently?
16 A. That's my job apparently. I don't mind what I'm called
17 as long as they're paying me!
18 MR WOLFE: Just looking at that briefly, please. You were
19 appointed to this post on 1 May 1997.
20 A. Yes.
21 Q. And as I say, let's look at your job description
22 briefly, 319-042a-013. Perhaps before we delve into the
23 detail of that, Westcare Business Services, could you
24 tell us something about that organisation and its
25 interrelationship with the three trusts?

1 description.
2 A. Yes.
3 Q. Where I'm bringing you to on this page is 013 of this
4 series. If you can confirm you're on the right page.
5 A. Yes.
6 Q. I'm obliged. We're dealing with that section halfway
7 down, which sets out the background to the organisation.
8 It tells us that:
9 "Westcare Business Services provides a range of
10 support services to the Western Board."
11 And then to the three trusts as they then were.
12 A. Yes.
13 Q. That is the Altnagelvin, the Foyle and the
14 Sperrin Lakeland?
15 A. Yes.
16 Q. And then the background piece tells us a little bit
17 about the litigation service --
18 A. Mm-hm.
19 Q. -- which you were to manage?
20 A. Yes.
21 Q. And it's described as:
22 "An important component of Westcare, providing
23 specialist legal services to the trusts, the board and
24 Westcare Business Services. It is owned by a consortium
25 of the trusts and the board and is accountable to them."

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

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

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

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

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

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1 I think, Bridget O'Rawe.
2 Q. That's Ms O'Rawe's role?
3 A. Yes.
4 Q. Director of personnel?
5 A. Not all the time, but would have been called in if her
6 expertise would have been needed.
7 Q. So I suppose if it was not a medical negligence case,
8 for example, if it was an employer's liability case, you
9 might have had the director of personnel in attendance?
10 A. Mm-hm.
11 Q. And then director of finance, if appropriate, I suppose?
12 A. Well, no, director of finance would normally have
13 attended most of them because there was a very big
14 financial aspect to it.
15 Q. Legal representative and then litigation officer.
16 A. Yes.
17 Q. If we go back then to 047-104-234. I want to bring your
18 attention to 12 October. Sorry, just before that,
19 25 June:
20 "Case discussed at Trust's scrutiny committee.
21 Legal directorate to contact coroner's office to check
22 details regarding inquest."
23 That implies that the DLS representative at the
24 meeting is going to check with the coroner's office?
25 A. Yes, that would have been the case, yes.

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

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

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

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1 Adam's death in November 1995. And when Raychel died in
2 2001, she died in June 2001, the coroner had asked
3 Altnagelvin for their statements by October 2001, and he
4 had asked the Royal for their statements
5 by December 2001. So that would be in keeping with what
6 you would expect?
7 A. Yes.
8 THE CHAIRMAN: You would have known, Mr Doherty, wouldn't
9 you, that if Lucy had died in April 2000, that it would
10 have been extraordinary that the coroner had not sent
11 out a request for witness statements by the end of 2001?
12 A. Yes, I would think so, yes. I'd agree with that.
13 THE CHAIRMAN: And anybody who had any experience with
14 inquests would know that too?
15 A. Mm-hm, mm-hm.
16 THE CHAIRMAN: Thank you.
17 MR WOLFE: Could we move on to the next page, please, 235?
18 The position having been settled at the end of the year
19 before, after a check had been made that there was to be
20 no inquest, the issue appears to have come on the agenda
21 again on 12 April 2002 meeting; do you see that?
22 A. Yes.
23 Q. It says:
24 "Dr Jenkins' report considered."
25 That was a report obtained by the Sperrin Lakeland

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

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

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

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1 Q. That was your understanding?
2 A. Yes. Mm-hm.
3 THE CHAIRMAN: Sorry, if the coroner had already confirmed
4 that there was to be no inquest --
5 A. I know, why would you go back again?
6 THE CHAIRMAN: Why would you go back and why would you go
7 back two years after a child's death when nobody's
8 bothered to collect a witness statement in between?
9 There's no hint at all from the coroner that there's
10 going to be an inquest for two years, sure there isn't.
11 A. No, there's not.
12 THE CHAIRMAN: In fact, there's no hint from the coroner for
13 three years.
14 A. Yes, mm-hm.
15 THE CHAIRMAN: So what I'm wondering is how anybody in the
16 Sperrin Lakeland Trust could have been under any
17 misapprehension that there was going to be an inquest
18 when it had been confirmed in October 2001, that's about
19 18 months later, that there was going to be no inquest
20 and then for three years there was no witness statements
21 gathered.
22 A. Yes.
23 THE CHAIRMAN: So who on earth could have been wondering
24 round the Erne Hospital thinking, "I wonder what date
25 the inquest is going to be on?"

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1 A. I really can't remember. If it was, it would have been
2 at scrutiny committee, but I'm sorry, I can't remember
3 that.
4 Q. Because if DLS, as at 12 April 2002, were going back to
5 the coroner, perhaps in light of Dr Jenkins' report, the
6 scrutiny committee would be looking to see what had
7 happened?
8 A. How they got on from it, yes.
9 THE CHAIRMAN: Mr Wolfe, 12 April 2002 doesn't say DLS are
10 going back to the coroner. The entry says:
11 "DLS to confirm possibility of inquest being held."
12 It says nothing that DLS are going back to the
13 coroner.
14 MR WOLFE: We'll need to check the transcript, but what was
15 your understanding, Mr Doherty, of what was to happen
16 in relation to confirming the possibility of an inquest
17 being held? What steps were to be taken, if any?
18 A. Well, in that note I have:
19 "12 April 2002. Case discussed at the trust
20 scrutiny committee. Dr Jenkins' report considered ...
21 DLS to confirm possibility of inquest being held."
22 I think I would assume that maybe that meant they
23 would be going back to the coroner's office, but it's
24 not stated there. I think that's the only way they'd
25 find out if an inquest was going to be held.

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

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1 A. I can't answer that. I don't know. I mean, if
2 Dr Kelly's saying that, then I have to go with that.
3 Q. Is your evidence that, so far as what your understanding
4 was, the clear indication via the DLS in October 2001
5 was that there wasn't going to be an inquest and that
6 position didn't change?
7 A. That's right and I think, at the time, that's why I've
8 written the note saying, "Bring this forward to the next
9 scrutiny committee", which would have been then shared
10 with the members of that committee.
11 Q. Could we go back then and look at the claims management
12 policy, which we had up on the screen earlier?
13 319-042a-004.
14 MR GREEN: Before we look at that, I wonder if we could just
15 stick with the chronology for just one moment? There's
16 a portion of the chronology which is incomplete. It's
17 in relation to a meeting on 8 April 2003 at 4 pm in the
18 Bar Library between Patrick Good, Donna Scott and
19 Dr Kelly. I'm not going to ask that the reference be
20 pulled up because claims of inadvertent disclosure and
21 retrospective assertions of privilege have been asserted
22 by DLS in respect of these documents, but if I may just
23 raise three discrete points without having the document
24 pulled up. It appears first --
25 MR WOLFE: What document are we referring to?

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1 tread with some caution as to how far one can rely on it
2 in terms of treating it as complete.
3 THE CHAIRMAN: Or what it actually means.
4 MR GREEN: Yes.
5 THE CHAIRMAN: Well, could we bring up the page from the
6 chronology, Mr Wolfe, that had the April 2003 entry on
7 it?
8 MR WOLFE: We're dealing with two different things.
9 THE CHAIRMAN: We are.
10 MR WOLFE: The note that my learned friend refers to is
11 a consultation at the Bar Library, it's not a scrutiny
12 committee meeting.
13 THE CHAIRMAN: I understand.
14 MR WOLFE: But so far as the April 2003 meeting in
15 Mr Doherty's chronology, we'll find it at 047-104-235.
16 MR GREEN: And you will see, sir, that we jump from -- well,
17 I'll not put it in the plural, I will express it in the
18 third person. Mr Doherty jumps from 18 March 2003 to
19 25 April 2003, and of course there is this very
20 significant meeting in the Bar Library on 8 April 2003.
21 THE CHAIRMAN: This was a meeting in the Bar Library, which
22 was in essence to agree an approach to what should be
23 done with the claim brought by Lucy's parents about her
24 death; okay?
25 A. Mm-hm.

23

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

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1 THE CHAIRMAN: Would we expect that to feature in your
2 chronology or not?
3 A. I think it should do, yes. I think it should have.
4 THE CHAIRMAN: And that would then record that there was
5 a meeting on 8 April, which is between the second and
6 third last dates on this page?
7 A. Mm-hm.
8 THE CHAIRMAN: And the point which is being made by Mr Green
9 is that at that meeting, apparently, Dr Kelly was
10 recorded as being surprised that no inquest had been
11 arranged, whereas the information which you've provided
12 on this chronology is that for some considerable time
13 before that it was clear that no inquest was to be
14 arranged.
15 A. Yes.
16 MR WOLFE: No doubt you will consider all of the
17 documentation and oral evidence to you in the round, but
18 it's evident from the document that my learned friend
19 refers to that it will have to be read with some care.
20 It doesn't expressly refer to Dr Kelly in the context of
21 indicating surprise that an inquest had not been
22 arranged before now. Perhaps it's a matter for
23 submissions by those concerned about it in due course.
24 The claims management policy, Mr Doherty,
25 319-042a-004. Could you help us with this? This

24

1 document, as we indicated earlier, is in its third
2 version on the screen in front of us.
3 A. Yes, mm-hm.
4 Q. Was there such a policy in place when the litigation
5 surrounding Lucy Crawford's case commenced in the spring
6 of 2001?
7 A. I think there was a previous draft of that.
8 Q. The purpose of the document is what, to provide a road
9 map through the litigation process?
10 A. Yes.
11 Q. This section in front of us, dealing with apologies and
12 explanations, I want to ask you just about that. There
13 is a statement of principle at 7.1 that:
14 "The Trust encourages staff to offer apologies
15 and/or explanations as soon as an adverse outcome is
16 discovered."
17 And those who are interested can read the rest of
18 it, but from that statement of principle, is it proper
19 for this inquiry to infer that the culture that the
20 Trust is attempting to promote is one of openness and
21 transparency?
22 A. Yes, I would agree with that.
23 Q. Just on this document, it does refer to "the Trust"; is
24 this document the Sperrin Lakeland Trust's?
25 A. It is.

25

1 to go to the family; we would have got legal advice on
2 that.
3 MR WOLFE: One of the things that was suggested on
4 Dr Kelly's part is that this desire to be more open to
5 the family is necessarily the subject of legal advice
6 in the litigation context.
7 A. Well, the decision, as I say, was not mine, but it had
8 been advised -- our legal people had advised that
9 it would not be proper to go to the family, but that was
10 taken out of my hands, unfortunately.
11 THE CHAIRMAN: When you say your legal people had advised
12 that, is that in the context of Lucy's case?
13 A. Yes, yes.
14 THE CHAIRMAN: Beyond Lucy's case, was that pretty much
15 a standard position, that if there was litigation going
16 on, doctors or nurses or managers were discouraged from
17 engaging with the families?
18 A. I'm not sure if -- I don't think I've ever come across
19 one this bad(?) before Lucy's case, to be honest with
20 you, Mr Chairman.
21 THE CHAIRMAN: What about since Lucy's case?
22 A. No.
23 THE CHAIRMAN: Okay.
24 MR WOLFE: One of the tasks that fell within your job
25 description was to collate statements for the litigation

27

1 Q. This culture of openness and transparency appears to
2 have encountered difficulty in the context of
3 litigation. We have had evidence from Dr Kelly who has
4 explained to us that, by the middle of 2002, he wanted
5 to go to the family because he was concerned about the
6 evidence that was accumulating. So by this point in
7 time you had a report from Dr Moira Stewart of the Royal
8 College of Paediatrics and Child Health, you had
9 a report from Dr John Jenkins, and by August of that
10 year you had a second report from the Royal College.
11 I wonder, can you help us with this? Dr Kelly, as
12 I've described, wanted to go to the family with
13 information but was held back from doing so; can you
14 help us with that?
15 MS SIMPSON: Before the witness answers, I think it would be
16 proper to find out if he was the person who made that
17 decision or he had a part to play in that.
18 THE CHAIRMAN: Were you aware of that?
19 A. Sorry, of having a part to play in it or ...
20 THE CHAIRMAN: In light of the clear-ish reports which the
21 Trust was receiving, were you aware that Dr Kelly wanted
22 to speak to the family to express regret or an apology?
23 A. Well, not that I remember, chair, to be honest with you,
24 no. But again, as counsel has pointed out, it would not
25 have been my remit to make the decision whether or not

26

1 process.
2 A. That's correct.
3 Q. That also applied when an inquest was to be held.
4 A. Yes.
5 Q. Dr O'Donohoe provided Dr Kelly with a witness statement
6 in August 2003, I believe.
7 A. Mm-hm.
8 Q. If I could just put it up on the screen, please.
9 047-038-118. I will put it in context for you. The
10 statement comes to Dr Kelly and then he passes it on to
11 you; is that right?
12 A. That's correct, yes.
13 Q. And this is Dr Kelly enclosing original statements as
14 promised. He's indicating you were to access Dr Malik's
15 statement. Dr Malik had, by this stage, left the
16 Trust --
17 A. Yes.
18 Q. -- and they're to be forwarded to Donna Scott and then
19 on to the coroner's office; is that the appropriate
20 procedure?
21 A. Yes, and there is a note at the bottom from myself
22 saying that they have been forwarded on to DLS.
23 Q. So that's, "Originals to Anne Cassidy", who's
24 a solicitor in the DLS?
25 A. That's correct, "For the attention of Donna".

28

1 Q. And you've signed off on that then?
2 A. Yes.
3 Q. So the process seems to be that statements go to the
4 medical director and then on to you --
5 A. Mm-hm.
6 Q. -- and then on to DLS for forwarding to the coroner's
7 office; isn't that right?
8 A. Mm-hm. In this case that is correct, yes.
9 Q. And Dr Kelly received the following statement, if I can
10 put it up on the screen. 047-053-148. You can see it's
11 sent to Dr Kelly on 24 August 2003. Could we highlight
12 the last paragraph, please? Dr O'Donohoe is saying:
13 "The only respect in which this report differs from
14 the previous version ..."
15 By "the previous version", he means, he has told us
16 in his witness statement, the version that he provided
17 for the review back in the year 2000. He says:
18 "The only difference is in respect to the infusion
19 of 500 ml of normal saline to which I did not refer
20 in the version I sent to you previously. Since this is
21 approximately 50 ml/kilogram, a much larger volume than
22 I would use, I believe this had been started following
23 the first episode of diarrhoea, i.e. before the
24 convulsion."
25 And then if we can go over the page, please, to 149,

29

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

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1 he then sets out a description of his understanding of
2 the state of medical knowledge at or about the time of
3 Lucy's death by reference to certain literature with
4 which he has been provided.
5 That appears to have been the statement that you've
6 passed on to DLS. Could we then have a look at the
7 statement that was eventually sent? A second statement
8 was sent to you directly by Dr O'Donohoe. If I could
9 have that up on the screen, please; it's 047-158-334.
10 So this is sent to you on -- if the facsimile stamp
11 on the top is right -- 12 December 2003, so it's about
12 four or five months after the statement that's given to
13 Dr Kelly.
14 A. Mm-hm.
15 Q. By the stage of this statement reaching you, there's one
16 new entry. If you look at the second paragraph, there's
17 a sentence which says:
18 "The intravenous fluid used was saline, 0.18
19 per cent."
20 And then the last paragraph, which I referred you to
21 earlier, which contained the comment, the critical
22 comment, in relation to the amount of normal saline that
23 had been used, and then the analysis by reference to the
24 medical literature, that drops out of this statement?
25 A. Mm-hm.

30

1 A. Yes.
2 Q. You then have faxed to you on 12 January 2004 a further
3 statement from Dr O'Donohoe that contains a number of
4 changes.
5 A. Mm-hm.
6 Q. Can you help us, Mr Doherty, in terms of why certain
7 content falls out of Dr O'Donohoe's statement and why --
8 MS SIMPSON: Sorry, sir. Firstly, if the content has
9 changed, the witness has to be asked whether he noticed
10 the content changed, that's the first question. And if
11 those changes had been made, was it he who made those
12 changes? Just for correctness.
13 THE CHAIRMAN: What we're getting to is a question of how
14 those changes came about.
15 Just before we leave this, looking at the changes
16 which are suggested by you on screen --
17 A. This is in the e-mail, chair, yes?
18 THE CHAIRMAN: On the e-mail, yes. Would you say that's
19 correcting grammatical errors and --
20 A. I think that that information would have been given to
21 me by DLS, having received the statements, to make
22 amendments and ... But you are right, the majority of
23 the errors are correcting grammatical errors.
24 THE CHAIRMAN: So when it says at the start:
25 "I would be obliged if you could bring the following

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1 to the attention of the nurses involved?"
2 Do you think that what follows is pretty much
3 a cut-and-paste job from DLS coming to you and you
4 forwarding that to the Trust?
5 A. Yes.
6 THE CHAIRMAN: As opposed to you going through the witness
7 statements of Jones, Swift, McManus and McCaffrey and
8 correcting, for instance, "Should 'giving' be read as
9 'given'", and so on?
10 A. That's correct, yes.
11 THE CHAIRMAN: So you say this is all DLS?
12 A. Yes.
13 THE CHAIRMAN: Okay.
14 MR WOLFE: Just in response to my learned friend's
15 intervention, let's take this process back a step.
16 Could we put up on the screen, please, 047-160-336?
17 Four/five months after having received a statement from
18 Dr O'Donohoe, via Dr Kelly, you find yourself writing to
19 the coroner on 11 December 2003, telling him that you
20 are awaiting a statement from Dr O'Donohoe; do you see
21 that?
22 A. Yes.
23 Q. Help us if you can: you are telling the coroner that,
24 but you have already received a statement from
25 Dr O'Donohoe and, as we can see from the compliments

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1 amendments go back to Dr O'Donohoe?
2 A. Again, I couldn't say yes or no to that. I really don't
3 know. I mean, I think that the time was that for all
4 statements that came in that they would have been
5 forwarded on. If there was something that was noticed
6 by our legal people, then they would advise accordingly.
7 I certainly wouldn't be taking any decisions as to what
8 should stay in or come out.
9 Q. Did you appreciate that the statement that you
10 ultimately sent on to the coroner in early January from
11 Dr O'Donohoe was different to the statement that you had
12 received four or five months earlier?
13 A. I would say no because, again, I don't read all the
14 statements through, and that's as simple as that.
15 Q. And in terms of the changes that were made to the
16 statement which I've pointed out to you now, is this
17 morning the first time you've noticed them?
18 A. I have to say yes. Again, I would not have been
19 involved in editing statements, advising on statements
20 and that. Basically, I think what I would understand is
21 we were basically a post-box that got the reports in and
22 forwarded them on to the relevant people.
23 MR WOLFE: Very well. I'm obliged. I have no further
24 questions.
25 MR GREEN: Can I help with a date? I think my learned

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1 slip that you signed off with Anne Cassidy, you
2 anticipated that that statement would go to the coroner?
3 A. Yes.
4 Q. It clearly hasn't gone to the coroner.
5 A. Yes.
6 Q. There is a process afoot, is there, to examine
7 Dr O'Donohoe's statement?
8 A. Well, I was certainly not examining Dr O'Donohoe's
9 statement.
10 Q. Right. So what do you understand is the position on
11 11 December?
12 A. Well, I understand from that there that I -- obviously
13 that Mr Leckey had been in touch with us looking for the
14 statements and I was trying to bring him up-to-date with
15 where we were at that time.
16 Q. You know that there is a statement because you've had it
17 in your hands and you've given it to DLS?
18 A. Yes.
19 Q. So in terms of process, what is happening to that
20 statement?
21 A. Well, I would imagine, if there were any amendments
22 being made to it, they would have been made and
23 Dr O'Donohoe advised, but I don't know.
24 Q. So your understanding of the process is that somebody is
25 making amendments to it and then those proposed

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1 friend said twice that Dr O'Donohoe's final statement
2 was sent to the coroner in January 2004. In fact,
3 if we can pull up the chronology at 047-104-236 --
4 THE CHAIRMAN: 12 December?
5 MR GREEN: 12 December. And if one looks at the rest of the
6 page and reads back down to that date, it might help the
7 inquiry to some extent with what was going on because
8 there seems to have been toing and froing about the
9 litigation, and then a consultation on 9 December 2003,
10 doctors O'Donohoe, Auterson, Mr Doherty, Donna Scott and
11 Mr Good, senior counsel, in attendance. On 10 December,
12 there seems to have been some robust analysis of where
13 the Trust were with this. Then, on 11 December,
14 "approval for settlement sought". 12 December, the
15 claim is settled and, on that date, Dr O'Donohoe's
16 statement is sent to the coroner.
17 So it may well be that DLS parked the sending of the
18 statement to the coroner until they knew exactly where
19 they stood with the litigation. But I just thought that
20 it might assist if the correct date were brought to the
21 inquiry's attention.
22 MR WOLFE: In fact, if we could have up on the screen,
23 please, 047-157-333. There appears to be an
24 inconsistency, perhaps, between the timeline produced by
25 Mr Doherty and this letter, unless the coroner was sent

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1 it on both dates.
2 MR GREEN: Perhaps the witness could be invited to deal with
3 that apparent inconsistency.
4 THE CHAIRMAN: Can you help with us that? You've seen from
5 the chronology a moment ago that it records that
6 Dr O'Donohoe statement was finally sent to the coroner
7 on 12 December, whereas what we have here is your letter
8 enclosing the statement; should I go by your letter of
9 6 December?
10 A. I think, yes.
11 THE CHAIRMAN: Thank you.
12 MR WOLFE: I have no further questions.
13 THE CHAIRMAN: Any questions from the floor? Ms Simpson?
14 Thank you very much indeed for coming. You're now
15 free to leave.
16 (The witness withdrew)
17 THE CHAIRMAN: We'll take a short break and then hear
18 Mrs Dennison, who I expect to be finished by lunch.
19 This will have to be addressed in submissions by
20 both the Sperrin Lakeland Trust, or the Western Trust as
21 the successor, and those who represent the various
22 doctors and others who were involved in the Sperrin
23 Lakeland Trust, but I should just say I'm having the
24 greatest possible difficulty accepting at the moment
25 that anybody really believed there was going to be an

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

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1 inquest. Thank you.
2 (11.18 am)
3 (A short break)
4 (11.35 am)
5 THE CHAIRMAN: Ms Anyadike-Danes?
6 MS ANYADIKE-DANES: Good morning. Can I call Mrs Dennison,
7 please?
8 MRS MAUREEN DENNISON (called)
9 Questions from MS ANYADIKE-DANES
10 MS ANYADIKE-DANES: Good morning, Mrs Dennison.
11 I'm going to ask you if you wish to adopt the two
12 previous statements that you've made, subject to
13 anything that you might say now in your evidence. Let
14 me just help you with that. You made a statement to the
15 PSNI. It's 115-033-001, dated 7 December 2004.
16 A. Yes.
17 Q. And then you also made a statement for the inquiry. The
18 reference for that is 276/1.
19 A. I don't have a copy of that statement, sorry.
20 Q. It will come up on the screen, the relevant parts of it.
21 This is your PSNI one.
22 A. I've got that one, yes.
23 Q. Let's have this up. Would it assist you if you had
24 a copy of it with you?
25 A. It might, if that's all right.

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1 before? Ever been required to look at medical
2 documents?
3 A. No.
4 Q. Deal with medical information?
5 A. No.
6 Q. And then I think when you made your statement to the
7 PSNI, you said that you were there until April 2004;
8 is that correct?
9 A. Yes.
10 Q. And you were then making your statement to the PSNI
11 in December 2004?
12 A. Yes.
13 Q. Did you return back at any time after April 2004 to work
14 in the coroner's office?
15 A. Yes, I did.
16 Q. And when was that, roughly?
17 A. I returned ... I retired from the Court Service and
18 I was there probably about a year before I retired, so
19 maybe about 2010.
20 Q. 2010, roughly?
21 A. Yes, to 2011-ish.
22 Q. Thank you. And when did you go back, were you doing
23 much the same job as you had been doing up until you
24 left in April 2004?
25 A. The coroner's office had quite changed in that time.

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1 When I went back, it was different type of work that
2 I was doing then.
3 Q. Can you help us with the difference in work between what
4 you were doing previously and what you did when you came
5 back?
6 A. At the time of this death, I was working part-time and
7 I was working 9 o'clock to 2 o'clock and that mainly --
8 in that time, that was taking deaths and when I went
9 back the second time, I set up inquests for hearing.
10 Q. Did you take deaths when you returned?
11 A. No.
12 Q. Okay. We have a job description for you. I'm just
13 going to pull up the first page of it and then, as I ask
14 you some questions, we'll go through particular parts of
15 it. But just so that you recognise it, it's witness
16 statement 276/1, page 7.
17 A. This is -- I had a quick look at this this morning --
18 one of the girls gave it to me -- and as I understand
19 it, this is a current --
20 Q. Yes.
21 A. This wouldn't have applied at the time of this.
22 Q. Ah. That's what I was going to ask you about.
23 A. Sorry.
24 Q. No, no, that's all right. Because on the very last
25 page, if we go through to page 20 of this, there are

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1 Q. I'm going to help you by asking you a few more detailed
2 questions about that, but that's in general terms what
3 your job was?
4 A. Yes, and we mainly all did the same thing.
5 Q. How many were in that office at that time?
6 A. As I remember, four.
7 Q. At any given time there would be four, would there?
8 A. Yes, there were four members of staff. There was
9 myself, and I worked in the morning. Then there was
10 another EO, Mr Ian Maxwell, and then there was
11 a personal secretary to Mr Leckey, but you also helped
12 with office duties, Denise -- I've forgotten her other
13 name -- and a clerk, Graham Kennedy. So that's four of
14 us.
15 Q. In terms of those who were mainly concerned with
16 receiving the reporting of deaths, who would they have
17 been in the office?
18 A. We all did that.
19 Q. You all did that?
20 A. Everybody.
21 Q. If you had not done anything like that before, what sort
22 of training did you have so that you could receive those
23 reports of deaths and know what to do with them, if
24 I can put it like that?
25 A. We just trained. It was a very small office, it wasn't

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1 a number of postholders. We don't need to worry about
2 those, we've redacted them. Unfortunately, in an excess
3 of redaction, we've actually redacted your name, but
4 your name would have been fifth down --
5 A. Okay.
6 Q. -- in fact, the longest line. That would have been your
7 name.
8 What I wanted you to help me with is: if that has
9 been agreed by you as being the job description, for
10 what period did you say this reflected your job?
11 A. So Sharon, the staff officer, has dated this
12 for November 2010, so this would have been at the second
13 stage going back. This wasn't in place at the stage of
14 the death of Lucy Crawford.
15 Q. So what, so far as you can help us with, was your job
16 description at the time of Lucy Crawford's death?
17 A. At this stage, when this document was written, there was
18 a coroner's service --
19 Q. Yes.
20 A. -- but in the days of Lucy Crawford, it was part of the
21 Northern Ireland Court Service.
22 Q. I see.
23 A. And it was based in Newtownabbey and it was a small
24 office. At that time, my role was to record deaths, set
25 up inquests and just general running of the office.

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1 very big, and you just sat with somebody and you just
2 learned hands-on, and you just -- it was a very
3 comfortable office to work in, so if I took -- when you
4 were learning, you just took a death and then you asked
5 the person to hold and then you discussed it with your
6 colleague, whoever was free. I just discussed it with
7 one of them and they said, "Do this, this, and this",
8 and you just -- that's how you actually learned to do
9 the job.
10 Q. So there wasn't a sort of programme set out, if you're
11 going to come in, "Now we'll start you with this and
12 then we'll work through in that way and by the time you
13 get to that you'll have reached the full range"? There
14 wasn't a programme like that?
15 A. No, and reading this now, that you get medical
16 terminology set out and all, which probably is very
17 helpful to the people, whereas you kind of learn that,
18 you learn a basic understanding and then you go for
19 advice after that.
20 Q. In fact, we can pull that up just as you mention it
21 because that was one of the things I was going to ask
22 you about. If I can take you to two pages and put them
23 side by side. So if you can put page 9 alongside
24 page 10, if you look at that bullet which is one up from
25 the bottom, starting:

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1 "The postholder processes reports of deaths via
2 telephone calls from the medical, legal and other
3 professions on a daily basis to progress coroner's
4 business in accordance with the coroner's service
5 charter."
6 And if you ignore for a moment the "coroner's
7 service charter" element of it, it goes on to say:
8 "This includes: recording the death on the coroner's
9 database; making recommendations to the coroner if an
10 autopsy is required and making arrangements for the
11 autopsy to be carried out; also referring and discussing
12 cases with the coroner's medical officer where
13 appropriate. The postholder is required to undertake
14 this duty without supervision during the weekend and
15 bank holidays on a rota basis."
16 That is reflecting what you say was the position
17 when you came back in 2010.
18 A. Yes.
19 Q. Did you do any of that in 2010?
20 A. Yes, there was no medical officer in our day, in the day
21 of this. So the postholder --
22 Q. Let's start first with 2010. I didn't mean to confuse
23 you. What I have just read out, did you do any of that
24 in 2010 when you came back?
25 A. No.

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1 guide me to where I was going with it and what he
2 thought or what the doctor had thought. You would kind
3 of like liaise between the two, collating the
4 information.
5 Q. Would it be fair to describe it as you're a gatherer in
6 of the information --
7 A. Very much so.
8 Q. -- which you then provide to the coroner or
9 the coroner's deputy, a decision is going to be made,
10 whenever that decision is going to be made, you then
11 inform whoever it is that has reported the death?
12 A. Yes.
13 Q. Would that be a fair way of describing it?
14 A. That does, yes.
15 Q. I wonder if you can help with this point before we get
16 into the specifics of Lucy's case: I know that, in
17 total, you were dealing with these sorts of matters from
18 1999 to 2004, so it might not be long enough to express
19 a view, but from your point of view, by the time you
20 left, were there more or less reports of hospital deaths
21 that you can recall?
22 A. I wouldn't ... I don't know.
23 Q. Did you have any sense that it was something that was
24 increasing or did it all seem much the same to you?
25 A. I never thought of it in those terms. I never thought

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1 Q. So you were entirely dealing with inquests and not this
2 aspect of it?
3 A. Correct.
4 Q. Maybe you can help us as to what elements of this you
5 did at the time of Lucy's death. So if we start with
6 processing reports of deaths via telephone calls from --
7 let's keep it to the medical personnel; did you do that?
8 A. Yes.
9 Q. That was to progress the coroner's business, but in any
10 event to carry out the coroner's work; that would be
11 right, would it?
12 A. Yes.
13 Q. Then you say, "This includes recording the death". If
14 you leave out the database part of it, you would have
15 recorded the death?
16 A. Yes.
17 Q. Is that right?
18 A. Yes.
19 Q. It says:
20 "Make recommendations to the coroner if an autopsy
21 is required."
22 Did you do any of that?
23 A. Not so much make a recommendation as to discuss --
24 Q. Whether one was required?
25 A. Yes, what I had taken down. And then the coroner to

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1 of it --
2 THE CHAIRMAN: Okay, that's fine.
3 A. -- like that. I never thought of it.
4 MS ANYADIKE-DANES: That's all right. I'm really going to
5 focus on that 1999 to 2000 period if I can put it that
6 way. About how much of your time would you have spent,
7 if you can even look at it in those terms, taking
8 reports of deaths?
9 A. Because of the hours I worked, a lot of my time was
10 taken with -- because you had a recording machine which
11 was on all night, so doctors left messages on that
12 throughout the night. So that had to be sorted as well
13 as deaths that happened maybe in a hospital during the
14 night. So those doctors were going to ring or accidents
15 or bodies that had come to the mortuary. So the morning
16 time in a coroner's office is a very busy time, so
17 mainly most of my time was dealt dealing with deaths
18 that had to be recorded.
19 Q. And just to go on to the point that you had made before
20 when I was asking you, if we see over on page 10,
21 nowadays, if one looks at the first bullet, it says:
22 "The postholder will undergo training in all tasks
23 to ensure effective business disposal and teamwork."
24 But more to the point:
25 "This training will include medical terminology."

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1 And then you will see, or at least you have seen,
2 that earlier in this job description, you are required
3 to be familiar with medical terminology. How did you
4 gain that understanding in 1999?
5 A. By using -- just ... There was a certain amount of
6 terminology that was familiar, you know, that was used
7 over -- myocardial infarction, I'd never heard of that
8 word until I went to coroner's, but became a familiar
9 term. So terms like that. So that became ... So just
10 by using some of the words.
11 Q. And then we also see from this that the first
12 highlighted part, certainly in this, that you might be
13 required to work unsupervised at times. I take it from
14 what you have said in the 1999 phase when you were
15 working there up to 2000, you were working 9 am to 2 pm
16 only during the week; is that right?
17 A. No, I also worked at the weekend on the rota.
18 Q. You did?
19 A. Yes, I did.
20 Q. Did you also work unsupervised in the way that it is
21 described here?
22 A. Yes. Probably, yes.
23 Q. So if you were doing that, if you were working at the
24 weekend or on bank holidays, who else would be in the
25 office at that time?

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1 A. Yes.
2 Q. Would this be fair: that your knowledge of the
3 circumstances in which clinicians reported was really
4 gained by noting the occasions when they did report?
5 A. Yes, probably.
6 Q. Then can you help us with this? So far as you're
7 concerned, what did it mean when we say "a clinician
8 reports a death"? What did that mean to you?
9 A. That the death had happened unexpectedly or unnaturally.
10 Q. Was it also possible for clinicians to phone up and
11 simply want some guidance?
12 A. Sometimes.
13 Q. Did that happen often?
14 A. Yes.
15 Q. How were you able to tell the difference between
16 a clinician who wanted some guidance and a clinician who
17 was actually reporting a death?
18 A. Because usually, they said they wanted guidance. They
19 were just making sure they preceded their report.
20 Q. If they told you that they wanted guidance and explained
21 the circumstances, would you make a record of that?
22 A. Yes.
23 Q. And where would you record that?
24 A. In the register. Well, in my shorthand notebook and
25 then my register.

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1 A. Some other person from the rota. There were always two
2 of you.
3 Q. So two of you, but doing the same thing?
4 A. Yes.
5 Q. Manning the phones really?
6 A. Yes.
7 Q. I understand. I wonder now if we can come to the issue
8 of the reporting of deaths to the coroner's office.
9 This area is governed by legislation. There's
10 the Coroner's Act and there's also the regulations.
11 Were you introduced to that and helped to see what the
12 obligations were on the part of those persons who were
13 reporting?
14 A. No. I don't ...
15 Q. Were you told that there were certain circumstances in
16 which -- let's keep it to medical practitioners or
17 clinicians -- were required to report? Were you aware
18 of that?
19 A. No, I didn't know that they were required by law.
20 I can't say that I did know that, no.
21 Q. Or those specific circumstances in which they had to do
22 so? Were you made aware of that?
23 A. Well, I knew that if it was an unnatural death that you
24 would have to report it.
25 Q. Yes.

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1 Q. If they wanted guidance, you put that in the register as
2 well?
3 A. Mostly, yes. I would have recorded that "death
4 certificate issued", yes.
5 Q. Well this, is where I wanted to be a little bit careful
6 to make sure I'm clear. If a clinician was reporting
7 a death, how did you record that that was the report of
8 a death?
9 A. I'm sorry?
10 Q. In fairness, let me pull up this register, 013-053a-290.
11 You have described this as the main register of deaths
12 in your police statement.
13 A. Yes.
14 Q. And you can see there, at the top left, there's a space
15 to identify the person who's reporting, then on the top
16 right the name and the date of birth of the person whose
17 death is being reported and then a place to include the
18 circumstances.
19 A. Yes.
20 Q. Does this mean this is a report of a death?
21 A. Correct.
22 Q. And who advised you, guided you in where and how you
23 actually record a death?
24 A. I would have sat with one of my colleagues when I came
25 to the office and watched them do it and then I would

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1 have just copied that, the way they did it.
2 Q. I wonder if I can show you this, and you may not have
3 seen it, but this is an extract from the coroner's
4 rules, the Coroner's Practice and Procedure Rules of
5 1963. If we can please pull up 170-001-037. There
6 we are. About three-quarters of the way down, you can
7 see, "Records, documents and exhibits".
8 A. Yes.
9 Q. And then at rule 34:
10 "A coroner shall keep an indexed register of all
11 deaths reported to him or to his deputy, which shall
12 contain the particulars specified in the second
13 schedule."
14 Firstly, were you aware of that, that that's
15 something that had to be done? That if a death was
16 being reported, you had to record it?
17 A. I didn't know that; we just did it.
18 Q. You didn't know from here, but you knew you had to do
19 it?
20 A. Correct, yes.
21 Q. If we just pull up 170-001-041, this is the second
22 schedule that is being referred to. You can see that
23 that is a register of deaths reported to the coroner.
24 A. Yes.
25 Q. Similar sort of information, although organised

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

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

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

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

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

14 A. Okay.

15 Q. This is really a guide, actually, to what the hospital
16 doctor ought to be doing before the report is made.

17 Just before that series of bullets:

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

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

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

3 A. Yes.

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

7 A. Yes.

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

10 Do you want to know that at the initial report?

11 A. Yes.

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

14 A. Yes.

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

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

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

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

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

5 A. Yes.

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

7 A. Not necessarily.

8 Q. "Date and time of death"?

9 A. Yes, you need that.

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

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

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

13 A. Yes.

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

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

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

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

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

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1 bullet point as the industrial disease.

2 MS ANYADIKE-DANES: Thank you. Then:

3 "Final conclusions as to the cause of death."

4 Would you want to know that at this stage?

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

7 --

8 Q. I understand.

9 A. -- and a pacemaker.

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

12 A. Yes.

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

16 A. Yes.

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

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

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

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1 report.
2 A. Yes.
3 Q. Yes. So you've put the clinician on hold, you try and
4 reach the coroner to see what has to happen next; would
5 that be the correct way of putting it?
6 A. Yes.
7 Q. And what might happen next?
8 A. I would discuss it with the coroner and he would say,
9 "Well, I think maybe this is the case for
10 a post-mortem", and I'd say, "Fine, thank you", and I'd
11 go back and say, "I've discussed it with the coroner and
12 he thinks this is a case for a post-mortem".
13 Q. If the coroner were to say that, "I think this is a case
14 for a post-mortem", what sort of post-mortem does that
15 mean? Does that mean, "I'll direct one, so the
16 post-mortem is under my authority"?
17 A. Yes.
18 Q. Or is it suggesting, "You can do one if you like for
19 your purposes, but I don't need it"?
20 A. If it was that case, the coroner would have made that
21 clear. If it was a hospital post-mortem then
22 the coroner would make that clear to me to say to the
23 doctor.
24 Q. Does that happen often, that the coroner volunteers that
25 the clinician might want to have a hospital post-mortem

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 A. I think so, yes.

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

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

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

25 A. Mm-hm.

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

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

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

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

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

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

8 THE CHAIRMAN: Right.

9 A. -- on an ongoing basis.

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

12 A. He usually was, yes.

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

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

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

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

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

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

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

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

17 A. No.

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

21 "On whose behalf was the pathologist acting?"

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

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1 "On whose behalf was the pathologist acting?"
2 And you see his answer:
3 "The pathologist would have been acting on my behalf
4 as HM Coroner for Greater Belfast."
5 Do you understand what that means?
6 A. That he would have been as if I was talking to
7 Mr Leckey.
8 Q. Is that what you thought was happening?
9 A. Well, yes, I was regarding his advice the same as
10 I would have regarded Mr Leckey's advice.
11 Q. So he was instead of the coroner?
12 A. Yes.
13 THE CHAIRMAN: Sorry, I think we need to be careful.
14 I think the coroner himself can clarify that because the
15 answer to the next question talks about Dr Curtis
16 providing advice to his office.
17 MS ANYADIKE-DANES: I'm going to come to that part.
18 THE CHAIRMAN: I'm not sure how far Mrs Dennison can help us
19 on the interpretation of Mr Leckey's witness statement.
20 MS ANYADIKE-DANES: I beg your pardon. I didn't mean to put
21 you in the position of trying to interpret Mr Leckey; I
22 was simply trying to know whether you had ever heard the
23 expression or had ever understood the except that the
24 pathologist would be acting on behalf of the coroner.
25 A. I never thought of it in those terms.

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1 By that, I mean anything that might have been
2 established by the coroner or perhaps maybe by a more
3 senior person in the office. Were you aware of that?
4 A. No, I don't think so. It was just a good working
5 relationship that we had with them.
6 Q. I understand. And on an occasion when the direction
7 that you were communicating was effectively, "This is
8 not a coroner's matter, you can issue your death
9 certificate", that would really mean that the matter
10 usually didn't come back at all to the coroner's office.
11 A. That's correct.
12 Q. I know it doesn't happen very often, so you might not be
13 able to generalise, but when you were telling the
14 clinician that a death certificate could issue, can you
15 help as to why it seems you indicated what could go on
16 that death certificate as opposed to simply leaving that
17 to the clinician to sort that out themselves really?
18 A. I ... I'm only guessing, but I'd have said Dr Curtis
19 maybe suggested to me that "1(a) gastroenteritis" could
20 have been a cause of death. That's the only reason
21 I would have got that or that the doctor -- I don't
22 know.
23 Q. I'm wondering if it is this way: when you were answering
24 me before about that line and you said, "That's where we
25 put the cause of death", irrespective of whether it was

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1 Q. We did ask you what role you thought Dr Curtis had. In
2 fact, I can take you to where we ask you that. It's
3 your witness statement 276/1, page 4. We ask you that
4 question almost precisely. It's at (1) right down
5 at the bottom:
6 "What was your understanding of the role or function
7 of Dr Curtis in the coroner's absence?"
8 And you have answered:
9 "Dr Curtis had no role."
10 A. I was thinking of that in the running of the coroner's
11 office, Dr Curtis had no role within our office.
12 Q. Yes.
13 A. It sounds all mixed up.
14 Q. No, no. So he generally didn't have a role?
15 A. He had no role within the office except in these unusual
16 circumstances --
17 Q. I understand.
18 A. -- except as a pathologist when called as a witness,
19 of course.
20 Q. The fact that you or your colleagues could, on the
21 isolated occasions when you needed to, contact the State
22 Pathologist's Office in the way that you had done, were
23 you aware of whether you were able to do that because
24 there was any kind of informal arrangement between
25 the coroner's office and the State Pathologist's Office?

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1 going to be a coroner's matter or whether you were going
2 to give a direction that the clinician could issue
3 a death certificate, were you required to try and insert
4 a cause of death there?
5 A. No, not necessarily. But if somebody had given me
6 a cause of death, I would have written it.
7 Q. I see. So you weren't obliged to do it, but if one was
8 given to you, you would?
9 A. I would have written it there so that I knew if somebody
10 asked me anything about it, I would have known what 1(a)
11 should have been.
12 Q. Yes. Then I wonder if I can ask you about this, if you
13 just give me one moment. (Pause).
14 You left the coroner's service after the period that
15 we've just been talking about in April 2004. Were you
16 aware then that an issue had arisen in relation to
17 Lucy's death by the time you left?
18 A. Um ...
19 Q. Let me see if I can help you because it's a very long
20 time ago to start thinking about that.
21 A. I think the cause -- if the cause of death of
22 hyponatraemia -- had that come through?
23 Q. I'm going to help you with something. This is a letter
24 that Mr Stanley Millar wrote to the coroner. He wrote
25 it on 27 February 2003. It's 013-056-320. We maybe

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1 need to pull up 321 so we get the two pages alongside
2 each other. Before you left, were you aware that
3 Mr Millar or anybody for that matter had contacted
4 the coroner, the coroner's office, about Lucy's death?
5 A. I can't remember, but I can remember the discussion of
6 hyponatraemia because we had never heard of -- at least
7 I'd never heard of hyponatraemia before, and then the
8 issue of that all arising from that.
9 Q. Was that before you left that that arose?
10 A. Yes. I can remember the discussion of hyponatraemia and
11 that sort of, to us, being an unheard of thing that we
12 had never come across before.
13 Q. Mr Millar, if you don't appreciate it, he was a chief
14 officer for the Western Health and Social Services
15 Council, and he was particularly assisting Lucy's
16 parents --
17 A. Right.
18 Q. -- through the process of trying to find out what had
19 happened to their daughter.
20 A. Right.
21 Q. So in the course of that, he learns about the
22 circumstances of a death of another child, which is
23 Raychel.
24 A. Right.
25 Q. And he puts two and two together effectively, and you

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1 reported, the two clinicians, Dr Curtis from the State
2 Pathologist's Office, have spoken -- that's Dr Hanrahan
3 who reported -- and the upshot of it was that
4 a post-mortem was not necessary. Were you ever asked
5 about the entry that you had made or the circumstances
6 of the phone calls or anything, do you remember that,
7 before you left, really?
8 A. No.
9 Q. Apart from when you were asked to provide a statement to
10 the PSNI, were you ever asked about the circumstances of
11 Lucy's death, or rather the report to you of it?
12 A. No.
13 Q. Was that the first time then?
14 A. When the police officer came to make a statement? Yes,
15 as far as I remember.
16 Q. And at that stage you were no longer working for
17 the coroner?
18 A. Yes, but I was still part of the Court Service. I was
19 in the Court Service and I was just across the road,
20 I wasn't far away. I was in Laganside, you know, so it
21 wasn't far away --
22 Q. But nobody asked you about that until that happened?
23 A. Not as far as I remember.
24 MS ANYADIKE-DANES: Thank you very much.
25 Mr Chairman, if you just give me one moment.

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1 can see in the top of the second page:
2 "I am left with two questions which you may be able
3 to answer."
4 The first is to do with whether the two deaths might
5 be related in terms of cause and then:
6 "Would an inquest in 2000/2001 have led to the
7 recommendations from Raychel Ferguson's inquest being
8 shared at an earlier date with the consequent saving of
9 her life?"
10 In other words, if they had had an inquest into
11 Lucy's death reasonably shortly after she died, would
12 they have learnt the lessons that may have been passed
13 on and affected the treatment that Raychel had got?
14 That is really the point he's getting at in that second
15 question.
16 The coroner replies to Mr Millar on 3 March. We see
17 it at 013-056a-322. It's a two-page letter and we don't
18 need to get into the second page. On the bottom
19 paragraph:
20 "At the time the death was reported to my office,
21 a note was made to the effect that Michael Curtis of the
22 State Pathologist's Department spoke to Dr Hanrahan of
23 the Children's Hospital. He concluded that
24 a post-mortem was not necessary."
25 So the coroner has got that the death has been

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1 (Pause). I have no further questions.
2 THE CHAIRMAN: Any questions from the floor? No?
3 Mrs Dennison, thank you very much for coming. Your
4 evidence is complete so you're free to leave now.
5 A. Thank you very much indeed.
6 THE CHAIRMAN: Mr Quinn, that brings an end to today's
7 evidence. I think there are a couple of bits and pieces
8 to be tidied up before we leave.
9 MR QUINN: There may well be.
10 THE CHAIRMAN: I'll rise for five minutes to deal with those
11 points. Tomorrow morning, Dr Curtis is giving evidence
12 first, but he is not available quite as early as other
13 witnesses have been, so we will not sit tomorrow until
14 10.30. I'll come back out in five minutes.
15 (12.58 pm)
16 (A short break)
17 (1.08 pm)
18 MS ANYADIKE-DANES: There are just a couple of questions and
19 I've indicated that to Mrs Dennison.
20 THE CHAIRMAN: Okay.
21 MS ANYADIKE-DANES: The first question, Mrs Dennison,
22 is: were there ever any circumstances where, in relation
23 to the same death, you could get a report from more than
24 one doctor?
25 A. A report?

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

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1 Dr Hanrahan?
2 A. Sorry, I can't remember.
3 Q. That's all right. And then this is the final question.
4 If a doctor contacts you and says, "I actually don't
5 know what the cause of death is" --
6 A. Sorry?
7 Q. If the death or the clinician who is making the report
8 says, "I don't know what the cause of death is, this is
9 something, it's most unusual, I think it needs further
10 investigation, I just don't know what the cause of death
11 is", do you know what the procedure is then?
12 A. It would mean then that the doctor would be unable to
13 write the death certificate.
14 Q. Yes.
15 A. So then a post-mortem would have to take place because
16 he's really saying, "I don't know what the cause of
17 death is".
18 Q. And if that happened, would you need to get any advice
19 or do you know what the upshot of that is? If you can't
20 write a death certificate, then we're going to have to
21 engage in some further investigation; would you know
22 that?
23 A. Yes. You would know that that was a post-mortem, that
24 the doctor is unwilling to write anything in the death
25 certificate and unhappy to write after discussion and

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

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

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1 severely wrong or there's a misinterpretation or
2 just ...
3 Q. But ultimately, if that was the case, then as you have
4 indicated, there would have to be --
5 A. A post-mortem.
6 Q. -- a post-mortem and --
7 A. If there was no resolution to it, yes, a post-mortem
8 would happen.
9 The other thing is, sorry, if another doctor phoned
10 in about Lucy Crawford, say in this case from the
11 Erne Hospital, and somebody in the office, because there
12 are only four of us and we sit as closely as this
13 (indicating), and say just for example a doctor phoned
14 in and said, "I'm phoning in to record the death of
15 a child, Lucy Crawford, she's been transferred to the
16 Royal", and somebody would just say -- I would just say,
17 "Has anybody taken the death of Lucy Crawford?", just as
18 simply as that in the office to my colleagues, and they
19 would say -- because maybe I'd taken it and it wasn't
20 in the register, and I'd say, "Yes, I've got that death,
21 that has been reported by a Dr Hanrahan". That's
22 sometimes -- so, you know, that may happen if that's --
23 Q. Then of course you wouldn't be recording that other
24 doctor's communication, if I can put it that way?
25 A. No, the one record of the -- that would stand then. You

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1 A. Then it starts immediately and you start -- you contact
2 the police officer and there's a central liaison
3 department for the hospitals and you contact them and
4 they start getting statements from everybody concerned.
5 Q. Remember the scenario I gave you, which is the one
6 we have here, which is the child's treatment really was
7 mainly in one hospital and then the child was
8 transferred to the Children's Hospital, where brainstem
9 death was determined. In a case like that, where would
10 the coroner be seeking statements from?
11 A. He would seek statements from everybody who has had any
12 part in her care at any stage.
13 Q. So that would be from both hospitals?
14 A. Correct.
15 Q. And once the post-mortem result or report has come
16 through and the coroner's made his decision, you say you
17 then immediately are contacting the police and
18 effectively the procedure is underway to gather in the
19 evidence, if I can put it like that?
20 A. Correct.
21 Q. Would it be common or unusual for a hospital involved to
22 not appreciate for over a year that the coroner has
23 decided that there should be an inquest?
24 A. Sorry?
25 Q. I didn't phrase that very well for you.

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1 know, that's what sometimes -- sometimes that has
2 happened, you know. I didn't mean to mislead you, but
3 that's --
4 Q. Just something that I should have asked you before.
5 When you said it was a small office when you were there,
6 1999 to 2004, and you all pitched in more or less, did
7 you also work on inquests yourself then or was it really
8 just the reporting of deaths?
9 A. No, I also worked on inquests, but that was really after
10 deaths were dealt with. If they were dealt with, if it
11 was a quiet morning, then that's when -- yes, other
12 things were required in the office.
13 Q. If the coroner had decided, or at least the guidance you
14 got from Dr Curtis was, "This is something that the
15 coroner needs to take on", and that's what the coroner
16 was going to do, can you help us with typically what
17 happens then and how long does it take before there's
18 any contact with the hospitals that have been involved
19 with the child?
20 A. What happens, they await the results of the -- await the
21 result of the post-mortem --
22 Q. Yes.
23 A. -- and then the coroner makes a decision.
24 Q. So let's assume the coroner has seen the result of the
25 post-mortem and says, "Yes, this is an inquest case".

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1 THE CHAIRMAN: We don't need to get into that because the
2 point is that there's a liaison department which
3 represents the hospitals to help you get statements in.
4 A. Correct.
5 THE CHAIRMAN: For instance, Mr Doherty, who gave evidence
6 earlier this morning, said he worked for -- I think it's
7 Westcare Business Services, is it? Yes, he worked for
8 Westcare Business Services. His office would be
9 contacted by the coroner's office to get statements.
10 A. Right.
11 THE CHAIRMAN: Does that ring a bell?
12 A. It does not. That's maybe a new system now.
13 THE CHAIRMAN: When you talk about a liaison department,
14 where would that -- of course, that would be from the
15 west. The liaison department for the Belfast hospitals,
16 where would that be?
17 A. In the Royal somewhere, I would have -- if I can
18 remember rightly, it was in the Royal somewhere.
19 THE CHAIRMAN: Was there a separate one for each hospital?
20 A. Yes, as far as I remember we had a separate person that
21 we contacted for each sort of ... I'm guessing now.
22 THE CHAIRMAN: Okay, thank you.
23 MS ANYADIKE-DANES: That contact would be made reasonably
24 speedily after the coroner had made his decision?
25 A. Yes. I think there was a standard letter that was sent

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

1 By that time, the Trust will have had it today, and
2 the Trust has a general idea of what we're saying today,
3 but we will also forward the papers to the other
4 parties, but specifically for the attention of
5 Dr Stevenson and Dr Webb.
6 MR QUINN: Thank you, sir.
7 THE CHAIRMAN: So unless there's anything further today,
8 ladies and gentlemen, I will adjourn until 10.30
9 tomorrow morning. Thank you.
10 (1.22 pm)
11 (The hearing adjourned until 10.30 am the following day)
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1 I circulated this this morning, I didn't include Mr and
2 Mrs Roberts. I did show this to Mr Roberts during the
3 first break and Mr Roberts has come back with another
4 issue, that he did inform me about last week, which due
5 to my omission, that I didn't put into the analysis that
6 I prepared in relation to the forensic analysis of the
7 notes. What it is is that Mr Roberts would also like --
8 THE CHAIRMAN: Sorry, which one is it?
9 MR QUINN: This is the issue of the forensic analysis of the
10 notes and I will date the papers and number the papers.
11 Really, what he's saying -- and I think this actually
12 bears some strength of argument -- is that he also would
13 like the tribunal of inquiry to consider investigating
14 Dr Webb's entry of 4 pm, which appears in the same page
15 as the "encephalitis/encephalopathy". If one were going
16 to investigate that entry, one may as well investigate
17 the entry made by Dr Webb. If I can bring the page up
18 and demonstrate it --
19 THE CHAIRMAN: I'll tell you what to do, Mr Quinn, in the
20 next half hour, we'll provide the facility for this to
21 be amended and circulated rather than discuss now how it
22 might be done. This paper will be circulated, finalised
23 in the next half hour and be circulated to everybody by
24 e-mail after that and we'll pick up the discussion after
25 Dr Carson finishes his evidence by Wednesday.

1 I N D E X
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3 MR KEVIN DOHERTY (called)1
4 Questions from MR WOLFE1
5 MRS MAUREEN DENNISON (called)38
6 Questions from MS ANYADIKE-DANES38
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