Wednesday, 12 June 2013

(10.00 am)

(Delay in proceedings)

(10.10 am)

THE CHAIRMAN: Good morning.

MR WOLFE: Good morning, sir. The next witness this morning is Dr James Kelly.

DR JAMES KELLY (called)

Questions from MR WOLFE

MR WOLFE: Good morning, doctor.

A. Good morning.

Q. I think you know the form by now. I have seen you sitting listening to the evidence most days. The first thing we do is ask you to ask you whether you wish to adopt some of the written documentation that you have provided along the way. You have provided two witness statements to the inquiry.

A. That's correct.

Q. They are WS290/1, WS290/2, dated 6 November 2012 and 21 January 2013 respectively. And then in addition to that, going back to 2005, you were interviewed by the Police Service of Northern Ireland, three, perhaps four sessions of interviews, and those interviews, at least the first of those interviews, encompassed a statement provided to you that was read into the record. Taking

all of that material together, do you wish to adopt that as part of your evidence to the inquiry?

A. I do indeed.

Q. Very well. The first thing I want to look at with you is just a little bit of your qualifications and experience. We don't have a CV from you, but your witness statement at WS290/1 at page 2 helpfully sets out your career background. Could we have that up on the screen, please? It runs on to page 3.

We can see, doctor, that you obtained your medical degree from Queen's University Belfast in July 1981; is that correct?

A. That's correct.

Q. And you obtained a doctorate, is that a master's?

A. Medical doctorate by thesis.

Q. In December 1988. You became a member of the Royal College of Physicians in July 1984; is that correct?

A. That's correct, yes.

Q. You went through the usual rotations as a trainee, but ultimately took to specialising in geriatric medicine towards the mid to late 80s; is that correct?

A. That's entirely correct.

Q. And you found yourself then in or about December 1988 taking up a position of consultant geriatrician in the Erne Hospital, as it then was?

A. That's correct. 1 December 1988.

Q. And you have worked in that environment, now the South West --

A. South West Acute Hospital.

Q. And you're still there?

A. In the same position as a consultant geriatrician.

Q. Yes. You took up the role of medical director at the Erne Hospital; isn't that correct?

A. That's correct, yes.

Q. And you took that up in or about 1 December 1999?

A. That's correct.

Q. And you served four years in that role?

A. Yes, that's correct. Chairman, at this stage would it be of assistance to the inquiry for me to give a little context about that post?

THE CHAIRMAN: Yes, thank you.

A. Just to outline for the inquiry that as medical director for, at that time, I was medical director for three hospitals, the Erne Hospital, the Tyrone County Hospital and the mental health facility called the Tyrone and Fermanagh Hospital. So that was the extent of -- the remit of the job covered all three hospitals. Traditionally, a medical director would be a full-time post. This post was a 0.5 whole time equivalent, it was a 50 per cent post. I was meant to get released, so to

speak, by one's colleagues. The problem for that for me was that I was a single-handed geriatrician, I was the first geriatrician appointed to that area, so I was single-handed with nobody to release me. So I had a job that in theory had a half whole time equivalent attached to it, but in practice I was released for two sessions. So effectively I was working one fifth for the whole job. To put that in context of today, the modern medical director would have a whole time post, they would have two assistant medical directors, and usually a team around them called a risk management team to effect the policies and governance agenda. I hope that's helpful to the inquiry.

THE CHAIRMAN: So the current medical -- sorry, what's the new hospital called in Fermanagh?

A. The new hospital is called the South West Acute Hospital.

THE CHAIRMAN: Does it have a full-time medical director?

A. No, the medical director role is fulfilled from Altnagelvin as part of the Western Trust, and that is a full-time post with assistant medical directors and covers ourselves, the South West Acute, and Altnagelvin.

THE CHAIRMAN: Thank you.

MR WOLFE: So to summarise that position, doctor, when you took up the role of medical director, one fifth of the

time in theory was supposed to be spent fulfilling that role?

THE CHAIRMAN: One half of the time in theory, but it only became one fifth in reality.

A. That's right.

MR WOLFE: Right.

A. If I may expand a little, I made representation to the Trust through the chief executive and ultimately to the commissioner to gain support over the next one to two years to fulfil that role. That didn't come in the first 18 months to two years. Not, I might say, because the chief executive didn't support that to be necessary, but it was really the money had to come from the commissioner.

THE CHAIRMAN: Right.

MR WOLFE: Doctor, just to unpack a little bit of what you've said, are you telling us this in order to explain that the role of medical director was under-resourced and therefore you were, if you like, working extremely hard to keep both ends of your job going? What is the purpose of this evidence?

A. I'm putting this into evidence for two reasons. One is to elaborate on the nature of the job, the extent of the job and also the limitations that I personally had in fulfilling that role. The job also expanded during that

time and you've heard oral evidence from Dr Carson in the last few times about how that job expanded.

Q. Yes.

THE CHAIRMAN: So in fact, the post of medical director from the late 1990s was becoming a more developed role because it had -- as governance began to take and to develop, the medical director's job became more complex?

A. Absolutely, chairman, and there is a reference, because I produced a document for the chief executive, and that could be called up to show the extent of that role. I sent this as a working document to the chief executive to effect change, which ultimately resulted in the post that I was in becoming a full-time post for the subsequent medical director.

MR GREEN: Can I get up and help? I think -- and the doctor will tell me if I'm wrong -- that reference is at 030-020-029.

THE CHAIRMAN: So your successor in 2003 took on the position on a full-time basis?

A. Yes.

THE CHAIRMAN: Did I understand you correctly that for the first two years you had no cover, so you were restricted in effect to doing the medical director's job for one day a week, but in your second period of two years or your third and fourth year, you did have some cover so

you had some more time?

A. I was successful in getting a locum, but as you can appreciate, when you have a locum colleague, you carry a lot of the responsibility in the work yourself. I had to cover 72 beds by myself up in those first two years. So outlined here is in the next three pages is a précis of what a medical director's role might be in terms of corporate, in terms of governance, in terms of managing change, and I think will assist the inquiry in conjunction with Dr Carson's oral evidence in understanding the role and remit of a medical director at that time.

THE CHAIRMAN: Thank you.

MR WOLFE: If you're saying, doctor, that the role perhaps for good reasons, certainly for budgetary reasons perhaps, wasn't as well resourced as it would be, for example, now, or was to become subsequently, did this have any impact on your ability to fulfil your role in association with the enquiries that were being conducted with regard to Lucy Crawford's death?

A. Well, it impacted on my role right across, I did not have the time or the support resource to monitor and to check and to audit to the extent that I might otherwise have desired. So if I was delegating, I would not necessarily have had the time or the back-up resource to

ensure that that was always delivered on. But that wasn't peculiar to inquiry business, this is across the board.

Q. You will appreciate, doctor, that we are interested in how the trust's inquiries into Lucy Crawford's death were being progressed.

A. Mm-hm.

Q. And as your evidence develops today, we'll see the pivotal role that you played in all of that. What I'm asking you at the get-go is whether you're introducing the evidence that you have just introduced about the pressures that your post faced and the lack of adequate resources -- are you introducing that evidence in order to explain that all of that context had an impact on your ability to effectively manage the investigations into Lucy Crawford's death?

A. Well, it's for others to judge how effective the investigations or reviews were, but it must have had an impact on every area of my work, including the inquiry work. The work is relevant to the inquiry.

Q. And can you be specific or is this just a general feeling that the quality of your work as medical director inevitably suffered because you simply didn't have the time to keep, if you like, all of the balls in the air at once?

A. I think that's a reasonable comment that you couldn't keep everything going at once and you had to devote time at one point in time to one strand of work, more time to that than perhaps to another, but I'm not presenting this as any mitigation or excuse for inaction or action on my part.

THE CHAIRMAN: We'll come to the details over the course of the morning, but in a sense are you saying, looking back on it, I wish I'd been able to do things somewhat better and somewhat differently, but at least some of this has to be understood in the context of the restrictions under which I was working?

A. I think that's a fair précis of it.

THE CHAIRMAN: Thank you very much.

MR WOLFE: Doctor, attached to your initial witness statement to the inquiry was a job description for the medical director's role. If we could have that up on the screen, please. WS290/1, page 32. I think it's on the next page. If we could have the other page up as well. I think it's dated 1999, from memory. February 1999.

That job description was presumably presented to you or formed part of your contract that you would have seen at the time?

A. That's correct.

Q. Could we pick up on your key professional responsibilities then. At 2.2 you had a corporate responsibility for clinical governance, undergraduate education, et cetera. Just in terms of clinical governance, what did that mean at that time?

A. Well, I think the inquiry will have heard evidence from others, oral evidence and witness statements relating to this. In Northern Ireland, clinical governance did not actually exist in the sense that we might understand it today. You're aware that it was introduced as a quality agenda and very much a responsibility for trusts to deliver on that quality agenda, but it actually became a statutory requirement so to speak in 2003. But this was in preparation for that because England and Wales were a number of years ahead, so they were introducing this into trusts in terms of readiness, getting ready for clinical governance. For my own part, I felt this was a key element of the job that I was taking on, and very early got into the work of clinical governance or preparedness for clinical governance. But it's fair to say that in 1999 when I went into the role, there was effectively no such thing as clinical governance within the Trust or within the hospitals at that time.

I have in that appendix to my witness statement provided some of the details of the work that went on

in that subsequent year to 2000 to establish some shadow structures of clinical governance, getting ready for the clinical governance legislation. That work involved modelling all the existing committees, all the existing services into heads of responsibility, clarifying the lines of accountability and responsibility, and bringing this quality agenda straight up to effectively the trust board level; and ultimately, the trust board passed that structure that I had put together with Mrs Bridget O'Rawe who was the director of corporate affairs at the Trust, accepted that and adopted it and we went into a shadow format in late 2000. I think I've already provided one of the first reports, annual reports as well, for you.

Q. Yes. I think what you have told us in your witness statement, or at least the documents would show that in or about November 2000 a clinical and social care governance structure was developed and various committees, essentially revolving around the issue of quality and health and safety and those kinds of issues fed into that central committee; is that broadly speaking the structure?

A. That's correct.

Q. And there was a committee which was known as the clinical safety and risk management committee.

A. That's right.

Q. That was chaired by Mr Fee?

A. That came under the responsibility of Mr Fee. That's correct.

Q. Yes. And although that structure wasn't in place in or around April 2000 when Lucy Crawford passed through the Erne's doors, so to speak, could I ask you this: when those structures were up and running in or about late 2000, albeit in shadow form, would an adverse incident such as the unexpected death of a child -- would that kind of incident have come through or passed over the committee led by Mr Fee in some shape or form?

A. Not directly in the manner in which you allude to. That was a structure where responsibility for clinical incidents, adverse incidents, risk management, was being defined. That was then managed down through the directorates and there would be monitoring ongoing of adverse incidents, risk management, through the directorate structure. But the important bit is that it would come back through, ultimately through Mr Fee as a report, usually on an annual basis, of issues arising out of incidents or learning from incidents, et cetera, might come up through that structure, over the subsequent one to two years that was developing.

Q. Yes. So could I ask you the question perhaps in this

way. In April and May 2000, there was the opportunity to subject Lucy's experience to an internal review, and we'll look at that in a moment and Dr Murray Quinn obviously assisted with that, so you had that approach in May 2000.

A. That's correct.

Q. Are you telling me that much the same kind of approach would have been adopted upon the implementation of these new governance structures, save only that there would be, if you like, a committee available to quality-assure what was being done, and that committee was led by Mr Fee, or have I picked that up wrong?

A. Well, it's more than just quality-assure. That committee would want to be assured that all of the processes for all clinical incidents, minor, major, adverse, near misses, would be instituted, that there would be recording, that that would map through the various directorates, that there would be discussions occurring at that level, and ultimately leading to a risk management and clinical incident report coming ultimately to the level of trust board to sign off on the quality assurance side of it.

Q. Again, on the job description we have in front of us, at 2.4 you had responsibility for medico-legal matters within the Trust; is that right?

A. Yes.

Q. And you were to work closely on that with the director of corporate affairs. So in your position you would have, if you like, an outward facing relationship with the legal side. You would be apprised of all relevant developments in medico-legal cases?

A. That's correct. That was effected through a committee called the scrutiny committee. Its design was to effectively manage the litigation process in as efficient a manner as possible.

Q. And the scrutiny committee was made up of members from the Trust Directorate of Legal Services and was it West Care?

A. That's entirely correct, trust legal services were delivered by a body called West Care, and they would organise the meetings, I would be present, as would Ms Bridget O'Rawe. They would produce the agenda, the cases would be discussed, decisions taken on next steps, et cetera.

Q. And Mr Doherty of whom we've heard something in various witness statements, he was associated with West Care?

A. He was indeed. He was the litigation manager. I think that was his title.

Q. And West Care was a body within the Western Board area that provided ancillary services such as human

resources, legal support, that kind of thing, to trusts within that area, including the Altnagelvin Trust and yourselves?

A. My belief is that it provided a service to three trusts, Foyle, which was a community trust, ourselves, Sperrin Lakeland Trust, and the Altnagelvin Hospitals Trust.

Q. At 2.6 of the job description then, you were to be responsible for disciplinary procedures associated with professional matters for medical staff.

A. That's correct.

Q. 2.7, you were to promote high standards of professional practice and undertake complaints procedure investigations as appropriate.

A. That's correct.

Q. So bringing all of these factors together that are set out in your job description, doctor, is it fair to say that at that time the medical director sat at the top of the pyramid in terms of when an adverse incident happened such as the Lucy Crawford incident, you are the person who directs, in association with the chief executive, the next steps?

A. My answer to that would be that the vast, vast majority of adverse incidents, clinical incidents, the responsibility would be as a delegated one belonging with the clinical directors and the clinical services

manager, and they would manage the vast, vast majority of them. The medical director would be more inclined to get involved if there was a series of particular issues or a more serious issue such as this one.

Q. Yes.

A. But the ongoing responsibility and management was almost exclusively at directorate level.

Q. So day-to-day adverse incidents that perhaps are fairly common do not reach -- did not at that time reach your door, but if the situation was particularly serious in the sense if you had repeated near misses, for example, or, as in this case you have the ultimate in adverse incidents in that you have a child's death, that kind of thing is likely to reach you?

A. That's entirely correct.

Q. And when it does reach you, how would you define your duties in a general way, first of all? How would you describe in principle your obligations?

A. Obviously, it depends on the nature of what is brought to your door. If it's a series of near misses, as you alluded to; I would want to look at the particular risk factors there were causing that to happen, and I would want to be assured that the clinical director, clinical services manager -- or the resources required to avoid that happening again were brought to bear. I might

choose to bring it to the chief executives to effect release of resources. So that might be one way of looking at that. If it's a more serious major adverse incident, then I might be the one initiating a review of that.

Q. And in this case, as we will see, you initiated the review in the sense of asking for it, calling for it by dint of contact with Mr Mills; is that fair?

A. Yes. I would answer that slightly differently. I would normally expect that the clinical incident would be flagged immediately within the directorate and I would hear it through that channel. So I would have expected the clinical services manager, who was Esther Millar, or the clinical director to make contact with me directly. However, because we had been putting such emphasis on clinical governance across the healthcare professionals within the Trust and I had in that year or six months before that effectively run 16 workshops on clinical governance, the whole issue of raising clinical incidents and not staying quiet about them and getting them looked at and investigated had come to the fore in the clinicians' minds. So I believe that's why Dr O'Donohoe actually used that phrase "I'm raising this under clinical incident reporting".

Q. We'll come to the detail of that in a moment. I'm just

trying to deal with it at the level of general principle at the moment.

A. Okay.

Q. So an incident is raised and maybe we just stick to the example of a death. An incident notification is raised and what are your options at that point? Is it a review of the type that we know about in Lucy's case, or do you have other weapons in your arsenal to explore a problem?

A. The usual method is the directorate would review it.

Q. And --

A. And provide a report to me or an update to me, and that would be the standard report. A death, however, can instantly set alarm bells going in a medical director's mind and therefore there might be a higher level of investigation or review as a result.

Q. Yes. So typically, then, the notification comes from the directorate within which the incident has occurred?

A. Yes.

Q. It should come to you if it's serious. And then you might direct a review. So in the example, if a review is set up, what is your responsibility with the review ongoing and it's in the hands of the directorate?

A. Well, usually, when a review is initiated, the persons carrying out the review get on with that review and

I would have as practice asked them to keep me updated on developments, keep me updated if any major issues are emerging that are putting patients or staff, whatever, at risk, depending on the nature of the incident. And it would be not just myself on this, it would be the acute services director if it's an incident that occurred within the acute side of the hospital, and that would have been Mr Fee. And as we discussed a number of minutes ago, Mr Fee carried that responsibility for clinical adverse incident reporting and risk management.

Q. How do you as medical director ensure that the review is being conducted in a sufficiently rigorous and thorough manner?

A. Well, you receive the updates and you hear what they're planning to do and you satisfy yourself that that is a reasonable approach, a comprehensive approach to the review.

THE CHAIRMAN: So for instance, in this particular review into what happened to Lucy, they started the review and apparently then contacted you and said they needed an input from a paediatrician and, on that basis, the engagement of Dr Quinn was approved?

A. Correct.

THE CHAIRMAN: And you say that's an illustration of the system, whatever imperfections there may ultimately be,

that's an example of the system working?

A. Very much so. I would also state that in a situation like this, you would make it clear to the people carrying out the review that there would be no resource constraints. You would not be in any way saying to them "I want you to do this", and not allow them to have the tools to do the job, so you'd be making that clear as you establish the review.

THE CHAIRMAN: Thank you.

MR WOLFE: As I understand the evidence that has been so far gathered by the inquiry, at that time, the year 2000, there wasn't, if you like, a rulebook to be followed or a procedure to be followed in terms of how a typical review would be undertaken.

A. That's correct. There was no template, no rulebook as you put it, and certainly not just within the remit of our own trust, but I'm not aware that there was a regional remit or regional terms of reference that you could adopt or a template that you could apply to this. It was very much something that was developed within trusts over a number of years.

Q. I think you would have observed the remarks of Dr MacFaul in his report to the inquiry, where he talks about the template being one of common sense and due process. In other words, if I can define what I think

he means by that, is that you investigate an issue in a manner which is proportionate to the seriousness of the issue and you take the necessary investigative steps to get to the bottom of the issue.

A. I think that's a nice way of describing what was there at the time, that people were relying on common sense and agreement amongst key individuals that this was a reasonable approach. So reasonableness would be a word to go with that common sense and the reasonableness applied to the use of resource as well, I suppose.

Q. As medical director, you said you would always indicate to those charged with conducting a review that resources and scope is, if you like, without restriction, I think is what you said. Now, clearly, in the real world there can't be an unrestricted investigation; is that fair?

A. I think the phrasing you've used there would be a phrase I would never use. If you can forgive me, I would have said to them, and I did say to Mr Fee, "Whatever it takes to complete this review, I will support". So that's how I approached that.

Q. And in that sense, were you leaving it to Mr Fee and Dr Anderson to, if you like, guide themselves in terms of where the review would take them?

A. Oh, absolutely, and to come back to me if they had

concerns in relation to the direction it was going in or if they wanted further advice. And as the chairman's alluded to; they came back in relation to external opinion.

Q. Again, I jumped into this specifically when I meant to keep it in the general. We'll come to the specific presently. In terms of the endgame of a review process, a report is furnished, and here we're back in 2000. The report is furnished to whom? To the directorate or to you?

A. Well, for the near misses and the less dramatic adverse incidents, that would stay within the directorate and ultimately might be reported upwards if there's a series of them or if there's specific learning. But a significant adverse incident or major adverse incident such as this one would be reported to the chief executive. The report would go to the chief executive.

THE CHAIRMAN: Doctor, can I ask you for an illustration? Can you give me one or two examples of adverse incidents which would stay within a directorate?

A. It might be an equipment, lacking a piece of equipment so that a patient got a minor complication and that might have happened two or three times over because somebody's recognised that we need to modernise this

piece of equipment. That would come through the directorate to a body called hospital council, and then all of the clinical directors and Mr Fee would decide that that needs to be prioritised, it would get prioritised in resources and would get addressed.

THE CHAIRMAN: Thank you.

MR WOLFE: Can I ask you, doctor, upon the furnishing of a report or indeed at some point along the way, when you as medical director are keeping in touch with developments during a review, would it be within your gift or within your responsibility, I should say, to highlight any flaws of approach or investigation which you came across?

A. Well, if I became aware of a problem I would of course feel that I had a responsibility to flag it up or make suggestions if I came across a significant flaw, yes.

Q. Because ultimately, you want an investigation or a review that's fit for purpose?

A. That's correct.

Q. And within the terms of your job description as medical director, is it fair to say that in the context of these significant reviews there's an onus on you to ensure that the reviews are fit for purpose?

A. I'm not sure if that responsibility lies as clear as that, but I would accept that if I had any indication,

notion or belief that a review wasn't proceeding according to the manner in which it should or if there were weaknesses that I felt I could help address or identify to the review team to address, I certainly feel I would have a responsibility to speak up and be involved, as would the head of the directorate and the chief executive.

Q. Let me take you to the issue of the paediatric arena, doctor. You're obviously an geriatrician by profession. We asked you in your witness statement about your experience, training, education in the whole area of paediatric hyponatraemia, paediatric fluid management. And your response, perhaps unsurprisingly, was that you had no experience or education in that field; is that fair?

A. That's correct. Obviously, at an undergraduate level I would have rotated through training in paediatrics. That would have been obviously mid/late 70s, and it would have been a number of weeks in paediatrics. I can for certain recall no teaching, training on fluid administration or hyponatraemia at that time.

Q. In your field of geriatrics, fluid management would be a medical issue that would come across your desk regularly?

A. I think fluid management would be common in all adult

medicine. These are sick patients coming in. It might be a little more common in care of the elderly through dehydration.

Q. In general terms, doctor, your medical education would have informed you of the need for caution in the administration of any drug and perhaps fluids would fall within that, if you like, general sense of caution?

A. Absolutely.

Q. Would you have known, doctor, of the risks associated with the use of low sodium preparations in patients, not necessarily children, who were suffering from gastroenteritis or that kind of disease?

A. I would have had no awareness of the issue of fluids in children at all, never mind specific conditions. To adults, care of the elderly, we would have had obviously knowledge of fluids and the importance of fluids and the importance of monitoring. If I could expand slightly, and it'll be helpful to the inquiry, No. 18 Solution, which is the focus of this inquiry, became almost out of the blue a common used product, shall we say, in adult medicine. It didn't exist in my training years, but it came in the subsequent years to become one of the most commonly used fluids. It became very common in adult medicine. I can say nothing about paediatrics in this matter, but in adult medicine it became very common

because of people wanting to avoid sodium in patients, particularly who might come into hospital with heart conditions or hypertension, high blood pressure, because you're trying to, in those patients, not add salt or sodium containing fluids to the mix. And also in some of the frailer patients, you were keen to avoid low sugar. So this product seemed to give you some sugar and low salt. So it became almost the number one fluid used in adult medicine over a period of five to ten years and would not have been used, for example, as Dr Anderson said, in theatres, et cetera, by anaesthetists, but at ward level it was used incredibly commonly, so I would have had experience of No. 18 Solution from that point of view.

Q. Getting back to my question, doctor, the point I'm wishing to address with you is whether you would have been aware in a general sense of the risks of applying or administering low sodium fluids in particular situations such as gastroenteritis disease.

A. I suppose I didn't treat a lot of gastroenteritis disease, but I would have been aware of the necessary requirements to monitor the electrolytes and to be careful with any fluid, no matter what was used.

Q. And of course you would have appreciated that the risks associated with low sodium fluids and the potential for

the use of such fluids in excess to create problems in terms of cerebral oedema and that kind of thing?

A. We would have had an awareness that an excessive drop in the sodium can give rise to problems, neurological problems including brain oedema, and equally an over-zealous correction of that could also do the same. The sort of levels, if I may continue with this discussion, the sort of levels that we in adult medicine would be using to seeing those problems are with sodiums of 115, 116, 117, and I would have occasionally managed patients down as low as 112. So there were things we became aware of from time to time, but it wasn't common, just regular.

Q. Yes. And of course, you highlight one of the dangers of trying to compare children with adults in this sphere. Let me move to 13 or perhaps 14 April, doctor. You received a report from Dr Jarlath O'Donohoe in relation to a child called Lucy Crawford; isn't that right?

A. A report?

Q. A report in the sense of a communication from him --

A. Yes.

Q. -- in relation to an adverse incident.

A. Absolutely.

Q. I introduced the topic in that way because there is an uncertainty about what day it was reported to you;

is that fair?

A. Yes. And I would say there's uncertainty in my mind too. My belief, if it helps the inquiry for me to continue with this, is that Dr O'Donohoe phoned me on the 13th, sometime after coming back from Belfast, and appraised me of the incident.

Q. And you reacted by contacting -- we'll come to the content of that conversation, but in terms of your action having received that phone call, you contacted Mr Mills?

A. My action was to try and contact Mr Mills, who I contacted at the first available opportunity, which was the next morning, on the Friday, and I was clear in my mind as I was contacting him that we were going to have to have a senior review of this adverse incident.

Q. Staying with the date thing for a moment, it would have been your expectation I'm sure that as soon as Dr O'Donohoe was aware of a problem, and the problem in this case can be defined by essentially what he told you, which was a concern that unexpectedly this child had suffered a significant deterioration and he wasn't sure whether it was drug-related or fluid-related, and we'll go to the detail of that in a moment. But the point I wish to put to you is this: as soon as he was aware of a problem, you would expect either yourself to

be told or his directorate to be told?
A. I wouldn't agree with that.
Q. Is that not right?
A. Immediate, chairman, in terms of this matter would be within the next 24, 48 hours, in terms of incident reporting. It would be very common for people to sit down in the cool light of day to fill out an incident form and hand it into the directorate that might be 24 or 48 hours old. Sometimes there's a little bit of information gathering to be done before you make a sensible report or raise the incident.
THE CHAIRMAN: But if you know -- if your instinct is straightaway that the incident is serious, then that can prompt a virtually immediate report?
A. I think it's good governance to do that, yes.
THE CHAIRMAN: And the incident was undoubtedly recognised as being serious by early on Thursday morning when plans were being made to transfer Lucy to Belfast?
A. That's correct. So Dr O'Donohoe seems to have raised it with me on that basis.
THE CHAIRMAN: Yes.
MR WOLFE: There may also be a premium depending on the circumstances, doctor, in an early report in terms of, if you like, potentially putting a stop to something that may still be happening or perhaps in terms of

information gathering?
A. I'd like to think that if there was something still happening that people are acting immediately and not spending time reporting it. That would be my first reaction to that. But, yes, I take your point that there could be circumstances where the sooner something's reported, the sooner you get more information.
THE CHAIRMAN: And that was Sister Traynor's reaction when she came on shift on Thursday morning, that she wanted the incomplete notes from the previous few hours to be completed as soon as possible.
A. Yes.
MR WOLFE: We know that -- just staying with the Sister Traynor thing for a moment -- she made an attempt to contact her line manager, Mrs Millar, on 13 April, after a conversation with Dr O'Donohoe and after a conversation with the nurses. In response to her coming forward, a form was completed on her behalf. Did she trigger the -- do we call it "clinical incident" or "critical incident"?
A. They're both the same.
Q. Let's call it "clinical incident". Did she trigger the clinical incident report or did Dr O'Donohoe in his report to you?

A. Most definitely, in my mind, Dr O'Donohoe reported it earlier. However, I think it's an example of the work that had been going on the previous months in trying to get the team thinking about this, that it came from two sources. I think that's very good governance. I would make the point on that, I don't know if you're going to show the form, but on that incident form you'll see a number, the number 10.
Q. Yes.
A. So this was the directorate using their form for the tenth time, so it's very early in their process of getting into clinical incident reporting using the form.
Q. And going back then to what Dr O'Donohoe reported to you, you told the police service, this is perhaps the fullest description that you've given of what you were told, the reference is 116-043-002, that Dr O'Donohoe outlined that he was reporting this matter under critical incident reporting; isn't that right?
A. I'm trying to find it in the page.
Q. It's the very bottom of the page. The majority of it is probably across on the next page.
A. Yes.
Q. If we could have 003 as well. He was telling you that this child had been admitted with diarrhoea and vomiting, subsequently suffered an unexplained collapse

requiring resuscitation, and should that be intubation?
A. It certainly should be intubation.
Q. "He explained that he transferred the child to PICU, the child was on a ventilator, and her prognosis appeared poor and that brainstem tests were planned."
The problem, as he defined it, was that there may have been a misdiagnosis, the wrong drug had been prescribed or the child had an adverse drug reaction. Dr O'Donohoe explained that there had been some confusion over fluids. Now, I just want to tease out, doctor, how that has been recorded compared to what you might have been told. In terms of how it's set out there, less emphasis, on one view, would appear to be being given to the fluid issue as opposed to these other speculative causes. Is that how it was reported to you?
A. I'm not sure exactly what you're asking me on that question.
Q. First of all, Dr O'Donohoe did mention these other potential causes; isn't that right?
A. Yes.
Q. A misdiagnosis, wrong drug or an adverse drug reaction. And then he explained to you that there had been some confusion over fluids.
A. That's correct.
Q. Is that the way it was recited to you?

A. It's difficult to recall.
Q. I appreciate that.
A. In any exact nature from these times. It was, how I do put it, a troubled phone call, is the way I'd describe it. He was agitated, upset, and he was speaking to me saying, "Jim, this is what's happened, I don't know what the cause of this is", and these were the words that was released. I think in that order, in all honesty, and that's why I've repeated those in my PSNI statement.
Q. I asked the question in this way, doctor, because in terms of what he would have known at that time he has described to us a concern being triggered because Dr Crean from the Royal Children's Hospital had come on the phone to him and highlighted to him a potential problem with the fluids. He then tells us in his witness statement that he went and got the notes and he checked and rechecked, is his language, and eventually realised that there had been this issue. And in terms of emphasis and importance, viewed from that perspective, you might have thought that he would be shouting the fluid problem from the rooftops.
A. I don't know how I'm supposed to answer that question. How would I speculate what he would have thought.
Q. Was he shouting the fluid problem from the rooftops?
A. Not at all. No, no, no, no. That's definitely not the

case.
THE CHAIRMAN: Do you see the point of the question? If the information coming from the Royal was raising a query about a problem with the fluids, if that's what the Royal had identified or recognised as the issue then it seems curious, if I put it that way, that the emphasis to you is "there's some confusion over fluids, but is it a misdiagnosis, was the wrong drug prescribed, was there an adverse drug reaction?", it seems to be the wrong way round?
A. I take your point, but that wasn't the way it was conveyed to me.
THE CHAIRMAN: Okay.
MR WOLFE: Did you respond, doctor, by, if you like, enquiring or interrogating any of these descriptions?
A. No, it was a phone call conversation. He was distressed. I did ask him at the time about the drug and he said that the drug diazepam had been used, so I enquired about that. That wouldn't have struck me as a drug I would be expecting a major adverse reaction to, so it didn't accord with me particularly.
THE CHAIRMAN: Let me ask you this: apart from the fact that you wouldn't expect an adverse drug reaction from diazepam, would it strike you that that would be consistent with the wrong drug having been prescribed?

A. It could be. Yes, it could be. I mean, I suppose how to put that, chairman, diazepam used in the wrong circumstances -- and remember, I have no knowledge of paediatric medicine --
THE CHAIRMAN: Yes, I understand.
A. -- could be very damaging to a child.
THE CHAIRMAN: Okay, thank you.
MR WOLFE: Did you interrogate the potential fluids issue that he was raising?
A. No, I didn't interrogate that at all.
Q. Okay. He has said in his evidence, doctor, that he told you about his conversation with Dr Crean. He said that in one part of his evidence and then I think you would have observed him clarifying that in fact he may only have referred more generally to his contacts with the clinicians in the Royal, or words to that effect.
A. Yes.
Q. Did he tell you about his conversation where Dr Crean raised this alert, if you like?
A. No. I am happy to state he did not discuss any of the views from Belfast with me on fluids. He did not report to me the different fluid regimes that he thought he might have prescribed versus what was administered. That was not shared with me in either that conversation or the next day.

Q. That was the next point I was going to move on to because he says in his witness statement that when asked did you ever make a report to anyone at the Erne that Lucy had not received the fluid regime which he had described to Dr Malik, he says he notified you.
A. Not at that time, the next day, as I instructed him on the phone, which was: we will need to do a review, I would like a copy of the notes retained to facilitate that review, and he left the notes round the next day, and that's where he's saying that the fluids I prescribed weren't administered. I got no detail, though, at that stage, I didn't get detail in terms of the volumes or the percentages that he wanted to achieve over an hour. There was no discussion with me on that at all.
Q. And no discussion about the electrolyte change?
A. Not at all.
Q. Again that's something he says was discussed with you, but you're not mindful --
A. More than not mindful, I would have noted that and recorded that at the time. That's too important an issue for me not to have picked up on if he had said that to me.
Q. That was a conversation, you think now on the Thursday, the 13th?

A. The conversation, as outlined in the PSNI statement, and my explaining to Dr O'Donohoe that this is likely to require review, which I will establish, and additionally the issue of the notes and then, as I said, he duly arrived with the notes the next day.
Q. And he came personally to you?
A. That's my memory of it, yes.
Q. And what was the purpose of that meeting? Was that simply to deliver the notes?
A. I wanted the notes to effect, start the review, and I would have told him at that point in time that I'd spoken to the chief executive and that a review was being established. I would have also indicated to him at that time that my belief was that that review was going to be led by Eugene Fee and Dr Anderson.
Q. And did you receive any further information from him at that point in terms of his worry in terms of what had happened to the child?
A. Only in what I've already stated there, that he was concerned in relation to what he felt he had ordered, prescribed, whatever phrase you want to use, and what had not necessarily been delivered. It would have been meaningless to me at that stage to hear numbers, we did not get into that at all. He was very distressed and I was trying to be supportive to him at the same time

and saying we'll get on with the review.
Q. But in fairness to Dr O'Donohoe, I want to try and see if you can help us with this. Was he at that time going into greater detail about the fluid prescribing error that had occurred and his sense of the potential implications of that?
A. Not -- I mean, the question is: was he going into detail about the prescribing error? No. What was he saying? He was saying there was a confusion between what I've ordered and what the nurses have given. So in my opinion, in the first 48 hours, fluids and fluid prescribing were highlighted as an issue to be looked at.
THE CHAIRMAN: Is it reasonable to infer from that that while he had raised with you on the Thursday issues about misdiagnosis, wrong drug prescription or adverse drug reaction, the only specific issue which he mentioned on Friday was that the fluids administered were not the fluids prescribed?
A. Certainly I don't recall on the Friday having discussions again about the drugs or any -- misdiagnosis as in a missed diagnosis versus a misdiagnosis. I'm not sure if somebody challenged me and said, "Are you sure he didn't say 'missed diagnosis' rather than misdiagnosis?" I couldn't be certain about that because

it was a phone call. There was still this concept about there may have been something else wrong with Lucy Crawford in that meeting that needed looking at.
THE CHAIRMAN: On the Friday?
A. On the Friday, yes.
THE CHAIRMAN: But your recollection is that the discussion on the Friday mentioned the wrong fluids in the sense of Lucy not receiving the fluids he had prescribed and the possibility that there may have been something else wrong which had not been identified?
A. Correct.
THE CHAIRMAN: Thank you.
MR WOLFE: By this stage, by the stage of this second encounter, first a telephone encounter, second a short face to face, by your description --
A. Yes.
Q. -- you had notified Mr Mills of the issue?
A. I believe I had spoken to Mr Fee very briefly the night before and alerted him that I'd be contacting Mr Mills, as I did on the Friday morning. I gave Mr Mills almost verbatim what's down there in terms of my understanding of it and that I felt there absolutely had to be a senior review of this case.
Q. Did you make any note of your two encounters with Dr O'Donohoe?

A. No. None at all.
Q. And having received the notes, do I take that to be all of the medical and all of the nursing notes?
A. I honestly can't answer that because I didn't check the notes. I wanted them there and I immediately passed them over to Esther Millar in the directorate to facilitate the review. I was keen to do that as quickly as possible to get the review and to make sure that we had a full copy, so that was passed to Esther Millar. I wouldn't have known if there was anything missing in the notes at all at that stage.
Q. Is it fair to say, doctor, that you never perused the notes?
A. At that stage, no, I did not.
Q. At any point subsequently?
A. I would have seen some aspects of the notes, but I wouldn't have perused them in that detail, yes, you're right, I wouldn't have gone through them in detail.
Q. So they came to your hands and went straight to Mrs Millar's hands?
A. That's correct.
Q. Perhaps you can help with us a number of issues that have arisen over the past week or so in relation to evidence in relation to the notes. Yesterday, Dr Anderson, when referred to certain notes -- you would

have heard his evidence, would you?
A. I did hear his oral evidence yesterday.
Q. When referred to, for example, the nursing note setting out what I was putting to him was the sequence by which bloods were taken, which followed an infusion of normal saline, he expressed surprise in relation to that, as if he had never seen it before. Can you help us in terms of that, did that surprise you, that evidence?
A. Oh, that definitely surprised me. It didn't make sense to me, that bit.
Q. Because I've had an opportunity and those who represent him can comment on this if it's appropriate, but the note he was referring to appears to have been part and parcel of the notes that eventually ended up in the hands of Dr Murray Quinn for the purposes of his review.
A. Mm-hm.
Q. But his evidence surprised you?
A. I'm not sure which question you're asking about that.
Q. I think what I'm saying to you is or asking you is: the note which I referred to, we can put it up on the screen if necessary, so far as you're concerned, did that form part of the notes that went to Murray Quinn?
A. That's my belief, yes. I have no reason to think anything else. It's the standard nursing record that's within the medical notes.

THE CHAIRMAN: And there is no reason to send Dr Quinn information which isn't also provided to Dr Anderson, who is part of the review team?
A. Absolutely.
MR WOLFE: In terms of the review, the notes presumably went then from Mrs Millar across to Dr Anderson and Mr Fee; is that the way it would have worked?
A. That would be my expectation. I can't say what actually happened.
Q. Yes. And in terms of giving them direction on where they would go with this review, what was done in that respect?
A. Well, I suppose Mr Mills was speaking to Mr Fee in terms of establishing the review. I had made it clear that this was a severe incident, adverse incident, needed senior review, and obviously there were a number of issues that were being raised in those first few days and that they would be a priority in that investigation.
Q. And how were they communicated to the coordinators of the review?
A. Well, I would have been speaking to Mr Fee on a regular basis.
Q. So you briefed Mr Fee in terms of --
A. No, I believe Mr Mills would have briefed Mr Fee. He set the review in place in that way, so he'd have

briefed him, but I would have been speaking to Mr Fee regularly.
Q. Yes. Clearly, what the coordinators of the review are told is their mission, if you like, or their terms of reference is of some significance, you would agree?
A. Yes.
Q. And this wasn't communicated to them in writing; is that fair?
A. No, we did not set a written remit for the review. They were to look at what was a serious adverse incident, find out what happened, see what the lessons were and that would be fairly standard for any of those types of review. They were to then consider what needed to be done and come back to us with any concerns in relation to that.
Q. Who identified Mr Fee to be a coordinator?
A. I'm pretty sure it was Mr Mills.
Q. Right. Why was he regarded as an appropriate choice, do you know?
A. If it's helpful to the inquiry, chairman, the reason the two individuals were chosen was Mr Fee is very senior, acute services director but also the senior nurse from the Trust, had experience of doing significant reviews in the past. Dr Anderson is the clinical director and had been for a number of years, and again would have had

that understanding of the directorate. So they were two of the most senior people we could have put in charge of it.
Q. Dr Anderson gave evidence yesterday, expressing, to put it perhaps mildly, an element of discomfort at having been selected for this task. He seemed to put it on a number of footings, but primarily his absence of experience or knowledge of the paediatric setting and, secondly, his absence of knowledge or experience in terms of conducting such reviews. Fair comment?
A. I need to tease out what the question is on that one, sorry.
Q. You don't always find a question mark necessarily at the end of what I say, doctor, but maybe I'll be more direct. That is a valid criticism, isn't it, that he was put into this situation when he was ill-equipped for the task?
A. If I can respond to the question in different parts. Number 1, if he's put into something, you don't put a clinical director into something -- if he's asked to do something and he agrees, he's agreeing. If he's not in agreement, he speaks up. This is a senior consultant who's a clinical director, who's used to doing reviews in obstetrics, et cetera. He speaks up and says, "Look, I'm not equipped to do this, get someone else to do it

or I'm happy to assist another paediatrician doing it", or whatever. That's what he does. That's one way of looking at it.

Second of all would be: does being a clinical director in the obstetrics and child health directorate exclude you from having the ability to do this review? Not at all. In fact, it puts you right in the mark for being somebody who could do it. If there are additional pieces of information or understanding you need, you are allowed to go and get them, either source them yourself or bring expertise to bear as required. That would be very, very common in reviews. You do not always have the super specialist of that subspecialty, shall we say, involved in reviews of this nature.

Q. His behaviour during the review would seem to suggest that he took a back seat.

A. I don't know how to answer that question.

THE CHAIRMAN: Can I ask, were you surprised when you heard his evidence yesterday?

A. Yes.

THE CHAIRMAN: Did he ever express any resistance to you about the role which he was being asked to play in the review?

A. Chairman, he expressed no resistance whatsoever and, more so, he didn't even comment that he was unhappy with

any aspect of the process. So it's not even just resistance, he didn't while he was actively doing it suggest that, "I'm unhappy with this" or "I'm uncomfortable with this".

THE CHAIRMAN: In fact, on one interpretation of his evidence yesterday he went beyond that by saying he really was uncomfortable about being the head of a directorate which included paediatrics and he really didn't know anything about paediatrics, and that's why at any meetings to discuss paediatrics there had to be the senior paediatrician present. Is that news to you or not?

A. It's news to me, but I'm prepared to accept that might have been his feeling and he might have been uncomfortable. Again, if he's in the job a number of years, he has to make a decision if he's not able to do the job. But there's no suggestion he wasn't able to do the job, and he was chairing directorate meetings.

THE CHAIRMAN: Thank you.

MR WOLFE: He described himself as providing assistance to Mr Fee, so in that sense I'm suggesting to you that he was taking a back seat, he wasn't getting involved in, for example, the meeting with -- or even the conversations with Dr Quinn. One was because he was on holiday and that might have presented a problem, but did

you expect him to be taking an assistanceship role as opposed to being a coequal in participating in the review?

A. I expected him to be being a coequal and I fully expected him to be at the meeting with Dr Quinn. As you've already pointed out to the inquiry, it was purely an accident of him being on annual leave. He would have been there otherwise.

Q. It would have been obvious to you when you read the review perhaps that he didn't participate in the discussion with Sister Traynor?

A. It wasn't obvious to me.

Q. It wasn't obvious?

A. No.

MR GREEN: May I rise for my learned friend, before we move away from Dr Anderson's comfort or discomfort with being clinical director, to ask Dr Kelly if he can help with whether the role of clinical director which Dr Anderson held at that time was one that was thrust upon him or one that he would have to apply for and be interviewed for?

A. And the answer is that he would have had to apply for, be interviewed for, and had a fixed term of office by and large.

THE CHAIRMAN: Thank you.

MR WOLFE: His lack of involvement with the Sister Traynor interview wasn't obvious to you?

A. No.

Q. He didn't participate in the initial telephone conference with Dr Quinn, which took place in or about 2 May. Was that obvious to you?

A. I wasn't aware of that.

Q. Mr Fee wrote the report and asked for, if you like, approval of the report and a contribution from Dr Anderson. Were you aware of that?

A. I was aware of that. It didn't come as a big surprise, Mr Fee being the senior manager would be used to preparing reports, and it was a common thing to happen if two people or three people were involved, that one would take a lead on doing a draft and others would edit, add, subtract as required. That would be a common methodology, shall we say.

Q. And prior to doing that, you would expect the authors to sit down and analyse the evidence, compare notes and reach conclusions?

A. I think I would have had that expectation, yes.

Q. His view was or his evidence has been that there was no such analysis carried out prior to completion of the review. Does that surprise you?

A. That surprises me. And I think you'll have to ask

Mr Fee in due course on that issue.
THE CHAIRMAN: But even if that surprises you, then what you might expect would be that if he didn't agree with the gist of the draft which had been prepared by Mr Fee, you would have expected him to make more changes to the draft than he did?
A. Well, he could have made substantial changes, he could have had another meeting, the two could have sat down together and redrafted the whole thing.
THE CHAIRMAN: Or he could have said, "I think you're on the wrong track completely here ".
A. Absolutely.
THE CHAIRMAN: Or he could have said, "I know we have to respect Dr Quinn, but his report just doesn't seem right to me ".
A. Yes.
THE CHAIRMAN: And to your knowledge he didn't say any of that?
A. Or if he was really feeling uncomfortable with the process, my door was always open, he could have come to the medical director and spoken.
MR WOLFE: At some point, I think during the time you were on leave, a request came in from the coordinators for assistance with a paediatrician.
A. That's my understanding, yes.

Q. And Mr Mills approved that?
A. That's correct.
Q. And I think you've said in your witness statement that that came with your approval as well, if you like, when you came back to work?
A. Well, yes. When I arrived back, I heard the review team had looked, I think it was Mr Fee told me, had looked for an external, and that Dr Quinn was engaged to provide that and I was not shocked and not unhappy with that.
Q. Given that this was a paediatric issue, it's perhaps no surprise that they went in this direction, but was any thought given to appointing a paediatrician such as Dr Halahakoon to the review team from the outset?
A. I think you could have done that. I didn't personally think of that. One of the problems would be in a very small department, if you appoint internal to, how will I put it, judge or to comment on a colleague on a serious matter, you might not always get what you want in the report or the full -- I would have a nervousness of keeping it that internalised.
Q. But you saw or you foresaw the need for some medical comment within the review, some medical understanding within the review?
A. I'm not sure what that question is.

Q. You have said that you had -- had you been asked perhaps, you would have had a concern about appointing somebody so close to it because of the need to provide some comment in the report.
A. Sorry, I didn't mean it quite like that. What I'm saying is any review of any sort of that magnitude, you would not routinely have the person's colleague chairing or leading the review. That runs risks straight off, so that would probably have been within our minds at the start.
THE CHAIRMAN: Whereas if it was a review within a directorate, for instance, that a machine which is out of date is affecting the treatment of patients, in those circumstances it's far more acceptable to have a colleague --
A. It would be quite normal in all of those situations, yes.
MR WOLFE: Dr Quinn, who was appointed, did you have any professional dealings with him prior to his appointment?
A. None at all.
Q. He has told the inquiry that he was a member of the area Medical Staff Committee and that you would have attended at that committee.
A. I can't recall if I did or didn't, but that's probably true. But in terms of professionally having any contact

with him, no.
Q. Sorry, only in that sense that he says that he would have known you from attendance at area Medical Staff Committee, perhaps once a year, I think he is talking about. Does that ring true?
A. It's probably true. I would put it to you in a different way. I didn't know Dr Quinn.
Q. Right.
A. Even if we were attending meetings. I didn't know. And an example of that is when we went to have the meeting with him, which I'm sure we'll come to later, I said to Mr Fee, "Do you know what Dr Quinn looks like?". So that's the context of that answer.
Q. Dr Quinn was identified and selected, if you like, for this role by Mr Mills.
A. Yes.
Q. Now, he was a doctor who had in his time done some work in the Erne Hospital.
A. So I'm led to believe.
Q. And on your behalf, a report has been submitted to the inquiry from Dr Durkin, who suggests that the medical director is the person who should ensure that no conflicts of interest exist in terms of who might be appointed to carry out such investigations or reviews. You understand?

A. I understand that, yes.
Q. And it would appear, correct me if I'm wrong, that no such check was made in this case.
A. Well, checks are a strange description of it. If I respond again in a slightly different way. My view is that there was no obvious conflict of interest. Dr Quinn had never worked with the paediatricians in that department before, that I was aware of. He may have done clinics or whatever in the Erne in the past, but that was before the more modern aspect of that paediatric department, and I would say to you that, you know, probably half of the paediatricians in the province had done some sort of either locum session or part-time session there in the past. The important point was he'd had no regular contact or, as far as I was aware, any contact with Dr O'Donohoe and the team.
Q. And procedurally, you established that?
A. Well, I knew that.
Q. How did you know that?
A. Because I knew the paediatric set-up from what it started, I knew who was coming over the years, I was there from 1988, before Dr O'Donohoe arrived.
Q. Yes. And his --
THE CHAIRMAN: And Dr Quinn had not been there in that time?
A. Not that I'm aware of.

MR WOLFE: His association with the Erne Hospital in terms of having worked for the organisation from time to time, that didn't -- was that known to you?
A. Yes. I'd known Dr Quinn as one of the paediatricians in Altnagelvin, had done sessions, work, whatever, I'd have known the other paediatricians, I would have known which ones would have done more work in the Erne than the others. So that was known to me, and to me, that in no way precluded him from doing this review.
Q. Dr McConnell of the Western Health and Social Services Board says that he spoke to you in terms of the need to conduct a wider review, and we'll come on to the detail of that in a moment. If I could just address this one point with you. He says that one of the issues that he raised with you was the need to avoid a perception of bias that might derive from Dr Quinn's involvement and in that sense there was a need to broaden this out. Do you recall him saying that to you?
A. I have no recollection of him ever saying that to me. I think he's referring to a different point in time when we had a conversation in relation to a number of the other streams of investigation that required to be undertaken by Dr O'Donohoe and that's when he said this needs to be widened out. That's what I believe.
THE CHAIRMAN: The Asghar prompted issue?

A. Absolutely.
THE CHAIRMAN: Okay.
MR WOLFE: But in terms, he was clearly aware that Dr Quinn had been retained?
A. He was more than aware of it because Mr Mills had told him at meetings, I'd written to him and told him --
Q. He was aware --
A. Well, he was fully aware. There's no doubt on this.
THE CHAIRMAN: You're just making the point he was deliberately informed rather than having become aware.
A. I follow now. Thank you.
MR WOLFE: That's merely the point.
A. Sorry.
Q. And given that he was aware, he seems to be saying that knowing the connection or knowing the close proximity, the Erne and the Altnagelvin where he worked, that that caused him to express to you a concern that there might be a perception of bias in using Dr Quinn, and while you were using Dr Quinn for that review there was a need to expand and to use somebody else to take up a further review. Now, just on the bias point, the perception of bias, did Dr McConnell ever raise that with you in the context of Dr Quinn?
A. I need -- I'm not clear, I have lost my train of thought on that one. If I answer it as I think. As part of the

LC review Dr McConnell at no stage, at any stage in that process, said to me directly or even indirectly through another, "I am concerned about Dr Quinn". And I had written to him, highlighting Dr Quinn, so he had numerous opportunities to come back. However, Dr McConnell and myself had conversations about taking other matters forward, including LC, and that led to it going -- I could say Dr McConnell was supportive of my decision to move this to the Royal College of Paediatricians and Child Health. So that's the context of him saying, "This will need a wider review than just involving Dr Quinn again".
Q. As this review set off, doctor, did Mr Fee or Dr Anderson ever come back to you for advice or guidance along the way?
A. I have no direct recollection of them specifically asking me for advice or guidance, other than I believe Mr Fee and Mr Mills must have had a conversation and the keenness for me to attend the meeting with Dr Quinn came out. So that might have been a way of me getting involved.
Q. We'll come to that meeting on 1 June in due course. But in terms then of how they were doing their work, they had set out on a course of requesting reports from clinical and nursing staff; isn't that right?

A. That's my understanding.
Q. Yes. That wasn't discussed with you?
A. No.
Q. And so in terms of their decision, it seems to have been a deliberate decision for whatever reason not to interview staff about their statements. Is that something that you were aware of?
A. No, I wasn't aware of it. I'm somewhat puzzled by it because most people who were doing a review like that would know they have to talk, not just take a statement.
THE CHAIRMAN: Does that mean if I might call them at the lesser reviews that are done within directorates it was commonplace for the staff who were involved to be spoken to directly?
A. I would think so.
THE CHAIRMAN: So it would be rather striking that in a more serious review, following the death of a child, the staff are asked to provide statements and are not spoken to directly?
A. Well, I would have expected them to be spoken to. That's all I can say.
THE CHAIRMAN: On the basis that although there might be no template, that seems to be a commonsense approach?
A. Well, I think the issue of writing out and requesting a statement would be a common approach.

THE CHAIRMAN: That's a good start?
A. That's where you start.
THE CHAIRMAN: But that's not where you leave it?
A. That would be my view.
MR WOLFE: Although the omission to speak to staff and interview them upon receipt of their statements or reports would have been evident to you when you received the review report?
A. It wasn't evident to me, no.
Q. So the review report was comprised of, as we'll see in detail later, a large number of appendices.
A. That's correct.
Q. And you had, if you like, it's called witness statements or statements, from each member of staff.
A. Mm-hm.
Q. With the exception, I think, of a recorded conversation with Sister Traynor and Staff Nurse Swift. There's no other record of a conversation with staff on that appendix.
A. Yes, that's correct. But I would have been hearing in the background of Dr Anderson speaking to Dr O'Donohoe, I'd be hearing in the background of Mr Fee speaking to nurses and enquiring of nurses certain things. So I had a full expectation that in the background, these conversations were going on,

cross-checking data. I didn't necessarily have an expectation that each of those was a formal interview, but there was -- how will I put it -- information or evidence-gathering around the statements ongoing.
Q. Another area of work that might have been explored by the review team, which wasn't, was a contribution from the family. Did you know that they weren't going to approach the family for evidence?
A. I didn't know that they had taken it as a direct decision to do it or not to do it, so I didn't know that at all. Am I surprised at it? Not really. It wasn't the standard of the time, it wasn't what was done routinely. It's completely different now. It's been completely different for many years now. But at that time it wasn't unusual to proceed with the review on some kind of, I suppose, humanitarian front, we don't want to upset the family so close to the event. I think that might have been the thinking. Not from the individuals doing this review, but the thinking generically at the time. It may have been around that area. But obviously one looks back and goes, "It's a glaring omission".
Q. Well, it's clearly a glaring omission, doctor, and we don't necessarily need the benefit of hindsight to say so because, as you would be aware from the report,

Dr Quinn was bemoaning the lack of detail around the incident or the event that happened at 3 am in terms of the nature of that event. And one of the, if you like, pieces of evidence that could have filled that gap would have been information from the family.
A. I think it would have helped.
THE CHAIRMAN: It's not hard to approach the family and say, "Look, we are doing a review. It would be helpful to have your input but we entirely understand if you don't want to engage".
A. And I think that's entirely the approach that would have been taken in the last five or ten years in these cases.
MR COUNSELL: Sir, leaving aside the entirely important role the family have in all this, I wonder if the witness could be asked to the extent he was made aware of the limitations in the role that Dr Quinn had in all of this, namely to the extent that he wasn't to be involved in any interviews with staff, doctors, family, and indeed wasn't provided even with the notes of the nurses and doctors who did provide notes, albeit of limited use. I wonder if we could explore with this witness the extent to which he was made aware of that by the inquiry team.
MR WOLFE: My learned friend's pre-empted me. That's helpful.

Maybe we'll move to that next. Another part of the strategy or the methodology for this review could have involved providing the expert clinician retained, that is Dr Quinn, with the reports that had been gathered from staff. Did you know that that wasn't done?

A. I had no involvement with the remit of Dr Quinn's involvement. I had no knowledge of what was being forwarded to him or not being forwarded to him. My belief is that everything that he would require would be forwarded and if there was anything extra that he needed that the review team would provide it to him. That was my belief at the time.

Q. As I understand the position, and we'll hear from Dr Quinn this week, he had, if you like, established the terms of his involvement by saying, "I will review the notes, if you like in a desktop exercise, and provide you with my view or my opinion". But it was to be no deeper than that. Was that your understanding?

A. That's contrary to my understanding. I was never appraised of any limitations of Dr Quinn's involvement, save, which I'm sure you're going to come to, his declaration at the meeting about not wanting to get dragged into medical litigation or complaints. So I had no knowledge that he had proffered this view or his ground rules for doing it or his limitation. I had no

knowledge of that until this part of the inquiry.

Q. Well, to put it in these terms, doctor: whether or not he imposed this requirement or this restriction, in terms of his involvement he considered the notes, he had a conversation with Mr Fee on 2 May, a conversation with yourself and Mr Fee on 21 June, and provided a written report.

A. Mm-hm.

Q. Self-evidently, he didn't interview the staff?

A. That's correct.

Q. He didn't interview the parents?

A. That's correct.

Q. And he didn't see the reports from those members of the clinical and nursing team who treated the child?

A. That's correct.

Q. Is that a superficial way of conducting a review?

A. I wouldn't have called it in those terms. I would have said that if, first of all, I'd been advised that Dr Quinn isn't content to do the review and these are the ground rules, then it may well have led to a different external opinion. I regarded it as Dr Quinn had the notes for a period of, presumably, 4 to 6 weeks, from getting involved in the review to producing his report. For me, from a distance, there was opportunity if he needed more information to gain that, he gained it

indirectly if he didn't want to gain it through interviewing staff. He could gain it through the review team or, if he wanted to come through my own office, if he period of, that was another avenue. But I suspect he wouldn't have used that avenue because I hadn't had any contact with him.

Q. So in terms, were you aware he wasn't being provided with the statements from the staff?

A. No, I had no knowledge of that. I had no knowledge of exactly what he was provided with.

THE CHAIRMAN: One of the misfortunes that I've discovered from the inquiry to date is that very often, medical and nursing records are incomplete and sometimes they're not easy to decipher. Sometimes they don't actually set out very coherently what is intended. If a review of what happened to Lucy involves Dr Quinn looking at the medical and nursing notes and not looking at the nursing and doctors' statements, which might throw some additional light, isn't that a restriction on his ability to contribute?

A. Well, I suppose, again, there's two ways of answering. One is, if he had those, it might have added further value. That's one way of answering. A second way would be, it's the common methodology for virtually all medico-legal and other external reviews, that they

receive the notes and provide a report.

THE CHAIRMAN: But Dr Quinn was specifically distinguishing this from a medico-legal because he was saying, "I won't do this on the medico-legal basis", so is the analogy with medico-legal not a bit strained?

A. It could be regarded as a bit strained, I agree. So I think at the end of this conversation it would have added value if he'd had the reports forwarded to him or if he'd been able to access them by saying to Mr Fee, "I'd like to see the report of such and such". I wasn't aware that he'd placed that restriction on himself.

MR QUINN: Mr Chairman, it can't be right that he wasn't aware that he had placed that restriction on himself. If one looks at the document at 036A-047-101, which is the report of the meeting of 21 June, which my learned friend just mentioned, one can see from any reading of that report that he bases his opinion on the notes and the PM report. So perhaps the witness could be asked some questions about why he came to that conclusion when evidently the note of this meeting contradicts that.

A. Do I answer that? Sorry, my belief is it doesn't contradict it. My belief is Dr Quinn's doing a report, he's highlighting how he's reached his conclusions. The bit that says, "I do not want to get involved in any medico-legal", was made to us at that meeting. I had no

knowledge of him stating that he did not want to meet family, discuss with family in advance. I had no knowledge going into that meeting that he wanted to restrict his review to any aspect of it. That seems to have been something that was discussed with Mr Mills only.

THE CHAIRMAN: A few minutes ago when you were asked did you know of the limitations that had been imposed by Dr Quinn in that he was not to be involved in any interviews and he would not receive the statements of the doctors and nurses, the gist of your response is that that was contrary to your understanding. So even if you didn't -- even if it was entirely understandable to you that he would not actually formally interview nurses and doctors, it was contrary to your understanding that he would not even receive the information which they had provided?

A. That's correct.

THE CHAIRMAN: But if that's contrary to your understanding, when you say it's contrary to your understanding do you mean that you specifically understood that he would receive the statements which had been provided for the purposes of the review, or were you saying that as a way of emphasising your surprise that he hadn't seen them?

A. I'm stating it on the basis that I didn't believe there

was any information that was out there that Dr Quinn couldn't have if he requested it, wanted it, or -- I am surprised that he didn't get the statements automatically, and I wasn't aware.

THE CHAIRMAN: If that came about because he said, "I will not receive the statements", does that strike you as being unhelpful to the contribution which he can make to aid the review?

A. Well, it doesn't preclude him from making a report, but I would have preferred if he was aware of them and had got the ones he wanted or information from them that he wanted.

THE CHAIRMAN: Thank you.

MR WOLFE: The comment that my learned friend alludes to on this note is that Dr Quinn provided his opinion on the notes and the PM report.

A. Mm-hm.

Q. Was communication such between yourself and Mr Fee and Dr Anderson that you didn't seek to inform yourself through them of just how they were going about their work?

A. Well, I was receiving briefings, but at that more specific level of what exactly have you sent Dr Quinn, what exactly is he asking for, no, I received none of that information, or if you want to put it the other

way, did you acquaint yourself with that, no.

Q. It surprises you, does it, that he didn't receive the reports?

A. Well, what surprises me is more this list of, I don't know, self-restriction or self-restraint in terms of the involvement in the review. That's news to me, to have come to this inquiry. That's what's really surprising me.

Q. It's a restriction that the Trust accepted.

A. Well, I can't answer that because it was never put to me, if you follow me. I wasn't aware of it. I would have been certainly puzzled and unhappy if I'd heard that.

Q. With respect, doctor, you're the medical director who is supposed to be giving oversight to this process.

A. That's correct.

THE CHAIRMAN: Can I ask you it in this way, doctor: when you said quite a while ago now this morning that there is no template for a review, but you would expect it to be done in a commonsense way, does it seem to you to be common sense that a person who's being asked to give a specific paediatric input says, "I will look at the nursing notes and records, but I will not consider any statements provided for the purposes of the review by doctors and nurses"? Do you struggle to see the common

sense in it?

A. Yes.

MR COUNSELL: I wonder if the witness could be asked whether he was made aware that -- and this will be Dr Quinn's evidence -- that Dr Quinn had recommended to Mr Mills that the Trust should obtain expert paediatric assistance from outside the Western Board area.

A. In direct answer, no, I was never made aware of that.

MR WOLFE: I'm not sure, if I can say through you, chairman, that that is precisely how Dr Quinn frames it. The nuance to that might be -- and my learned friend can correct me if I'm wrong -- that Dr Quinn said that if a medico-legal report is required, you should look elsewhere for an expert.

A. Yes.

Q. Because he wasn't doing it. Is that something you were aware of?

A. Only when we went to the meeting on 21 June. He proffered that directly to myself and Mr Fee, and I was happy to accept that restriction.

THE CHAIRMAN: I'm going to stop in the next few minutes at whatever point suits, Mr Wolfe, because the stenographer's been going for two hours.

MR WOLFE: I'll leave it until after the break. What I think is a short question might develop.

THE CHAIRMAN: We'll break for a few minutes.
(12.01 pm)
(A short break)
(12.17 pm)
MR COUNSELL: I wonder if I can just clarify what it is that Dr Quinn said? Because there appeared to be some confusion just now from Mr Wolfe as to whether or not Dr Quinn had put it in the way that I suggested. Can I ask that page 115-041-002 be brought up? It is an extract from Dr Quinn's police statement. Just so that the witness can clarify whether or not he was aware of any of this. Reading from the second line, Dr Quinn says:

"I then telephoned Mr Hugh Mills and said that whilst I would review the records and discuss them with representatives of the Trust, I was not willing to become involved in preparing a report for a complaints procedure, nor in preparing a report for medical/legal purposes. I made it clear to him that I would not interview the doctors involved, the nurses or the family, and that if I accepted the papers, it was only with a view to reviewing the records and discussing the issues which occurred to me as I read them. My recollection of events is that I recommended that they obtain an opinion from a consultant paediatrician from

outside the Western Board area for such purposes."

It's those constraints that I had in mind.

THE CHAIRMAN: Perhaps, Mr Counsell, the ambiguity is "for such purposes". I know it's clear that Dr Quinn said he wouldn't do a medico-legal report for litigation purposes. But for such purposes, is that broader than medico-legal, does Dr Quinn say?

MR COUNSELL: Well, we're going to hear from Dr Quinn on Friday about that. It's really the broad thrust of that that I wanted put to the witness and I think his answer was that he wasn't aware of any of that.

A. Yes.

MR WOLFE: I think that's helpful, thank you.

Just on the issue of investigative opportunities and methodology, which we've been looking at, one final point before we move on, doctor, is that this child was obviously transferred to the Royal Belfast Hospital for Sick Children and, self-evidently, perhaps, clinicians there might have had a view on how it came to be that she ended up in that situation, moribund and essentially hopeless. Were you aware that no steps were taken to engage with clinicians at that hospital to see what they could offer to the review?

A. I wasn't aware when the review process was ongoing. It was obvious from the report that it wasn't incorporated

into it. I can't speak for the review team, but I suspect their interpretation was that the events that led to Lucy's demise all occurred in the Erne Hospital, hence the review was focused in that area. But I can't speak for what their thinking was, but I suspect that's what it was.

Q. In retrospect, perhaps Mr Fee regrets the fact that they didn't pursue a joint review.

A. I think that's what we would all feel, that there was potential to add value and more in-depth analysis, and we may have got to answers earlier if that had occurred.

Q. So although the sentinel event, as it has been called in another sense, occurred in your hospital, you would readily recognise, I think, that there were people who had treated Lucy in the Royal who might have had something useful to contribute to your exercise?

A. I recognise that, but would say clearly that that would not have been in any way the way reviews would have been done in the years 1999/2000. I would not have been aware of any joint reviews ongoing, as a medical director, that occurred.

Q. Leaving aside joint reviews and applying this sense of reasonableness or common sense, why would a self-respecting review deprive itself of such useful evidence perhaps as what those clinicians who treated

the child simply at another site -- why would you deprive yourself of that input?

A. Well, you shouldn't. My belief is that if you felt there was additional information they should bring to bear, you should go and get it.

Q. My scheme this morning is to pursue various themes chronologically, if I can, so taking a slight detour, and we'll come back to the issue of your engagement with Dr Quinn and the report that was published by the review team in a short while. But if I can ask you about two or three things before we get there. The obligations under the Coroner's Act in Northern Ireland. Could I ask you about that?

You are aware, I hope, that Mr Leckey in a statement to the Police Service of Northern Ireland in 2005 said that as well as clinicians in the Royal being under an obligation to report under section 7 of the act, he thought that those doctors concerned with her care and treatment at the Erne Hospital should have been notifying the death to his officers because he says they would have been aware that Lucy was being transferred out of the Erne in a moribund state and had something to contribute, if you like, to the circumstances, that test that goes within section 7, the circumstances of the death.

Were you aware that none of the clinicians in the Erne Hospital had been in contact with the coroner's office?

A. I think I probably was aware and I wouldn't have expected them to be. I would have -- the convention, the normal practice, not just then but for years and years afterwards, was that it was where the death occurred and it was the treating clinicians at that point that would make a referral to the coroner. So that would have been my own expectations at that time.

Q. Did you consider that there was some geographical restriction written into section 7 of the act in the sense that you are only expected to report the death if it occurs within your geographical location?

A. Sorry, I lost the question. Apologies. I heard the geographical bit. What was the start of it.

Q. Let me put the question slightly differently. The coroner has made his view known that there was an obligation resting not just on Royal clinicians but also Erne clinicians to report the death. Do you agree with him?

A. I'm not going to disagree or agree with a coroner in his interpretation of the legal situation. My viewpoint is or was at that time and was clearly at that time that the death was reported by the team where the death

occurred. That was standard practice. If the clinicians in the Erne had learnt that it hadn't been reported, then they would have had an obligation to report as well. But once it's reported, it's reported. I wasn't aware of any concept of dual reporting if that's what Dr Leckey is referring to. This, as far as I was aware -- and I'm presuming as far as the clinicians were aware -- was already reported to the coroner's office by the PICU staff.

Q. And how did you obtain the understanding that it had been reported?

A. I think I gathered that understanding by Dr O'Donohoe saying that when the brainstem tests were being done, that it would be referred to the coroner, but I didn't have it any stronger than that.

Q. Did he tell you it had been reported to the coroner?

A. I can't say for certain he told me it had been. He told me it was their intention to report it to the coroner.

THE CHAIRMAN: Is it still the position that in circumstances such as Lucy's or any other person that the report to the coroner would not come from the treating hospital as well as the hospital where the death occurred?

A. I think it is the same. Now, if, again, the --

THE CHAIRMAN: The law hasn't changed, but when you said

that was the position, that was the convention at the time and for years afterwards, I thought that you were hinting that the convention has changed.

A. No, I don't think it has changed. I think clinicians would be more aware of the need to possibly ensure it has been reported. Sorry, just to explain that. That awareness comes from the outreach of the coroner's office in recent years.

MR WOLFE: Dr O'Donohoe appears to have emerged from his conversation with PICU staff, knowing that the coroner was not going to pursue this case. That's what he has said. Were you aware of that?

A. No. At no stage before this aspect of the inquiry was I aware of that.

Q. Were you aware that the post-mortem that had been done was a consent or hospital post-mortem?

A. No. I believed it was a post-mortem at the direction of the coroner's office. That's what I believed, I believed it actually was a coroner's PM.

Q. The documentation that was sent to the hospital in terms of the post-mortem report didn't state that, did it?

A. No.

Q. Would it normally state that?

A. I can't answer that. I don't receive coroner's PMs often enough to make that comment. It felt entirely in

keeping with my belief that this was a coroner's PM, it was done by the senior pathologist, who I would have known would have worked closely with the coroner, and therefore my full belief was that this was done at the direction of the coroner's office and that the report would be going back to the coroner's office and that an inquest would be scheduled in due course.

Q. And presumably then you weren't aware that a death certificate had been issued?

A. I was not aware until well into this inquiry.

THE CHAIRMAN: Can I take it from that that on your understanding of events, this was clearly a case for the coroner?

A. I think it would be my understanding and if that's -- and I think it would be the understanding of all the other clinicians as well.

THE CHAIRMAN: You mean in the Erne?

A. I think so.

THE CHAIRMAN: Thank you.

MR WOLFE: Could I have up on the screen, please, WS290/2, page 5? We were interested in hearing from you, doctor, in terms of when it was that you discovered that there wasn't to be an inquest. It appears that you're saying, if you look at answer (c), on what date did you become aware that a coroner's inquest was not being arranged.

You say:

"I learned later in 2002 through the scrutiny committee discussions that no inquest was planned."

A. Yes.

Q. Is it not the case, doctor, that you knew long before that that an inquest wasn't planned?

A. I don't think it was the case before that, and I was at those scrutiny meetings, asking what was happening about the inquest.

Q. Could I put to you that Mr Mills has told the inquest the Trust was made aware on 12 October 2001, through the legal representatives of the Trust, that there wasn't to be an inquest. And Mr Kevin Doherty has said as much as well. Mr Mills goes further. If I could have up on the screen, please, witness statement 293/2, at page 8. Question 15. We're asking him a question arising out of his earlier witness statement and asking him to identify the other Trust employees who were made aware on or from 12 October 2001 that an inquest into Lucy's death was not planned. He has identified, you, Dr Kelly, and Ms O'Rawe.

A. Mm-hm.

Q. Let me ask you this: how could you fail to understand that an inquest wasn't planned at the same time as your senior colleagues?

A. I don't know the answer to that question. All I can respond with is that at the scrutiny meeting in November, which has the legal team who have the -- the Trust engages for medico-legal and managing inquests, I'm asking them, "What's happening about the inquest?", and nobody is saying to me, "We've already heard there's not going to be an inquest".

Q. Because as I understand the process, it was Donna Scott of the legal team who notified the Trust, perhaps through Mr Doherty, in late 2001, October 2001, that there was to be no inquest or no inquest was planned. Was that the same lawyer or officer that you were speaking to at the scrutiny committee?

A. If you go back to my witness statement, it'll clarify who was at the scrutiny meeting that time. But Donna Scott would have been one of the people who would regularly have attended the scrutiny meetings. So I'm asking at that scrutiny meeting and I'm being told that they're going to check it and find out. So I'm going -- the trust's legal team, who manage inquests, are not telling me that there's definitely not going to be an inquest, and I do the same again after the litigation process proceeds further and we get a medico-legal opinion from Dr John Jenkins, I'm also asking in 2002, any word yet on the inquest?

Q. Because as you obtain Royal College reports, you're explaining to the inquiry that your reluctance or perhaps your failure to share these reports with the coroner was because in due course you thought there would be an inquest.

A. In due course, I fully expected there to be an inquest, and the message I was getting from the Trust legal team is: it's not unusual for it to take two to three years to have an inquest. So at that stage I fully believed there was going to be an inquest.

Q. What appears to be unusual, doctor, is that the same legal team who's providing the Trust with the information that no inquest is planned in October 2001 appears to be the team that's advising you "hold on, there might still be an inquest, we can't confirm whether there's to be an inquest until sometime later".

A. Well, that seems to be the case.

Q. And you're saying these issues were discussed at the scrutiny committee meeting?

A. Yes, on two occasions after what you're putting to me, October 2001.

Q. The scrutiny committee meetings, as I understand it, are the subject of a claim for legal privilege. Is that your understanding?

A. I wouldn't be aware of that.

Q. The other issue I wanted to deal with with you is the notification to the Western Board of Lucy's death. You were engaged in advising Mr Mills that a report should be made; isn't that right?

A. Correct.

Q. You emphasise in your witness statement that it was necessary to inform Dr McConnell in particular because he carried responsibility for the safe delivery of services and performance of the clinical teams.

A. Mm-hm.

Q. And because Dr McConnell was involved in any areas of underperformance or quality of care issues. I just want to understand how that works. The Western Board is the commissioning body in old money, isn't that right?

A. That's correct.

Q. And they would commission services from the Erne Hospital?

A. Correct.

Q. And Dr McConnell was, as I understand it, the director of public health within the Western Board.

A. Yes.

Q. And his responsibilities would span all of the hospitals in that region, in that board area; is that fair?

A. That's my understanding.

Q. In terms of him carrying a responsibility for the safe

delivery of services and performance of clinical teams, how did you understand that worked vis-a-vis the Erne Hospital?

A. Well, Dr McConnell was in regular contact with the main trust board executive directors and through particularly Mr Fee and Mr Mills, met them on a regular basis, engaged with them on performance in relation to the commissioning and would have been, both in the past and at that time, regularly contacting individual clinical teams and checking on matters. So it was before and after, and in fact in this example Dr McConnell initiated a phone call to me to enquire the details.

Q. You have said of him that he had a responsibility to be satisfied that an incident was properly reviewed and for disseminating any lessons learned across the Western Board and possibly, if relevant, across the wider Health Service.

A. Certainly that was my feeling at the time.

Q. Is that still your understanding?

A. My understanding of what his role at that time was, yes.

THE CHAIRMAN: We've been told earlier in the inquiry by Mr McKee that from 2003, the responsibility for the quality of service provided by each Trust was imposed on the Trust. Right?

A. That's right.

THE CHAIRMAN: Was that responsibility transferred to the Trust from the Western Board or did the responsibility simply not exist or was it not imposed on any institution before then?

A. That was clinical governance, a new responsibility putting quality and delivery of quality of care on the same footing as perhaps financial matters and contract delivery. That's a very different thing than what was in before. So quality before was more disparate throughout the trusts themselves, through the commissioners and presumably through the department issuing guidelines and guidance.

MR WOLFE: Could I put to you for your comment something that Mr Frawley has said to the inquiry. Mr Frawley, as you will remember, was the general manager of the Western Board at that time, and you knew him?

A. I would have had no regular meetings -- a medical director didn't meet the general manager of the Western Board or, for that matter, director of public health. That was done through other executive members of the board.

Q. Yes.

A. But I knew him.

Q. Your interaction in terms of the board would have been with Dr McConnell?

A. Correct.

Q. As a general rule or general observation?

A. Yes.

Q. As I understand it, Mr Mills, chief executive of the Trust, his interaction would have been with Mr Frawley on perhaps a monthly basis? We'll ask him about that.

A. Yes, he had monthly basis with Mr Frawley and subsequently Mr Lindsey. He had regular performance meetings with the senior management team of the Western Board, if I call it that, which would include Dr McConnell, Martin Bradley, I think Dominic Burke was there at the time, a range of officers like that, they would meet on the team. I wouldn't be included in those meetings.

Q. Yes, and the point I wanted your observations on was something Mr Frawley has said. If I can have it on the screen for you to read it, WS308/1, page 8. He is talking here, if I can contextualise it, about the obligations that rested with the Western Board in circumstances where there was an unexplained or unexpected death such as Lucy's. He says in a series of bullet points that his response at that time would have been to seek assurances that an investigation had been initiated, and of course those assurances were given, you were giving those to Dr McConnell, Mr Fee was

engaged with Mr Bradley and Mr Mills was having meetings from time to time with Mr Frawley.

It was also his role to ensure that the relevant professional leads in the board had been advised. One of the professional leads was Mr Bradley, who was the chief nursing officer at the time. Dr McConnell was the director of public health. So in those terms they were the professional leads and they had knowledge of the case; isn't that right?

A. Correct.

Q. Then the point I wanted to bring you to is this. He says:

"Where the investigation and its conclusions resulted in the preparation of a formal report [such as here] I would had an expectation that the report would be shared with the board in order to enable the board to consider whether the board needed to initiate any action in light of the report. In making such a judgment, I would seek the views of the relevant professional leads in the board on whether the findings, conclusions and recommendations proposed by the Trust were a proportionate and appropriate response to the incident that had been investigated."

Can you say whether that was your understanding of the function of the board?

A. It ties to some degree with my understanding of reporting to the board, yes.
Q. And that's right, there's a symmetry there. You're reporting to the board because you believed you were obliged to under the commissioning arrangements; is that fair?
A. I don't think I would put it explicitly under the commissioning arrangements. That's at the time who we felt we were reporting to on any incident relating to delivery of services.
Q. Is that because of the board's, if you like, responsibility for the population of that area?
A. Yes. I think so.
Q. It won't be lost on you, doctor, that the Western Board obviously carried responsibility for the Altnagelvin Hospital, where Raychel was to be cared for, 14 months after Lucy's death. And it would seem, on the basis of Mr Frawley's understanding, that if the board was in receipt of a report from your hospital, part of its role, part of the board's role was to analyse that report to see if lessons could be learned which might be of wider significance?
A. I understand.
Q. And again, would that have been your understanding of one of the functions of the board?

A. Well, it would have been my belief at the time, yes.
Q. Could I ask you about the Department of Health and Social Services and your -- that is the trust's relationship at that time. Dr MacFaul in his analysis for the inquiry has criticised the senior management team of the Trust, of which he regards you as a part, for not reporting the death to the department. Was the death reported to the department?
A. Not as far as I'm aware. I can only state in response to that that at that time there was no reporting arrangement to the department that I was aware of. I'd never received anything from the department indicating that that would be a route that I would have to report incidents to, major, minor or otherwise, and certainly not by 2004, I think it was, when they produced a major incident reporting mechanism. There wasn't even clarity as to who you might want to seek advice from. So none of those things existed in 1999/2000, as far as I was concerned. The only link to the department through the senior management team that I was aware of was Mr Mills would have had meetings with the department.
Q. You spoke there about a mechanism having been introduced in 2004.
THE CHAIRMAN: Sorry, just put that in context with me. When you say that Mr Mills had meetings with the

department, what sort of issues would you expect Mr Mills to bring to these meetings?
A. That might be issues in relation to delivering on strategic objectives for the region, so new policies being introduced, so Mr Mills might be getting appraised of what was coming down the line in terms of clinical governance, what was coming down the line in terms of appraisal and revalidation. Also I'm sure they were discussing matters such as the human organs and consent and blood transfusion became a huge thing. That's the type of regional issues I think were being discussed.
THE CHAIRMAN: They're coming down from the department. Those meetings presumably would also give an opportunity for the trusts to bring information into the department.
A. Yes, I certainly would be aware that Mr Mills would bring back problems in relation to manpower issues, et cetera, but I honestly would have to -- I wouldn't get minutes of them or be briefed on them by Mr Mills. So that's a question that will have to be more fully looked at with Mr Mills.
MR WOLFE: What was the specific mechanism introduced in 2004 to ensure that adverse incidents such as unexpected deaths were imparted and communicated to the department?
A. There was a circular came out from the department that made it mandatory to refer everything to the department.

There were numbers and people to contact, and there was even a specific form to do it on.
Q. Have you had the benefit of considering the report provided to the inquiry by Professor Gabriel Scally?
A. I did see the report, yes.
Q. In that report he expresses the reason that there was no direct managerial responsibility between the Trust and the Western Board in the sense that really that was the commissioning body, there was no -- they didn't have an oversight or a formal management role in the sense that he describes. Moreover, he said and expresses the opinion that the Trust was accountable to the Department of Health and Social Services, pursuant to, I suppose, the mechanism by which the Trust was created, which is the 1996 commissioning order or implementation order.
Again, was it your understanding at the time that the management responsibility was from the department to the Trust in that line?
A. De facto it wasn't in practice. It may have been at the time, but I wasn't aware that that was the way it was meant to happen. De facto, it was the Western Board officers were, you know, in contact regularly, talking about issues, issues not just to do with -- what I would perceive to be to do with commissioning. The department were not doing that.

Q. Mr Frawley in his statement has expressed the view that he would have expected the Trust to notify the department of an untoward death because, as he says, he's following, I suppose, the opinion expressed by Professor Scally, because the trust's line of accountability was to the DHSS, he explains it. Again, you're saying that was de facto the position but not the practice?
A. Before that circular in 2003/2004, that is a surprise to me, and the interpretation of it is probably correct, but on the ground practice was the complete opposite, you reported to the board.
Q. Could I have your observations on this? Dr McConnell in his witness statement, first witness statement, suggested that he believed or he was aware that the Trust had reported this death to the department. And when pressed on that, he said in a second witness statement that information provided by Mr Fee and Mr Mills suggested to him that the department had been notified.
A. All I can say in response to that is I'm unaware of that, unaware of the information that might have been supplied and I did not believe at that time or around those couple of years that this had been formally referred to the department.

Q. Could I also have your comments, please, on something he said in terms of the mechanism for reporting to the department? If we could have up on the screen, please, WS286/2, page 4. Maybe the reference is wrong. Perhaps if I read to you:
"Following the creation of the trusts in the 1990s [he says], Trust chief executives reported individually and collectively through regular meetings to a senior officer within the permanent secretary's department on issues within their trusts. Any major events such as Lucy's death might have been considered relevant to report within that line of management."
So he's saying that while there wasn't this formal obligation that you talk about in 2004 to report deaths to the department, there was nevertheless a mechanism by which it might be considered relevant to report a death. Again, is that something that was known to you?
A. I'm disappointed if that was a recognised mechanism and people like myself in a medical director position were not aware of it. But, again, you will have to address that question directly to Mr Mills. It was Mr Mills meeting with the permanent secretary were the meetings I was alluding to earlier, but I have no knowledge and cannot recall ever seeing any mechanism for reporting, either when I was a clinical director or as a medical

director during those years.
Q. You, as we will look at this afternoon, had a meeting in 2001 of the medical directors group, at which you learnt about the death of Raychel Ferguson, and that was discussed. You'll recall that?
A. I think we need to be more precise on "discussed" and the details.
Q. I think what you said is on the fringes of that meeting, you discussed with Dr Fulton --
A. Correct.
Q. -- I don't want to get into the detail of that now, but through that meeting, as I understand it, observations were made to the chief medical officer, and indeed one of her representatives, I think Dr Carson --
A. That's right.
Q. -- was at the meeting. So that was, if you like, a forum by which the death could or perhaps should have been reported.
A. Well, it's not a forum that was used before or afterwards. It was not a mechanism. In fact, you will hear, presumably this afternoon, Dr Fulton and myself had a conversation about whether we could raise it at this forum, and I encouraged him to raise it. But it wasn't a mechanism for doing that. Quite the opposite, it was very much a mechanism for the department to share

with medical directors major strategic initiatives. That's where appraisal and governance was being driven through that medical directors' meeting. It wasn't a lot of information or learning coming from the Trust through the medical directors. That was not the purpose of that or the mechanism.
Q. So far as you understand, the Trust didn't report this death to the department in that nobody ever advised you that that had happened, and moreover you would say that it is your understanding that there was no obligation, indeed no mechanism to do that?
A. Well, it was my understanding. I can't say as Professor Scally has recorded, I can't say there wasn't, I'm saying I was completely unaware of it, and it wasn't what was happening on the ground de facto at the time.
Q. In fairness, I think Professor Scally remarks that there may not have been a mechanism, certainly he hasn't described a mechanism. It might come as a relief to you. What he was saying is there was nevertheless this managerial link in place that meant that to the extent that a death would be reported, it would be in the direction of the department.
A. And I'm coming at this not at relief, with disappointment that no mechanism existed for such an important issue.

Q. Yes. Could I move on then to another issue before we reach your meeting with Dr Quinn on 21 June. You and your colleagues had through your interactions with the Western Board's officers kept them in touch with various developments around Lucy's case, the fact that a review was being instigated and Dr Quinn had been appointed; isn't that right?
A. That's correct.
Q. And you wrote to Dr McConnell on 15 May 2000. If we could have up on the screen, please, your letter. It's 036a-046-098. If we could have alongside it the second page, please. The purpose of this letter, doctor, was to inform Dr McConnell of developments in the case?
A. Developments? Well, Dr McConnell -- we had received notification that the event had happened and that a review was planned through Mr Mills. Mr Mills and myself had a conversation on that morning of the 14th to ensure that happened. Again, we felt that was the reporting accountability mechanism. Then Dr McConnell rings for an update and this is my letter to provide him with an update on where things are or a summary of events. He was interested in events rather than what necessarily was where things were in terms of the review.
Q. By this stage in the development of the case, you were

in a position to provide greater clarity to Dr McConnell in terms of what had happened? You were still awaiting Dr Quinn's report, but Mr Fee had met with Dr Quinn already and you were able to notify Dr McConnell of Dr Quinn's preliminary view; isn't that right?
A. Well, I'm notifying Dr McConnell. I'm not part of the review team, I'm not sitting with the notes, I'm notifying Dr McConnell based on briefings I am receiving from Mr Fee in line with my original instruction to keep me updated. And I believe he had a conversation with Dr Quinn on 2 May, and I'm presuming the details in this letter reflect that.
Q. Yes. One of the things you say, doctor, at paragraph 1 on the left hand page is the history before the seizure is described. You explain how the child was admitted with a background of diarrhoea and vomiting and dehydration, which is described as severe:
"The SHO had difficulties obtaining venous access for fluid replacement and called the consultant paediatrician into the ward. Dr O'Donohoe attended and gained venous access and commenced the child on a fluid regime for a shocked infant. The child's sodium was noted to be low at 127."
Where did you obtain that information from?
A. Well, that would be information I obtained from Mr Fee.

I didn't have the notes to cross-check that, so that was my interpretation of what he was telling me. I fully appreciate, looking at that, that that information as regards the timing of that would be at the time of the seizure and would have been better placed in the next paragraph.
Q. Because reading it in that way or writing it in that way might suggest that this child was coming into hospital with an electrolyte difficulty already?
A. Quite the opposite from what I was intending, obviously, and quite the opposite of the way I would have read it. I would have read it that the child's in, the drips and all the rest are started, venous access is got, so the child is in, so it's not a sodium related to the child coming in, it's a child relating to the child's ill period, but I fully accept that it would be better placed in the next paragraph.
Q. The doctor was told that the parents, that is Mr and Mrs Crawford, had been advised that a review was underway; isn't that right?
A. That's what I believed.
Q. And you now know that the Crawford family reacted, let's say, with surprise when they were told that a review had been conducted.
A. Yes. That came as a surprise during the complaints

process in the exchange of letters where the Crawford family indicated that this was the first they'd heard of a review occurring.
Q. Do you now accept that they weren't advised of a review?
A. Of course I accept that if that's what they're saying, but you're aware that the information that was being conveyed to me was that Dr O'Donohoe had told the family in that first meeting that he had given the notes to Dr Kelly and an investigation is planned. I naturally believed from the review team as well that the family had been informed that an investigation review was ongoing.
THE CHAIRMAN: But you told me earlier that you would not expect the review team itself to alert the family to that.
A. No.
THE CHAIRMAN: So if the Crawfords knew, it could only have been because Dr O'Donohoe happened to mention it to them?
A. Correct. And Dr O'Donohoe -- the review team believed Dr O'Donohoe had mentioned it to the family, that an investigation was planned.
MR WOLFE: There was also a suggestion that a health visitor should notify them of that fact.
A. I don't know the details of that suggestion.

Q. Very well. Could we go to the last page of the letter, please? You tell Dr Kelly [sic] that you'll be happy to provide him with further details as investigation reports come out and you're happy to receive from him any suggestions or additional comments. I understand that you have no record of receiving a reply to this letter.
A. I didn't get a reply to that letter. It's not a question of no recollection.
Q. You didn't get a reply to the letter?
A. Yes.
Q. Dr McConnell, I think it's right to say, cannot recall making a reply. You are adamant you didn't receive a reply. Did you expect to receive a reply?
A. Not particularly. I expected that if he had any issues or wanted any clarifications, that he would lift the phone and speak to me.
Q. And in due course --
MR COUNSELL: I wonder if Mr Wolfe is moving away from this letter, the witness could be asked going back to the letter, just to identify the source. I wonder if the second page could be brought back up rather than the last page?
THE CHAIRMAN: If you could drop page 100, thank you.
MR COUNSELL: The source of the information that he has

included in both numbered paragraphs 2, so the first one on the first page and the second one on the second, in particular looking at the first page, page 098, his reference there to "the description of the form of seizure being more in keeping with the child going to decorticate rigid", and the source of his information on the next page that there are concerns in connection with the source of fluid replacement.
A. The answer to those is that it's information I'm receiving from the review team, most likely directly through Mr Fee.
THE CHAIRMAN: Thank you.
MR WOLFE: You say you didn't have the notes, doctor. Did you draft this letter or did Mr Fee draft the letter?
A. No, I drafted the letter. Mr Fee had no input into that letter at all. I'm drafting it on information I've been receiving over the previous weeks from Mr Fee. The notes, for clarity, remained with the review team and my understanding was that they held them with Mrs Millar so that individuals in the review team could -- or individuals who were asking [sic] statements could access them directly.
MR WOLFE: That would be a suitable moment.
THE CHAIRMAN: We'll break until 2 o'clock. Thank you.
MR GREEN: Sir, if you'd be good enough just to forestall

rising for a moment, I wish to raise an issue relating to the scrutiny meeting of 15 November 2001 and formally to get it on the transcript and ask through you, sir, if DLS would be good enough to reconsider their claim of litigation privilege over the notes of that meeting. It has arisen in this way. You will recall that a few moments ago Mr Wolfe was suggesting that Dr Kelly knew that no inquest was planned by October 2001. I have very clear instructions from Dr Kelly on this matter. Not only does he not seek to hide behind DLS's assertions of privilege, if that was a suggestion --
MR WOLFE: I'm conscious that there's an application in mid flow and Dr Kelly is still here. Whether anything might be said in the application that would affect the evidence that Dr Kelly is about to give --
MR GREEN: I'm quite happy for Dr Kelly to be invited to withdraw from the room. That is perfectly appropriate. Thank you, Mr Wolfe.
(The witness withdrew)
THE CHAIRMAN: He can't read the transcript either then. We'll work that one out later.
MR GREEN: The position is, as I've said, that it was suggested to Dr Kelly that he must have known by October 2001 that no inquest was planned. And as I said, not only does Dr Kelly not seek to hide behind

DLS's privilege over relevant notes on this point, but I am positively and actively requesting on his behalf that DLS reconsider that claim of privilege, first whether it's properly conceived and, second, even if it is properly conceived whether in the interests of fairness and an open inquiry they ought to waive it.
My instructions are quite clear on this point, that at the Scrutiny meeting on 15 November 2001, Dr Kelly was still asking, in effect, what was happening with regard to the inquest or the plans for the inquest. And my instructions are that the Scrutiny meeting records, if they have been prepared with a modicum of competence, ought to disclose that he was still making that enquiry by then. Additionally, there was a meeting between Dr Kelly, Bridget O'Rawe, Kevin Doherty and a Ms Finnegan on 12 April 2002, and my instructions are that in that meeting Dr Kelly was still asking what was happening with regard to an inquest.
THE CHAIRMAN: He is saying that he wouldn't have been doing that if he had been told in October 2001 that there was to be no inquest.
MR GREEN: That's right, but he was asking for clarification about what is the position with all of this. His stance on this, as I understand it, is that he found out towards the end of 2001 that no inquest was planned.

2002, that no inquest was planned. And that in April 2002, he was still wanting confirmation from DLS about the position with regard to an inquest. I'm aware that if privilege is properly asserted, nobody, and not even this inquiry, can compel its waiver, but I would simply draw this point, Mr Chairman, to your attention, that if this assertion of privilege is to be persisted with, it is inconsistent with the approach that DLS has taken with regard to another document. If I may give an example and have pulled up on the screen, please, 036c-043-101.

These are Dr Kelly's notes of a meeting between him, Patrick Good, before he took silk, Donna Scott at the Bar Library, in April 2003, and if you go down to point 3:

"New developments re possible coroner's inquest."

At bullet point 3:

"Inquest is likely. Surprise that one was not arranged before now!"

And you can see one bullet point up:

"Decision will be based purely on the report from Dr Sumner."

And on the next page at point 3 on that page under the global heading "Discussions":

"Coroner's inquest will be dependent on Dr Sumner.

We must await developments."

And then Dr Kelly's name at the end.

Now, no doubt, if the Trust or DLS wanted to take a consistent position with all of this, they would have been shouting privilege from the rooftops as soon as that made its way into the inquiry domain and indicated that this didn't amount to a waiver of privilege, this was inadvertent disclosure. They have not done so and I simply invite them, through you, sir, to take the same open approach with regard to the scrutiny meeting on 15 November 2001, and then a meeting I've already mentioned on 12 April 2002, bearing in mind that Dr Kelly is confident that, as I say, if those records have been compiled with a modicum of competence, they will support what he says on the timing of when he obtained knowledge that there was to be no inquest.

THE CHAIRMAN: Well, Mr Green, there's always an issue for a party in any setting about whether it chooses to exercise its right to claim privilege.

MR GREEN: Of course.

THE CHAIRMAN: That's one issue. The Trust has chosen to exercise its right and I can't go against that.

MR GREEN: That's right.

THE CHAIRMAN: There are two points. One is whether the claim is properly made and the second is whether it has

been waived. And if it had been waived in relation to a document, does that mean it's a waiver in relation to all documents?

MR GREEN: That's certainly an arguable position. I don't want, without considering it with a little more care perhaps over lunch, and as the afternoon progresses, to make any sort of bold and overly broad submissions as to what the waiver of one document entails in terms of implications for other documents. But I can see in immediate terms the force in the proposition that you have just put.

THE CHAIRMAN: And the traditional concern about waiver for a document but not other documents is that that has the potential to distort the information in a way which is improper.

MR GREEN: Exactly.

THE CHAIRMAN: That's why you can't pick and choose which privilege documents you disclose.

MR GREEN: Exactly, you can't just dip your toe.

THE CHAIRMAN: I think that rather than deal with it today, we'll have to deal with this tomorrow morning now that Ms Simpson is on notice on it. If it means -- we are progressing with Dr Kelly. We'll see if we finish him today. If we do finish him today and he needs to be recalled on any point that emerges, that can be quickly

arranged.

2.05. Thank you.

(1.15 pm)

(The Short Adjournment)

(2.05 pm)

(Delay in proceedings)

(2.18 pm)

THE CHAIRMAN: Mr Wolfe, just before you resume, I think there have been some initial discussions at least over lunch between the parties about the privilege issue and so on, which was raised before lunch.

MR WOLFE: That's right.

THE CHAIRMAN: I think on this, if I understand Mr Green's point, Mr Green, am I right in interpreting your submission as really saying that you're not so much interested in a general debate about whether the documents are privileged or not, you simply want to extract from the document one or two facts which would either support or go against Dr Kelly's contention that he queried at two meetings in November 2001 and April 2002 --

MR GREEN: Exactly. I would be very happy for everything else to be redacted, insofar as that's possible, without distorting context.

THE CHAIRMAN: Okay. Could that be thought about,

Ms Simpson, overnight as an option?
MS SIMPSON: The difficulty, as I would see it, is if we waive privilege in relation to that document, do we waive the wider privilege in relation to the remainder and then do all the other parties in court say, "There may be documents that we want to see"? That's obviously the difficulty. I have taken preliminary instructions in relation to the document that appeared on the website and certainly it's my view that that was clearly an inadvertent waiver of privilege, and I'll obviously address that tomorrow morning.
THE CHAIRMAN: My sense of this is that there's a short cut through it, which I'm not sure that anybody at this stage would be seeking to take advantage of in the sense of: can you confirm or do the documents confirm or otherwise Dr Kelly's evidence about querying when the inquest was going to take place.
MS SIMPSON: I haven't had a chance to look at the document to see what the contents say.
MR GREEN: Even beyond redaction, I'm perfectly happy for relevant information to be summarised in a separate document and provided to us, if you like the equivalent of a written admission in a criminal case.
THE CHAIRMAN: Thank you.

MR WOLFE: Doctor, I want to bring you to the meeting which you had with Dr Quinn in the company of Mr Fee on 21 June 2000. You were going to that meeting because Mr Fee had requested your attendance in the absence of Dr Anderson, but you also had your own business, isn't that right? You wanted to ask Dr Quinn a question in relation to the safety or competence of Dr O'Donohoe?
A. That's not quite accurate. It was Mr Mills who fairly early on in the process suggested that the three of us would go to Dr Quinn. Mr Fee was obviously extremely keen when he learnt that Dr Anderson wasn't going to be available because of annual leave that I attend, and your other point in relation to I wanted to clarify myself on some of the safety performance issues, if I could, I thought that would be valuable for me to be in the room for that.
Q. Yes. Now, in advance of the meeting, did you prepare by looking at the notes or taking any such steps?
A. I did not. I was fully under the belief that I was going to the meeting to receive the report.
Q. Right. You, as I understand it, made a record of that meeting.
A. I made some notes of that meeting, yes. It wasn't designed to be a minute of the meeting. It was notes that I took as we were conversing.

Q. Do I take those caveats as intending to convey the view that they don't pretend to be a full account of the meeting?
A. Well, they're not an accurate minute of everything that was said, discussed, and you can see the brevity of them, they don't reflect that duration of a meeting.
Q. Could we have them up on the screen, please? There's two pages. I will have them side by side, 036c-004-007 and the following page, please.
You presumably made handwritten notes and had these typed up thereafter?
A. That's correct.
Q. You didn't retain the handwritten notes?
A. No. That was, as you will see from my evidence and folders, was my common practice at that time was to immediately type things up that night.
Q. As you're aware, Dr MacFaul has expressed the view that there was apparently, based on what Dr Quinn would say about this note, it isn't fully accurate. So Dr MacFaul expresses the view in critical terms that there was this failure to maintain an accurate record.
A. Does the note convey most of what was discussed? Is it a reasonable record of the meeting? I would still maintain that's a reasonably good note of the meeting.
Q. How long did the meeting last?

A. It was at least an hour.
Q. Right. And it was held at Altnagelvin Hospital at Dr Quinn's office?
A. Correct.
Q. Were you interested as an attendee at the meeting in, if you like, the review issues that were being discussed? Or was your interest by distinction only in raising this issue about the safety or competence of Dr O'Donohoe?
A. No, I was very interested in what Dr Quinn and Mr Fee's interaction in terms of the review -- very interested in that and obviously had my own aspect to ask Dr Quinn about.
Q. Could I deal with an issue of process before going to the substance of it. You arrived at the meeting, I think you say, expecting to receive a written report and, self-evidently, Dr Quinn hadn't prepared a written report.
A. That's correct.
Q. Indeed, is it the case that he had no intention up to that point of providing a written report so far as you're aware?
A. I'm not able to answer that. I wasn't aware of what his intentions were as I went into that meeting. I fully believed that he was going to provide a written report as part of his review from the moment he was appointed

to the end, and at no stage did I deviate from that view until I went into that meeting.

THE CHAIRMAN: Did Mr Fee lead you to understand that the report would be provided at this meeting?

A. I expected -- I can't say he led me to believe it. I expected that was what the meeting was for and I was going to receive a report.

THE CHAIRMAN: Thank you.

MR WOLFE: In any event, there reached a point at the meeting when a request was made to provide his views in writing.

A. That's correct.

Q. And did he initially indicate at the meeting that that wasn't his intention?

A. Initially, no. I didn't get told at the start of the meeting "I'm not -- this is all you're getting or I'm not doing a written report". It was when I asked that I needed a written report, was when I first heard, "I'm not keen to do a written report for the following reasons".

Q. Could you set those reasons out for us?

A. There were two. First, he did not want to get dragged into any medico-legal, and equally he did not want to get involved in complaints processes that -- his phrase was "that often arise from situations like this", doing

reports like this. It was a surprise for me to hear that, but I acquiesced and said, "I understand that, that's fine, but I still need as a medical director to see a written report of this".

Q. And upon your insistence, he agreed to do so?

A. Yes.

Q. Now, when Dr Quinn was interviewed, or I think the parlance is doorstepped, in relation to a UTV documentary, he used the phrase that he was sweet-talked, and he has explained the context for that remark. It'll be a matter for others to judge, of course. He says the context for that remark was that he was sweet-talked into providing a written report, having hitherto been inclined only to provide his opinion or his views orally in the course of a meeting. Could I have your view, please, in terms of whether, in the context of that meeting or in the mood of that meeting, you had to act as a persuader?

A. Well, I think "sweet-talk" is the wrong phrase. I think "pressurise" is equally a wrong phrase. I think I convinced him I needed or we needed a written report. If it was his intentions all along not to provide a written report, then yes, I told him we needed a written report and he acquiesced. There wasn't a major protest or any delay once we got beyond the two items

that were making him reluctant.

Q. Very well. In terms of the report that you were to receive, Dr Quinn has made it clear that it was -- what he was providing you with was a summary of his views and that his report has to be read in conjunction with what he spoke about at the meeting. Is that fair?

A. It's not my recollection of how we left the meeting.

Q. What is your recollection?

A. My recollection of how we left the meeting is he'd given us a verbal report and that he was going to put it in writing, not summarise it, shorten it or in any way adapt it significantly. He was going to give us a formal, written report that I, in all honesty, presumed he had already mostly prepared.

THE CHAIRMAN: Well, if he can start the meeting by providing you with the opinion which he's formed then one would assume in the normal course of events he has some notes which form the basis of that opinion and those notes also turn out to be the basis of the written report. Does that seem the position to you?

A. It makes sense to me that that was happening.

THE CHAIRMAN: Subject to any toing and froing or any afterthoughts on his part?

A. Yes.

MR COUNSELL: Mr Chairman, I wonder if I can follow up on

that question by asking Mr Wolfe to ask the witness whether he recalls that Dr Quinn did indeed have some handwritten notes in front of him at the time of the meeting.

A. Apologies, I have no recollection of any notes that he had in front of him. He did have paper in front of him because he took us through the calculations in the room that afternoon.

THE CHAIRMAN: Just one other point on this. This note on the screen now, was that sent, after that note was drawn up, was that sent to Dr Quinn?

A. No, that was a note I was taking purely for my own benefit in the room. It wasn't meant to be a minute to be used by anyone else.

THE CHAIRMAN: Right.

A. So even as I was taking it, I had no intentions of typing it up and forwarding it to anybody.

THE CHAIRMAN: Thank you.

MR WOLFE: You did say, and just to follow up on my friend's intervention, that Dr Quinn took you through some calculations.

A. Yes.

Q. On that day. I will want to come back to the document that's on the screen, but if I can just put another piece of information into the mix that Dr Quinn says was

part and parcel of this meeting. If we could have up on the screen, please, witness statement 279/1, page 36 and have alongside that, if we could, I think it's 279/2, page 10. Just to orientate yourself, doctor, Dr Quinn says that in advance of this meeting, he had prepared a document which, as you can see before us, contains some calculations, with the intention that he would be taking his visitors, that's you and Mr Fee, through a number of points. And the left-hand side is the document which he would have had with him, the right-hand side is him kindly transcribing it for us.

You obviously didn't see the note on the left-hand side?

A. I don't recognise those notes at all.

Q. But he had papers in front of him is what you say?

A. He had paper in front of him.

Q. And you say that he took you through some calculations?

A. Yes.

Q. You can see, it's easier to read the right-hand side, obviously, you can see that in terms of calculations he has set out the rate of fluid which he says would have been applicable depending upon the degree of dehydration, and then he sets out the fluids he says or he reckoned on the basis of the information in front of him she had actually received, and then he divides that

over a seven-hour period, which is the period between the time of admission and the time of the, let's call it the event at 3 am. Is that the kind of calculations he brought you through?

A. That's very similar to what I recall. He wrote it down. It would be important for the inquiry to recognise, this is the first time I'd ever seen these types of calculations done. It's not done in adult medicine or care of the elderly medicine with fluids. So I'd never seen it done. He actually did the calculations in front of us, myself and Mr Fee, on the paper. But I cannot say he didn't have other papers on his desk, representing what's on the left there of the screen.

MR COUNSELL: Sorry to interrupt again. I wonder whether it would be helpful to the inquiry if you had up in front of you on the screen perhaps the document on the right, which is easier to read, and compared that with Dr Kelly's note, which we previously have had on the screen.

MR WOLFE: We can do that. We can keep the right-hand up on the screen and move back to 036c-004-007.

Doctor, can I ask for your comments in relation to this? Dr Quinn would say that in terms of the issues that he intended to go through at the meeting, the right-hand document is something he had prepared in

advance and he would say that to the extent that your record has left out any of those issues, it isn't accurate. In other words, there were issues contained within the right-hand side which were raised at the meeting and which you haven't captured in your note. Do you follow?

A. I follow.

Q. He hasn't, as I understand it, specified what they are, but one can see the question:

"Was there renal compromise urinary output noted? Any oedema of face or peripheries?"

Do you see that?

A. I do.

Q. Can you remember whether that -- that appears to be perhaps two issues, renal compromise followed by a second issues of the face or peripheries. Were those two issues discussed?

A. I don't recollect that, but they may have been. I can only rely on my notes, on my recollection of the meeting. That would not have struck me as a very important aspect at that point in time, but it could well have been asked of Mr Fee and I wouldn't have necessarily scribbled it out. I can't answer that with certainty is what I'm getting at.

Q. So if there was oedema of the face or peripheries, that

might be relevant to the extent to which there was fluid overload?

A. Absolutely, yes.

Q. So it would be relevant?

A. Sorry, yes. I can understand it was relevant, yes. So ongoing, I didn't pick up on that at the time that that question was asked in such a fashion that it was obvious that it was a question in relation to fluid.

Q. I think I'm right in saying that that's not contained in your note unless it's disguised in other medical language which I wouldn't necessarily understand.

A. No, I don't think my note reflects any discussion on renal compromise.

Q. There is a third point, I think, which may not be mentioned in your note, and it's the question about four fifths of the way down the page:

"Resuscitation? Adequate?"

Is that an issue that was discussed?

A. I think that would have been discussed.

THE CHAIRMAN: Sorry, it's not one way, is it? There are issues on the notes that Dr Kelly made which aren't in the note which is prepared by Dr Quinn. Is that right?

MR COUNSELL: That's quite right, sir.

MR WOLFE: Getting back to the substance of the meeting

then, doctor, you have said in the account that you gave to the PSNI that Dr Quinn provided you and Mr Fee with a step-by-step analysis of the case; is that fair?
A. Yes.
Q. And he provided you with his opinion on the treatment given and, in particular, on the fluids administered. Now, in terms of the fluids administered, Dr Quinn emphasised in his account to the police that he recollects points out particularly to Mr Fee that he needed to ascertain from the staff involved in the care of the child just what precisely the child received in terms of volumes of fluids given, both before the event at 3 am and after that event. You understand the point?
A. I understand the point.
Q. And do you recall whether he was at pains to emphasise the need for clarification on that?
A. I'm not sure. Can you ask the question again? Sorry, I've lost the trail of it.
THE CHAIRMAN: Dr Quinn, when interviewed by the police, said that at this meeting he emphasised strongly to Mr Fee in your presence that Mr Fee needed to get clarification from the staff as to exactly how much fluid Lucy had received. Do you agree from your memory of the meeting that in fact he did so?
A. I don't remember it in that terminology that he was

adamant or very, very keen to sort this out. He may have been saying things like "it's difficult to ascertain for certain here", and basing the calculations around that. I'm not sure, I can't be certain. My notes are my notes.
MR WOLFE: Yes. Your notes contain a reference halfway down the page on the left-hand side to 250 ml of normal saline. That's what is suggested was put in after the resuscitation. Do you know where that figure emerged from?
A. My belief is that there was a lack of clarity in that in the earlier phase of the review Mr Fee was charged with finding it out and he checked with nursing staff, and that's where that figure comes from. I may be wrong, but I believe he checked it with the critical care nurse as to what was given. That's what I believe.
Q. Who would that have been?
A. I'm not sure who was on that night.
Q. We don't have a statement to that effect.
A. Siobhan ...
Q. MacNeill?
A. MacNeill. That's my understanding. I may be wrong.
Q. It's Dr Quinn's point that in terms of whether he was ever told that 250 ml had been given, it didn't happen, he didn't receive that figure.

A. I can only state that that figure is noted there because that figure was discussed on the day.
Q. And indeed --
MR COUNSELL: Just to clarify that, I think Dr Quinn's evidence said he doesn't recall when [inaudible: no microphone].
A. My understanding of the process was that nurses were asked how much did they think was given for 500, and a phrase was, "250 by the time she got to intensive care" and then something like 30 ml per hour after that. So that's where I think the 250 comes from and that's why it was in the room being discussed.
MR WOLFE: Of course that figure is inconsistent with the account contained in the notes from Dr Malik and it's inconsistent with the 500 ml that's written in to the fluid balance chart.
A. I can't answer. I think the context was how much was run in before they got to intensive care. Then there's some after that. So all I can say is I wasn't involved in any discussions in relation to how much fluid was run in. Is that a correct figure? Is it bigger, smaller than that? I had no involvement in discussing with any staff before I went to that meeting. This is notes of presumably Mr Fee raising this issue of the fluids.
Q. Yes. Back to the point that Dr Quinn says that he was

emphasising with Mr Fee the need for the clarification of precise amount of fluids received. He said in his witness statement to the inquiry at 279/1, page 15, that he considered this information was required because if more one fifth normal saline had been run in than had been recorded, this could have explained in his mind the rapid deterioration of Lucy's condition. Moreover, he says, if 500 ml of normal saline had been run in after the collapse, and if given over a short period, then this could explain the contribution to the cerebral oedema or it could have contributed to the cerebral oedema. Do you follow?
A. I understand Dr Quinn's view.
Q. In terms, then, of whether this issue was raised, I think you have said you can't recall this being raised.
A. I don't recall that type of discussion that we were leaving there with major uncertainty about the fluids still to be sorted out. I did not leave the room with that impression that there was a major piece of work to do to find out what fluids exactly had been given.
Q. Another issue that I'm sure was discussed at the meeting, doctor, was the relative causes of the electrolyte imbalance. Do you recall that being discussed?

A. The ...
Q. The drop in serum sodium, for example, from 137 to 127.
A. I don't remember specifically any discussion on the drop, but there was recognition of the sodium level being low.
Q. Dr Quinn, I think, recalls that in discussing the cause of that, he says there was a discussion of the cause of that and he put forward the view that the changes to the electrolyte balance could have been contributed to by the use of the Solution No. 18, by fluid and electrolyte loss, in other words vomiting and diarrhoea, and possible, what he calls, IADH effects in the child, in other words the syndrome of inappropriate diuretic hormone. He says all of those issues were discussed at the meeting. Do you recall that?
A. No.
Q. Well, in terms of the reduction from 137 to 127, was there any discussion about that at all?
A. I don't recall specific discussion on the drop in electrolytes. I certainly recall that there was discussion on low sodium.
Q. Yes, and in terms of then accounting or seeking an explanation for the cause of that low sodium, was that discussed?
A. Yes, and causes of the low sodium were felt to be the

gastroenteritis, it was also mentioned that bronchopneumonia can cause a low sodium. They were things that were mentioned specifically.
Q. And not the fluids?
A. Well, I don't recall anything suggesting that the No. 18 Solution or the hypotonic fluids had caused this dramatic drop in sodium.
Q. Would it not be -- when you think about this in retrospect, is that not a remarkable omission?
A. Not if the phrase "the fluids were appropriate" was given at the start or during the process.
Q. Well, the phrase that was used was that the fluid type was appropriate. Isn't that right? The choice of fluid was correct? But you were also told that fluid replacement at 100 ml per hour was greater than normal?
A. Correct.
Q. So if it was greater than normal, albeit the note records not grossly excessive, does it not seem in retrospect somewhat strange that this issue was not discussed, the contribution played by the fluids?
A. Well, I can't answer that other than it wasn't discussed at that point in time.
Q. So just to be clear, there's two sets of fluids we're interested in, the pre-collapse fluids, you're telling us that the fluids were, if you like, and I realise this

is loose in the language -- you were told that they were perfectly fine, is your recollection?
A. Well, you're aware that before I went to the meeting, our belief was that the volume of fluid, that 100 ml an hour, was higher than normal. We weren't dissuaded of that at the meeting. We were taken through the calculations and shown that if Lucy was 10 per cent dehydrated, the recommendation would be 80 ml an hour, et cetera. So it wasn't that the fluid management was perfect -- was not a feeling as we went through that discussion.
Q. But you were told in terms of the -- well, in terms of the electrolyte issue or the reduction in sodium, you weren't led to believe that the fluids was a factor?
A. I wasn't led to believe the fluids had caused the reduction in the sodium, no.
THE CHAIRMAN: On Dr Quinn's note, the penultimate entry is:
"Drop in sodium 137 to 127."
If you're right, then on your evidence the drop in sodium was never discussed.
A. I don't recall the specific drop being discussed in that way.
THE CHAIRMAN: Because if you look at the last couple of lines of his note, the note suggests a view forming that fluids given, query too much, query 500 ml normal saline

run in freely as emphasised. So both of those support the suggestion that there's too much fluid.
A. Yes.
THE CHAIRMAN: And the immediate next entry is the drop in sodium is 137 to 127.
A. Yes.
THE CHAIRMAN: Which, on an interpretation of the note, might suggest that the excessive fluid is followed by a drop in sodium?
A. Yes. And I would say to you, chairman, that the saline at resuscitation was definitely discussed, and this 250 versus 500 was discussed, but I have no note and no recollection of hypotonic fluid being discussed and the sodium falling as a result.
THE CHAIRMAN: Thank you.
MR WOLFE: In terms of the discussion of the 500 versus the 250, as you've described, were you apprised of Dr Quinn's view that if 500 ml had been run in it could have contributed to the cerebral oedema?
A. I was indeed.
Q. And were your thoughts in relation to that affected by the view that 250 ml was the figure?
A. No, I still felt or we felt 250 ml is still higher than you would have anticipated, so it was a lot even for a shocked infant. Therefore, to us, the clarification

or the volume didn't take away from the potential of that giving rise to brain oedema.

Q. And was the issue clarified in a definitive way in terms of whether it did contribute to the oedema?

A. No, I don't know how it could have been clarified. It was put out there as one of the putative reasons for the brain oedema.

THE CHAIRMAN: That would register with you, wouldn't it? Because you told me this morning that although you didn't know a great deal about hyponatraemia, you knew that an excessive drop in sodium can give rise to problems and an over-zealous correction can give rise to oedema; right?

A. Absolutely.

THE CHAIRMAN: So are you saying that the impression you were getting was that if this was something towards 500 ml of normal saline, that might be the over-zealous correction?

A. Well, it could be, yes.

THE CHAIRMAN: Is that what you were thinking at the time?

A. At the time, the context of this was more the presentation of a major event at 3 o'clock with likely brain injury and fluid poured in on top of that was likely to cause even more injury and oedema. It wasn't specifically addressing the issue of changes in sodium.

THE CHAIRMAN: Thank you.

MR GREEN: Before Mr Wolfe moves on, may I ask him to invite Dr Kelly to deal with the run-up to and the way in which Dr Quinn's bottom line view is recorded in Dr Kelly's note was expressed, namely what appears in the middle:

"Dr Quinn does not feel that the extra fluids caused the brain problem."

MR WOLFE: Thank you. I'll reach that in due course.

In terms of the reassurance that you took from the discussion, were you leaving the meeting thinking that mismanagement in terms of what was obviously a fluids error had not caused the child's deterioration?

A. I think that's a reasonable summary of the conclusions we were reaching. We left that meeting that, yes, there had been fluid above the normal regime. Yes, there had been fluid used at resuscitation, but it didn't seem to have been the direct cause of the problem. That was how we left the meeting.

Q. There are two notes. My learned friend Mr Green highlights the line which says:

"Dr Quinn does not feel that the extra fluids caused the brain problem."

Is that a reference to the fluids that went in before the collapse?

A. Yes, that's the reference to above 4 hours at 100 ml.

It follows logically from that.

Q. There's then a note under that in relation to the fluids post-resuscitation. At the end of that, it says:

"Events remain unclear."

How would you interpret that note?

A. Well, in other words, at the end of this process of talking to Dr Quinn we did not have a definite pathophysiological method of deterioration and death, but we had a number of possibilities. So Dr Quinn wasn't entirely sure what had occurred and couldn't give us a definitive answer.

Q. It would have been discussed at the meeting, would it not, that running the normal saline in the unrestricted manner in which it was run in was something that couldn't be approved of?

A. Absolutely, and the not recording properly and not having proper signatories on prescribing, they were all issues that we all recognised as unsatisfactory.

Q. But where it says on the left-hand page:

"Could after a hypoxic incident this[that is the use of a high volume of normal saline] have produced the cerebral oedema? Events remain unclear."

Should we not be reading that, doctor, as indicating that in terms of the reassurance that you took from the meeting, you may have obtained reassurance in respect of

the pre-collapse fluids, but in terms of what happened after the collapse there was an indication or a possibility that the fluids run in may have exacerbated the situation?

A. Yes, that's correct. We were being taken through a range of possibilities leading to a hypoxic event with brain injury and an explanation in relation to what was on the PM, but could fluid added at that time, even though it wasn't grossly excessive at 250 ml, could that have added to the oedema in a hypoxic brain? That's the nature of that discussion.

Q. And Dr Quinn couldn't be definitive about the impact of the use of normal saline?

A. He couldn't be definitive.

Q. And so what you were left with was a situation where there had been fluid mismanagement both before and after the child's collapse and in terms of the period after those fluids may well, on one view, have exacerbated a bad situation and contributed to the oedema?

A. Well, my view was what Dr Quinn was telling us was that this could have been some major hypoxic event, resulting in major brain injury, and fluids on to an injured brain already may result in the oedema found at the PM. He was providing an explanation. That seemed to make sense to me, even if it wasn't 500 ml.

Q. Yes. So it wouldn't be right to conclude from what Dr Quinn was saying to you that there was no evidence of mismanagement of this child's case?
A. Well, as I said already, Mr Fee and myself left the meeting going, "The fluid regime was not administered correctly. It was not prescribed correctly, it was not recorded correctly, but it did not seem to be the major cause or the problem in relation to Lucy Crawford's death".
Q. A question is posed again on the left-hand side about could there have been earlier seizures resulting in hypoxia for 15 to 20 minutes prior to catastrophic seizure event.
A. Yes, that was discussed in the room.
Q. Was that left as an issue upon which nobody could comment because the information wasn't there to address it?
A. Well, I think, from memory, Dr Quinn was asking Mr Fee, could that have happened? Could there have been a prolonged seizure? Could there have been a number of earlier, more minor seizures, each contributing to further brain insult or injury or hypoxic damage? And that was a question he was posing to Mr Fee.
Q. And again, in order for the doctor to reach a conclusion on that, was he provided with any clarification?

A. My understanding is Mr Fee checked with the nursing staff in relation to that issue.
Q. When?
A. I don't know when exactly.
Q. But he wasn't in a position to clarify the position for the doctor at the meeting or subsequently?
A. I don't recall what exactly he said in relation to that issue. He didn't think there had been a prolonged absence, but I can't recall exactly what way he put it.
Q. If he had been able to provide an answer to it, it wouldn't have been left with a question mark?
A. Yes.
Q. And he asks:
"Did significant coning occur and when?"
Was that an issue that was --
A. Yes, that was discussed.
Q. And again, that wasn't an issue that was resolved?
A. No, again he's taken that, presumably, from his look at the PM report, and he is going, "Did coning occur at that time?"
Q. So in terms of the objective of the review, which was to establish whether there was any act or omission on the part of nursing and medical staff that could have contributed to Lucy's demise, you were leaving that meeting presumably with the view that that issue had not

been resolved conclusively?
A. I was leaving the meeting with -- we didn't have absolute clarity as to what happened, but we had received reassurance that the likely volumes of fluid that had been administered in the first phase were unlikely to have caused Lucy Crawford's rapid deterioration, decline and ultimately her death. So that was what we were leaving the -- we were still leaving the room with, not clarity as to what had actually caused that sudden acute deterioration and potentially coning, we had also introduced to the mix at that meeting, from the PM report, the possibility that the bronchopneumonia was significant and had added hypoxic injury as well. So this was the range of options that was being considered as to that significant event that led to the death.
Q. But in terms of the impact of the normal saline on the reading of this note, as we've discussed, this could have contributed to the cerebral oedema in a way which might have affected her prospects?
A. Yes. I think the reading of the note is that if 500 ml had been given, that certainly could have. 250 is still above the norm but not excessive, but it still could have in a severely injured brain added to brain oedema that would be seen at post-mortem. That's how

I interpreted that discussion.
Q. Now I'm going to move away from this area.
MR COUNSELL: Can I just ask, before my learned friend does? There has been a slight reference to the post-mortem report, and I just ask that the witness clarify when it was that Dr Quinn, if he has a recollection, was provided with the post-mortem report. Because, of course, it certainly was not provided at the time that Mr Fee provided the case notes.
A. Chairman, that's entirely correct. The post-mortem report arrived to the Trust through Mr Fee a number of days before the meeting with Dr Quinn. So a copy was taken by Mr Fee into the meeting and in the early part of the meeting Dr Quinn had an opportunity to read it through and use that in part of his briefing to us. So it could not have been given to him much earlier than that because it had arrived so late with the Trust. I think the date on the post-mortem report was 13 June. Mr Fee might be able to elucidate exactly what date he received it on, but we took it with us to the meeting, and my belief is that it was left with Dr Quinn at the meeting.
MR COUNSELL: I just want to explore that last part of the witness's answer because the inquiry will hear from Dr Quinn that he was not left with a copy of the

post-mortem report, although he does accept that he was shown it at the meeting.

THE CHAIRMAN: Is that possibly correct?

A. It's possible, but we took the PM report for him at the meeting, so I can't believe we took it away with us.

MR WOLFE: I said I was going to move away from the meeting, but was there any discussion about the type of fluid administered to Lucy pre-collapse?

A. In terms of No. 18 Solution?

Q. We know that the notes show that you were told that it was an appropriate fluid.

A. Yes, and to me there was no doubt that that fluid that he was talking about was No. 18 Solution.

Q. Yes.

A. So we were told that that was an appropriate solution, that's what I recorded down and I believe Mr Fee had already been told that in the conversations on 2 May.

Q. Just to be clear about that, it was an appropriate -- you were being told, as it appears from the calculations that were discussed, this was an appropriate fluid to be administered to a child that was 10 per cent dehydrated?

A. I can only say it wasn't done in that fashion: this is the appropriate fluid for a 10 per cent -- it was the fluid used, chosen, was appropriate.

Q. Yes. I'll put it another way. You were examining

various degrees of dehydration; isn't that right?

A. Yes.

Q. And regardless of the degree of dehydration, the fluid that was being used for the purposes of the discussion was Solution No. 18?

A. Correct.

Q. And you were advised that that was an appropriate fluid for each of those scenarios?

A. Correct. There was no change or saying that saline would be the right fluid to use in this situation.

Q. You will recall, and we'll move on to deal with her shortly, that Dr Stewart brought to your attention the APLS materials?

A. That's correct.

Q. And she made it clear, didn't she, that in terms of what they call replacement or resuscitation fluids, the appropriate fluid was normal saline?

A. Yes, she drew it to our attention or my attention that APLS guidelines would clearly recommend using normal saline, not No. 18 Solution.

Q. And moreover, you were leading the charge, if you like, through the scrutiny meetings on behalf of the Trust on the medico-legal process, and in that context the Trust received a report from Dr Jenkins; isn't that right?

A. Correct.

Q. He also advised that in terms of replacement fluids, the appropriate approach was normal saline?

A. Correct.

Q. And each of those points or each of those professionals in terms of the advice they were giving about the appropriate type of fluid were in a contrasting position to Dr Quinn? They were all talking about the same thing, but one was saying that the appropriate fluid is Solution No. 18, the other two were saying that the appropriate fluid for replacement is normal saline?

A. Well, that's correct, put in that way. Dr Stewart was also immediately after saying APLS guidelines, saying there's ongoing debate on the solutions and would recognise that No. 18 Solution was used frequently. Dr Jenkins specifically in his report says similar, that he would not be surprised at No. 18 solution used in the province for both replacement and maintenance, that it was common practice, I think, is what I'm interpreting in the way he put it in his report.

MR WOLFE: We might look at that as we move on.

MR GREEN: Just before we move off this part of the LiveNote, if we go towards the top:

"And moreover, you were leading the charge, if you like, through the scrutiny meetings on behalf of the Trust in the medico-legal process and in that context

the Trust received a report from Dr Jenkins; isn't that right?"

There are actually two questions there rolled into one. Just that so we're very clear about this, I wonder if they could be split into their two component parts and the answer to each ascertained.

MR WOLFE: Okay. You were attending the scrutiny meetings. I will leave out "leading the charge" in case that's what's inflamed --

A. I did not lead a charge and I was not leading the scrutiny meetings.

Q. No, no, you weren't.

A. I was attending the scrutiny meetings and DLS, CSA, were managing the process of litigation(?) and taking that report. It was forwarded to me as a preparatory minute or note or agenda for the meeting.

Q. I want to take you through a couple of meetings that you had then after the report, the verbal report, that you received from Dr Quinn. You met with Dr Asghar shortly after he sent a letter to Mr Mills in which he referred to the treatment received by Lucy Crawford; isn't that right?

A. Yes, that's correct.

Q. And Mr Fee attended that meeting with you; isn't that right?

A. That's correct.
Q. The purpose of that meeting was to advise him that you were considering putting his complaint on a competence-based footing; is that right, to have a review carried out?
A. No, that's not correct.
Q. Is that not correct?
A. No. I think it'd be fair to say that Dr Asghar had raised some clinical issues in relation to competence, but the majority of what he was raising was around the area of professional conduct, I would put it, or personal conduct. He was feeling he was being harassed, bullied, et cetera, so that needed to be investigated fully. But alongside that, he was quoting cases.
Q. Yes. And one of the cases he quoted was Lucy Crawford; isn't that correct?
A. That's correct.
Q. And he said to you or said to Mr Mills in the letter that this child had been given excess of fluids and all through the night fluids were running at 100 ml per hour, and he recognised that the child had suffered a cerebral oedema.
A. Yes.
Q. Now, was that the subject of conversation with him at the meeting?

A. Well, that was a subject of conversation, all aspects of his letter were the subject of conversation, but the majority of that meeting related to the issues around the harassment and bullying and how we were going to take that forward. We did explain to him that there was an ongoing review in relation to the Lucy Crawford case and that external opinion was being sought through Murray Quinn. So he was made aware of that and that the other issues that he was raising in relation to competence, shall we say, of Dr O'Donohoe would be fully investigated. I also told him at the time that that would be a different stream of investigation from the harassment and bullying and that we may need a further external opinion on these other cases, but firstly the directorate would look at those other issues of competency.
Q. In terms of his knowledge of what had become of Lucy, do you understand why his views weren't put into the count, if you like, for the purposes of the review investigation?
A. Well, I would go -- he wasn't there on the night, he had no direct involvement, his views were considered by the review team because they were put to Dr Anderson and to Mr Fee to consider as part of the overall review. I agree, you could have put in a redacted version of his

letter as part of the information, but Dr Anderson, I believe, spoke to Dr Halahakoon in relation to Dr Asghar's complaint and felt that Dr Asghar was, how will I put it, finding as much dirt as he could to throw at Dr O'Donohoe at the one time.
Q. The first point you make there in response to my question is that Dr Asghar wasn't involved in the care of the child.
A. That's my understanding.
Q. But for that matter, neither was Sister Traynor involved in the care of the child, and yet her view, albeit on her account a misrepresentation of her view, was taken into account by the review.
A. Well, my interpretation of that is Sister Traynor is involved because she's the senior charge nurse or nurse in charge of the ward, therefore the practices within that ward rest with her, lie with her, the changes that are required.
Q. She was asked to give a view as to the practices --
A. Yes, within the ward.
Q. And yet here you had from Dr Asghar, apparently, a contrary view in terms of what was appropriate practice with regard to this child. And yet, and this is the second point you make, you say his views were taken into account by the review. That doesn't appear

to be the case, doctor.
A. I believe they were. The views were conveyed formally to Mr Fee and to Dr Anderson. They looked at them and considered them as part of their review.
Q. They may well have known about the views, but in terms of taking them into account for the purposes of the review, I think the response that certainly Mr Fee has made is that his views were not -- didn't form part of the review process.
A. Mm-hm. Well, I think anybody's comments or views would have been taken into consideration, so they may not have formed a specific part of the review process because he wasn't there on the day, hadn't had any involvement in things, but I can't imagine that if he put something in writing it's not at least looked and considered.
THE CHAIRMAN: Sorry, the answer you gave me a few moments ago completely contradicts that. You said a few moments ago that Dr Anderson, you believe, spoke to Dr Halahakoon in relation to Dr Asghar's complaint and felt that Dr Asghar was finding as much dirt as he could to throw at Dr O'Donohoe. So the view was that Dr Asghar was just throwing dirt.
A. Yes.
THE CHAIRMAN: How do I take that as being consistent with Dr Asghar's opinion about the fluids Lucy was given as

being given any credence or credibility by the review team if he's regarded as just throwing dirt?
A. Well, to me, the review team, which is Mr Fee, Mr Anderson, receive Dr Asghar's letter, it's not ignored, it's taken, the contents of it are looked at and considered, and Dr Anderson goes to Dr Halahakoon and checks these issues out with him. It's clear, he wasn't there on the ward, so to me the review team was considering those aspects. They may not have given them due weight or incorporated them directly into the report, but they looked at them to see did they need to give them more weight or evidence.
THE CHAIRMAN: And were Dr Halahakoon's views taken into consideration as part of the review?
A. I don't know the answer to that.
THE CHAIRMAN: Well, on the basis that Sister Traynor --
A. Yes.
THE CHAIRMAN: -- you say there's a reason for taking her views into account.
A. Yes.
THE CHAIRMAN: Would there equally be a reason for taking Dr Halahakoon's views into account?
A. That could be considered, yes.
THE CHAIRMAN: But you don't know if it was?
A. I don't know for certain if it was or not.

THE CHAIRMAN: But it would be inconsistent to take account of Sister Traynor and not take account of the views of the senior paediatrician?
A. I take the point on that, that the senior paediatrician could have been asked also the same questions Sister Traynor was being asked, but I don't know if she was or wasn't.
MR WOLFE: You met with Sister Traynor on 23 June; isn't that right?
A. That's correct.
Q. The record of the meeting says you discussed Dr Quinn's opinion on the case, Dr Asghar's letter and Dr O'Donohoe's professional competence and conduct.
A. That's correct. I was keen to meet with Sister Traynor, Dr Halahakoon, to highlight any areas that were emerging that needed to be considered. I also was very concerned at Dr Asghar's letter and the relationships that were obviously ongoing within the department, and wanted those to be addressed. But most importantly of all, I needed to satisfy myself that there wasn't a safety [sic] of care of children that was ongoing.
Q. Did you have Dr Quinn's report at this point?
A. I don't believe I had his written report. I believe I based it on his verbal report and my notes of the meeting. So I was sharing his report that he had given

to us on the Friday or two days earlier.
Q. The note of the meeting, 036A-007-013. If we could have it up on the screen. Sister Traynor, when she gave evidence, was somewhat, I think I'm right in saying, perplexed by the nature of the note that has been recorded and certain of the things that were attributed to her.
It records and attributes to her that she noted that Dr Quinn felt it was unlikely that the fluid regime prescribed or the initial management of the child contributed to the death. In what way was she supposed to have noted that?
A. Because I took her through all the aspects of my note that Dr Quinn had alluded to us and that aspect of the conclusion that the fluids at 100 ml for four hours had not contributed to the major decline in Lucy Crawford. I took her through all that in the same detail that Dr Quinn had taken us through it and clarified for her that that was the message that was emerging out of that meeting. Also, as you see, I'm raising the issue from that meeting of the -- possibly of an unobserved anoxic event as well.
Q. And Sister Traynor, who was not on duty that night, was confirming for you that there was no possibility of unobserved anoxic events?

A. She didn't feel that that had happened.
Q. You see the point, doctor?
A. I do.
Q. And what position was she to advise you that she doesn't feel that that had happened?
A. She's obviously been talking to her staff and finding out what's been happening.
Q. Obviously why?
A. Because that's what a sister in a ward would do.
Q. Did she tell you that?
A. No, not directly, but I know she had discussions with the staff after the event.
Q. This was a short cut rather than going to the parents or the nurses directly to find out about this?
A. It wasn't intended to be a short cut at all on my part. This was issues raised in the room with Dr Quinn and if an opportunity arises for me to ask that question, I was going to take it. It wasn't aimed at a short cut or in any way to interfere or get in the way of Mr Fee doing his work.
Q. And what did you do with that information?
A. Well, that was a note for me to make sure that I was clear. I would have shared that information, the discussions I'd had with Sister Traynor and discussions I'd had with Dr Halahakoon with Mr Fee. I'd have shared

that information of both the interviews with Mr Fee.
Q. Did you give him this note?
A. I wouldn't have given him that note.
Q. Because, as we will see, the report that eventually emerges from Dr Quinn is left again without this clarification of what precisely happened around the time of the event. So clearly, the information wasn't passed back to him.
A. And that would rest -- because this was not clarifying that event. I wouldn't regard that note or that comment by Sister Traynor as clarifying that. This is me: are you aware of any potential unobserved event that might have added to the anoxia and the brain injury? And Sister Traynor is simply saying no. So this wasn't, as I said earlier, in any way to replace Mr Fee or others sorting this out.
THE CHAIRMAN: For Sister Traynor to have given you a reliable account of that, she would have had to have gone through the events of the night before with the nurses. I don't understand from the evidence that she gave to this inquiry that she did that.
A. Well, I can only --
THE CHAIRMAN: What she specifically asked the nurses to do when she came on and heard there was a problem, she asked the nurses then if they wanted to complete the

nursing record.
A. Yes.
THE CHAIRMAN: She didn't sit down and quiz them about how exactly the sequence of events had unfolded the night before.
A. I can only record what Sister Traynor has said to me there and then.
MR WOLFE: Sister Traynor was, if you like, one of the original reporters of this incident in that she went to Mrs Millar.
A. That's my understanding.
Q. And expressed the concern that there had been a problem over prescription of fluids and a problem over administration of fluids, and she explained to this inquiry that she was concerned that -- and indeed suspicious -- that the fluids had contributed to this child's deterioration.
A. Mm-hm.
Q. Did you hear her evidence?
A. I didn't hear her evidence, no.
Q. That is, I hope, a correct and adequate summary of what she said. During your discussion with her, did she reflect with you upon that concern and the fact that Dr Quinn apparently had resolved it?
A. Reflect in what way?

Q. Did she speak to you about her concern or her suspicion that the fluids had in fact caused the problem?
A. No. I think it would have been an understanding as the review was established that there was concern from staff about the fluid regime. So I don't think there was any surprise in Sister Traynor having had that view at the start. But there was no discussion here from Sister Traynor going, "I'm really surprised at that, I don't agree with it", or other querying of it.
Q. You then had a meeting, doctor, on the same day, I think, with Dr Halahakoon.
A. That's correct.
Q. If we could have up on the screen, please, 036A-008-015. The note records that you shared the results of the post-mortem and the external review provided by Dr Murray Quinn. You highlighted the issue of fluid prescribing and the resuscitation issues raised.
A. Mm-hm.
Q. Again, doctor, you didn't have Dr Quinn's report at this point?
A. No, I'm doing the same -- I believe I'm doing the same as what I'd done with Sister Traynor an hour or so later. I'm taking her through the report that is given to me some days earlier by Dr Quinn and sharing with her the interpretation that Dr Quinn had put on the figures,

et cetera, and also sharing with her the post-mortem findings.
Q. And in terms of the highlighting the issues of fluid prescribing, what was that in real terms?
A. That's me saying upfront to Dr Halahakoon and to Sister Traynor to some degree, "Look, fluids were not properly prescribed here, the prescription wasn't properly signed for, therefore there was in that sense mismanagement". So I was highlighting that to say, "Don't be waiting for a formal report to come out. This is something that needs to be addressed".
Q. But doctor, is it not worse than that? There was actually a fluids error here. It's not just a communication issue, it is the fact that this child had received fluids which wasn't intended for her, both in terms of type and volume?
A. I think that's correct.
Q. But was that recognised?
A. At that stage, I think it was recognised that because of the prescription, the child got fluids it was not intended to get. That's the point I'm trying to emphasise here.
Q. And in terms of the resuscitation issues raised, what were they in real terms, or what did you discuss?
A. In terms of -- obviously, Dr Quinn had asked the

question in his meeting about resuscitation issues, so I was covering with Dr Halahakoon, are we sure resuscitation was handled appropriately? So that's what that's about.

Q. You then had a meeting with Dr O'Donohoe on 28 June.

THE CHAIRMAN: Let's break for a few minutes. I'll resume in ten minutes and we'll sit today until about 4.30. Doctor, I'm afraid it doesn't look as if we'll finish your evidence today, but I understand from speaking to Mr Wolfe that between the rest of this afternoon and tomorrow, when I understand that you can facilitate us by coming back, we will get you finished tomorrow. We've then got also tomorrow Mr Fee and we've got Dr Quinn on Friday. We won't leave here on Friday afternoon without having finished those three witnesses. Thank you.

(3.32 pm)

(A short break)

(3.50 pm)

MR WOLFE: Could I bring you, doctor, to your meeting with Dr O'Donohoe on 28 June. You met with him, as I understand it, to take him through the report of Dr Quinn; is that right?

A. I did, or went through the same aspects that I'd gone through with Sister Traynor and Dr Halahakoon, the same

process.

Q. Again, drawing his attention to the fluid prescribing issues, as you've described?

A. Absolutely.

Q. And in a sense, doctor, were you pre-empting the report that was being written by Mr Fee and Dr Anderson by speaking to these people?

A. Not at all. I had a heightened awareness in my mind of safety issues and wanted to make sure the practice was absolutely safe in the department of paediatrics. I had letters from Dr Asghar, raising concerns, and therefore I wanted to be sure that any early aspects that I could convey to change things for the better would occur. So I was just taking that opportunity to provide an interim summary.

Q. Were you telling each of the people that you saw, starting with Traynor, Halahakoon and then Dr O'Donohoe that Dr Crean had reassured you in terms of, if you like, the safety of the use of Solution No. 18, notwithstanding the excessive volume that had been given in the context of Lucy?

A. I wasn't telling them in any way that I had been reassured. It wasn't a phrase that was in the discussions. I was simply providing a factual report of what we'd heard the week before.

Q. And what did you tell Dr O'Donohoe in terms of what Dr Quinn was saying?

A. Identical to what I'd told Dr Halahakoon and Sister Traynor. There was no change in the message.

Q. Dr Quinn's written report, when did you get to see that?

A. I think the following week when it came into the Trust.

Q. Was it not received the day after?

A. It wasn't sent to me, it was sent to Mr Fee.

Q. Right.

A. So that's why I didn't have my own written copy and that's why, if I'm correct, Dr O'Donohoe in his oral evidence relates to me not giving him a copy on the day.

Q. You received it then before it formed part of the review report?

A. Yes. I received a copy of it from Mr Fee's office within a matter of days of it arriving in the Tyrone County Hospital office.

Q. And you read it presumably?

A. Yes.

Q. If we could have it up on the screen, please. 033-102-271. That's the second page of it and that's where I want to start. It appears, doctor, that in the paragraph at the top of the page there was a factual error in that Dr Quinn has concluded that it was upon reviewing the child's electrolytes in or around that

time that it was decided that because the sodium was low that normal saline should be given. The fact is that blood wasn't taken from Lucy's arm until Dr O'Donohoe had arrived at the hospital, by which time, on the account that he provided to you in August 2003, in a statement, much of that bag of normal saline, on his account, had been run in.

A. Provided to the preparation for the inquest, not to me.

Q. Yes. It was addressed to you.

A. Yes, but I was a conduit for passing it on.

Q. Yes. I mean nothing other than the letter was addressed to you.

A. I follow.

Q. And I'm only using that as a reference to indicate that factually that description contained within Dr Quinn's report is wrong, at least by comparison with another account that would have been out there to be harvested or to be gathered if somebody had sought to do so.

A. I understand that.

Q. And it appears that this misunderstanding of the facts, if I put it in those terms, may well have been significant in that if bloods were taken after saline had been run in, that might have had the effect of raising the serum sodium either marginally or perhaps more significantly, depending on the view you take of

the evidence.
A. Yes, I understand that.
Q. Now, of course, I think you've commented on this earlier. It would have been your expectation that the staff appointed to carry out this review would have taken steps to interview staff to ensure that the facts were properly and accurately provided?
A. Yes.
Q. And so it's clearly a flaw of the report that this kind of thing happened, this basic factual sequence wasn't provided accurately to Dr Quinn?
A. Yes. Well, that's correct in stating it like that, that it could be put like that. Equally, anybody studying the notes in that level of detail could find out for certain what time the blood tests were taken and deal with that matter themselves.
Q. Yes. Well, however you approach it, Dr Anderson and Mr Fee were in the position of having access to the staff or access to the notes or both in order to address this issue. The important thing is that it's the Trust that's briefing this doctor, Dr Quinn, and he should be provided with clarity on the facts; isn't that right?
A. I would support that, yes.
Q. Then if we go over two pages to 273, please. He refers again to the process in relation to normal saline and he

says this time that he's not certain how much normal saline was run in at that time.
A. Mm-hm.
Q. But he says that if it was suspected she was shocked, then perhaps up to 20 ml per kilogram could have been given. There are a number of issues there. First of all, if it was suspected that she was shocked. There is no evidence on the clinical notes indicating that she was shocked; isn't that right?
A. That would be my understanding, yes.
Q. And even if she was shocked, the most that she should have got was 180 ml as a form of fluid correction for the shock; isn't that right?
A. That seems to be correct.
Q. And thirdly, he's expressing an uncertainty about how much normal saline was run in, whereas you say that any uncertainty was, by your recollection, corrected at the meeting on 21 June when he was told 250 ml had been run in?
A. That is my belief.
Q. So I wonder, did it jar with you when you read this report that he has forgotten about that or he has got it wrong, we have clarified it for him?
A. Well, I think the issue for me here is precision. The 250 ml was an approximate 250 ml, it wasn't: this is

exactly what's been run in because it wasn't on a drip counter that would measure it specifically. So that 250 ml is what I believe the nurse was reporting through Eugene Fee to that meeting. So I can see how, if that's the phrasing that we used on the day, Dr Quinn would quite reasonably say, "I'm not entirely certain. Was it 250, 260, 240?"
Q. But is the point not a bigger one than that? Because we see in his notes the question mark about 500.
A. Yes.
Q. And just to repeat your language of a few minutes ago, anybody reading these notes would have seen the reference to 500 ml run in in 60 minutes, which, as I understand it, was the note recorded by the prescriber, Dr Malik.
A. Yes.
Q. So I'm wondering, doctor, how you and your colleagues who have been cautioned by Dr Quinn that an excess of normal saline could have contributed to the cerebral oedema, how this issue could have been left in the way it was left in this report.
A. I'm sorry, as I said, my interpretation at the time was that this wasn't that inconsistent. We weren't saying to Dr Quinn at the meeting with absolute certainty 250 ml, we were saying, "This is what's been reported,

this is what we believe", and then there might have been 30 ml an hour after that. That's my understanding. But the difficulty for me repeating this to you is I wasn't the one saying it, I didn't go and search this information from the nurse, I wasn't bringing this information into the room, Mr Fee was. So the more I keep saying this, the more I'm conscious it wasn't me giving Dr Quinn this particular piece of information.
Q. Yes, doctor, but at the end of the day the report ends up on your desk.
A. Yes.
Q. And as you indicated this morning in your role as medical director, you must have some scrutiny function --
A. Yes.
Q. -- to, if you like, superintend the process so as to ensure that, for want of a better word, it's a quality process?
A. And I'm responding to say when I read this at the time, it did not jar with me that this is outwith the conversations we had with Dr Quinn; it's entirely consistent with Dr Quinn. I agree, it would have been better to see phrasing of, "I believe somewhere between 250 and -- may have been administered" and then finishing the line. That might have been a better

phrasing based on the knowledge that I seemed to take from the meeting, but it didn't jar with me that this is completely wrong.

You raised the other issue about timing of the blood test, et cetera. I had no knowledge of that, it wasn't something that -- I was assuming what was down here was correct, I had no knowledge that it turned out to be different from that.

Q. Did you read the medical notes at this time?

A. I read the medical notes, yes. I'd gone through them briefly. I had not gone through them in great detail.

Q. Did it jar with you that there was 500 ml written into the notes in two places?

A. Oh yes, I'd seen that. But what's often written in notes isn't always what's been administered, and the key here was to find out, through the nursing staff, exactly what was administered, and that seemed to be an ongoing confusion at the start of the review that Mr Fee and the team were clarifying, and that's to my understanding, because I wasn't doing this clarifying, to my understanding that's where the 250 or the 500 comes down more towards the 250 line.

Q. I would understand that that would be one source for clarification. But where you have the prescriber writing a note which says, "500 ml given over 60

minutes", I think that's verbatim, but if you have the prescriber saying that, why stop at the nurse in terms of your investigation?

A. Well, that's true, they could have. The review team could have checked that out if they wanted to double-check it if they weren't convinced that what the nurse was telling them was correct. But the nurse is the only person who's in the room -- how do I put it -- monitoring, watching those fluids, checking, changing the bag when it's done. We've no doctor in the room doing that.

Q. Well, of course that's not correct, doctor. This happens in a short period over the resuscitation. Dr O'Donohoe comes in and sees that the bag is nearly run through. Surely, on the view -- in the way that Dr Malik has written it, he has written a note which suggests that it's gone in in 60 minutes.

A. Well, I can't comment on that aspect of it, was he there for the whole hour watching the fluid, whereas I can comment that my experience is that nurses are the ones that check and watch the fluid administration and measure it.

Q. Of course you can't, doctor, but the point here is that from a management of this child's perspective, given her 500 ml is a whole lot worse than giving her 250 ml, and

it seems that a decision was made to settle on the 250 ml without checking it out with the doctor.

A. Well, I can't answer that for you. I don't think the phrase I would use is "settle on" at all.

THE CHAIRMAN: Well, opt for?

A. Opt for? Well, it was a figure that came from the nurses and was presented, 250 plus the 30s thereafter per hour.

THE CHAIRMAN: The basic problem here is that, as you now know better than I do, this review didn't really turn up what went wrong at all.

A. Absolutely. That is what's wrong.

THE CHAIRMAN: I understand how governance was developing around 2000 and I heard Dr Carson's evidence on that yesterday. But what you had here was a girl of 17 months who came into the hospital, not very ill, and within a few hours she was effectively dead.

A. Yes.

THE CHAIRMAN: And to the extent that Dr Quinn contributed to the review and to the extent that the review was conducted by Mr Fee and Dr Anderson, it didn't identify with any real clarity the mistakes which had been made.

A. I agree.

THE CHAIRMAN: And it may be that a result of that is that lessons which should have been learned were not learned

in time for Raychel Ferguson to be treated in Altnagelvin.

A. I understand the implications of that.

MR WOLFE: You told the police service when they interviewed you, doctor, that you regarded the review done by Messrs Fee and Anderson as extremely comprehensive. It clearly wasn't.

A. I agree. At the time, receiving a 67-page document with appendices and the way it was laid out with an external review, it appeared to me at the time that this was a substantial and good review. I wouldn't have passed it if I didn't think that at the time. But that's what I thought it was. I, as you've heard before from others and myself now, would look back on that and go, "No, by any standards of modern years, that wasn't good enough". It should have involved, as you've drawn to my attention, the family from the outset. It should have involved more rigorous interview and cross-checking with individual members of staff, and a different approach that would be used nowadays, such as root cause analysis, would achieve those things.

Q. Should it also have involved more rigour on your part? Let me give you an example, an example we looked at earlier. You have told us that you weren't aware that the nursing staff and clinicians were not the subject of

interview in respect of their statements.
A. Mm-hm.
Q. In fact, you assumed that there was a process of going back and forward to the medical staff and the nursing staff to clarify what they were saying. Now, you could have identified that flaw in the process with better communication with the coordinators?
A. Well, I can respond to that by saying I set up a process where I had very regular communication, particularly with Mr Fee, and I didn't pick up on that, despite having regular updates and hearing that he was talking to people, translated to me into that he was cross-checking items with members of staff. So I accept the point that, of course, questions asked in a certain way may have elucidated for me, but it doesn't happen, and yet despite having regular meetings with Mr Fee it was not drawn to my attention that we were not planning to or were not going to interview. If it had been drawn, I would have immediately said that that's unsatisfactory.
Q. Of course it is. And what was also unsatisfactory, doctor, according to Dr MacFaul's report, is the fact that in a situation where fluid management of this child was so obviously the focus, the three clinicians who arguably had most to say about that issue, Auterson,

Malik and O'Donohoe, provided witness statements for the review, which said nothing about the fluids that she actually received and said nothing about the inappropriateness of those fluids. How can a review of this type leave untouched three clinicians who failed to deal with that issue?
A. I agree, they should have addressed that issue more formally, more directly, and not simply relied on statements. I agree.
Q. It's simply embarrassing, isn't it, that three doctors treating the child who knew what was prescribed, should have known what she got, and should have had something to say about the implications of what she had got didn't say a word?
A. Well, I think they should have included aspects of that in their statements and they should have volunteered information, even if they weren't asked directly.
THE CHAIRMAN: Do I take it that you were disappointed to hear that the Friday before, Dr Auterson had thought it was so obvious that he didn't state the obvious?
A. I was shocked to the core.
MR WOLFE: Of course, you would have had all those statements in front of you.
A. Yes.
Q. And you would have read them?

A. Correct.
Q. In order to lead you to be impressed, as you told the police, with the quality of this report. Did you miss the fact that they hadn't said anything about the fluids?
A. Yes. I missed the fact that they didn't have that detail in their statements and was interpreting that the follow-up conversations that were ongoing, as far as I was concerned, had covered those issues. And the example we've just been through was of the follow-up with the nurses to find out was it 250 versus 500, et cetera.
Q. The report in its conclusions, that is the review report -- perhaps if we could have that up on the screen. If we start at 033-102-264. There you have the background and the purpose of the review. If we can go over the page, please. Then you have the findings. It says:
"Neither the post-mortem result or the independent medical report on Lucy Crawford provided by Dr Quinn can give an absolute explanation as to why Lucy's condition deteriorated rapidly, why she had an event described as a seizure or why cerebral oedema was present on examination at post-mortem."
So in terms of the report, you were no further on

than you were at the beginning in terms of what had caused Lucy's demise; is that fair?
A. I think in terms of absolute clarity, that's fair. We had a number of issues that had been raised as potential mechanisms or additional factors that could have been relevant, but as you quite rightly say, we had not got a definitive answer.
Q. And yet the review, if you like, stopped there when, as Dr MacFaul notes, there was further evidence to be garnered, the parents, clinicians at the Royal, seeking a discharge note from the Royal, going back to the clinicians who cared for Lucy, asking them further questions. But none of that was done.
A. I agree. They're all areas that could have improved a final report.
Q. In terms of where the report went after it was finalised, a copy was sent to you.
A. A copy was sent to me, it went to the chief executive.
Q. And what, was it considered?
A. It was considered and discussed. My understanding was that the chief executive also spoke to Dr McConnell and members of the Western Board at the time on the findings of the review. There were a number of actions that had to happen from the review and the directorate was charged with implementing those and there were other

aspects beyond that that needed addressing that people like myself considered as well.

Q. You have set out a chronology in your witness statement for the various events around that report. You had a meeting with Mr Fee on 24 July; is that right?

A. I believe so.

Q. And on 25 July, you discussed with Mr Mills that you were awaiting the final report from Mr Fee.

A. That's right.

Q. So the 24 July meeting with Mr Fee presumably told you that the report's on its way, it's imminent?

A. That's correct.

Q. And you were able to update Mr Mills in that respect?

A. Yes.

Q. And then on 31 July, you received the report?

A. Yes.

Q. And then, as I understand your chronology, in terms of work that you did in relation to the report, it's silent?

A. I disagree.

Q. I've obviously missed it. What steps were taken by you in respect of the review report after 31 July?

A. Well, at any subsequent meetings with Dr Halahakoon and Mr Anderson I reminded them of the issues. I also had an issue that had arisen in terms of transfer of

children and anaesthetists, so we brought that issue ultimately to hospital council to try and address. So there were a range of issues that had to be addressed beyond the recommendations.

THE CHAIRMAN: Let's not go beyond the recommendations yet. In terms of the recommendations, how did you obtain reassurance that the recommendations had been implemented?

A. Well, firstly I had personally spoken to Dr Halahakoon and Sister Traynor. I had spoken to the directorate when the report came out and asked them to assure that they were implemented. And I checked with Esther Millar, who was the clinical services manager, some months later, that this was ongoing and proceeding and I was reassured that it was.

THE CHAIRMAN: Well, how long would it take to arrange a meeting with the family?

A. Well, as you say, rightly allude to, it wouldn't have taken very long to arrange it. It didn't happen.

THE CHAIRMAN: When Mrs Millar -- when you checked with her some months later and you were reassured that the implementation of the recommendations was proceeding, did you ever say, "How did you get on with Mr and Mrs Crawford?"

A. I didn't personally say that. I had received letter

correspondence, including directing who was going to meet the family, and that their plans were to meet it. I didn't personally double-check that that had happened and I regret that.

THE CHAIRMAN: Were you interested to see how the family responded?

A. Of course I was, but I didn't check with the front line managers that they proceeded as they told me they were intending to do.

MR WOLFE: In fact, the sequence with the family was that they initiated the complaints process; isn't that right?

A. That's my understanding, yes.

Q. So 31 July, the report is published. 22 September, they initiate a complaint, two full months later.

A. Yes.

Q. And they haven't heard anything from the Trust.

A. I was horrified.

Q. In fact, by contrast with the approach taken by Altnagelvin in the case of Raychel's death, where they wrote to the parents of Raychel very quickly after the death to offer a meeting, it appears on the accounts that have been received from the Crawford family that nobody in the Trust, leaving aside the health visitor who called with them, commendably on a number of occasions, but nobody at a high level in the Trust

contacted the Crawfords at all. In fact, it was they who contacted Dr O'Donohoe to seek a first meeting.

A. That seems to be the case, yes.

Q. And then, notwithstanding the recommendation contained in the review, a meeting isn't arranged to discuss the findings?

A. Yes.

Q. And the first they know about the fact that a review has taken place, according to Mr Crawford's letter, is on 11 October, when in response to the complaint, they are told that a review has taken place without their input.

A. Yes.

Q. Even at that stage there's an unwillingness to provide the Crawfords with a copy of the review report. The tone and the content of the correspondence is: we would prefer to meet with you rather than send you the report and it's only belatedly in January 2001 that a version of the report was provided.

A. That's correct.

Q. Now, wearing your medical director's hat, you had responsibility for complaints at a corporate level; isn't that correct?

A. Not directly in that sense. It was delegated down to the director of corporate affairs, they had their own department for managing complaints. So it was Bridget

O'Rawe's department that managed all complaints and correspondence with family.

Q. Well, did you know during this process that in fact a meeting had yet to take place?

A. Clarify for me, when did I know?

Q. Well, did you know --

A. I didn't know --

Q. -- during this process that a meeting had not happened?

A. No. I did not know until the family put in the complaint. I immediately informed Mr Mills and expressed my concern that this had happened in this way.

Q. And what explanation was obtained?

A. There was no explanation.

Q. Somebody had forgotten about it?

A. Well, the directorate had indicated not only that they were going to do it but who were the persons who were going to attend, had put it in writing, and clearly identified to me that was going to happen. I was shocked, based on the fact that I had written confirmation that they were planning to do this, that it did not happen.

Q. Do you know why, at the end of the day, the family didn't receive the report that was sent to you?

A. I don't know specifically why, no.

Q. You know that the report they received didn't contain

the recommendations?

A. I didn't realise that until you told me. I thought it was that it just didn't contain the appendices.

Q. It didn't contain the appendices either.

A. That's the bit I would have been aware of.

Q. Do you know of any reason why they didn't receive the version of the report that was otherwise published for internal consumption?

A. My understanding of them not receiving the full report and the appendices was that the -- this is my understanding, it may not be factual, my understanding was that Mr Fee and Mr Anderson felt that to give out statements that had been given in confidence, out to the public domain, was not what they wished to do. That was not a decision I was specifically involved in or was really aware of what they were doing, but the message from the director of corporate affairs was to Mr Fee: can you provide a version of the report or a summary report that could go to the family and that then was ultimately supplied. But I'm sure Mr Fee will clarify that for you.

THE CHAIRMAN: Can you think of a reason why the family would not be told that, for instance, there was a recommendation that there is a need for prescribed orders to be clearly documented and signed by the

prescriber?

A. No, I can see no reason for them not to be told that. They should have been told.

THE CHAIRMAN: Can you see any reason for them not to be told the second recommendation about the importance of standard protocols to be readily available?

A. Of course they should have been told that.

THE CHAIRMAN: Can you see any reason for them not being told of the recommendation that the team members involved would benefit from a joint meeting and discussion?

A. No, I agree. All the recommendations should have been in there, including to meet the family.

THE CHAIRMAN: Yes, exactly. So you can think of no justification for excluding the recommendations?

A. No, I can see none.

THE CHAIRMAN: Other than, of course, the embarrassment that by the time the family were told about the existence of a review in October 2000, they would have seen from the full report, even without any appendices, that almost two months had passed since somebody was due to come and meet them.

A. Yes, I agree. I don't think that was the reason they weren't included, but it is embarrassing.

THE CHAIRMAN: Sorry, what is the reason that they weren't

included as far as --

A. I do not know.

THE CHAIRMAN: Then you don't know what the reason -- you can't say what the reason wasn't if you can't tell me what the reason was.

A. True. I accept that.

MR WOLFE: Can you think of any good reason -- you put up a reason and I realise that you're perhaps speculating about it in terms of why the family may not get the statements from the staff, you say provided in confidence. But leaving those aside and that may be an explanation, we can tease that out perhaps with Mr Fee. Dr Anderson has given his evidence and he would say that he was not engaged at all in relation to the efforts with regards to the family. But in terms of Dr Quinn's report, why shouldn't the family have seen that? Is there a good reason to explain that?

A. I can't think of a good reason.

MR WOLFE: That might be a convenient point for the day.

THE CHAIRMAN: Doctor, we'll break at that level. I'm sorry we didn't complete your evidence today. We will complete it tomorrow morning. Thank you very much. We'll start at 10 o'clock tomorrow.

(4.30 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X

DR JAMES KELLY (called) 1

Questions from MR WOLFE 1