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2 (10.00 am)  
3 THE CHAIRMAN: Good morning. Mr Wolfe?  
4 MR WOLFE: Dr Trevor Anderson, please.  
5 DR TREVOR ANDERSON (called)  
6 Questions from MR WOLFE  
7 MR WOLFE: Sir, as you know, this next stage of the inquiry  
8 is going to be looking at the review that was  
9 established by the Sperrin Lakeland Trust in or  
10 about April 2000.  
11 Dr Anderson was one of the coordinators of that  
12 review; isn't that correct?  
13 A. That is correct.  
14 Q. Before we get into your evidence this morning, doctor,  
15 what we do with all of the witnesses who kindly come  
16 along to the inquiry is get them to identify and confirm  
17 the written evidence that they've given to date and at  
18 the end of this little sequence, ask you to adopt that  
19 evidence if you're prepared to do so in order to  
20 supplement the oral evidence that you're going to give  
21 today. Do you understand?  
22 A. Yes, thank you.  
23 Q. You have provided two witness statements to the inquiry  
24 to date. That is WS291 and WS291/2. They're dated  
25 2 November 2012 and 31 January 2013 respectively. You

1 otherwise known as the Urban Mission Hospital?  
2 A. No. Well, it may initially have been called that, but  
3 when I went there it was the McCord Zulu Hospital, the  
4 Christian Mission Hospital in Durban.  
5 Q. And you worked there for some 20 years or so?  
6 A. Altogether about 25, but the last few years was on  
7 a part-time basis.  
8 Q. And then you returned to Northern Ireland, took up  
9 a position in the Erne Hospital as it was then called,  
10 on 1 April 1998?  
11 A. That is correct.  
12 Q. And you were consultant obstetrician at that hospital.  
13 A. Correct.  
14 Q. In the years from 1999 to 2004, you were clinical  
15 director for that directorate, for the, I think it was  
16 called, you can maybe help me with this --  
17 A. Women and children's health.  
18 Q. And you have told us in your witness statement that the  
19 role of clinical director, so far as you are aware,  
20 didn't come with a job description, at least you didn't  
21 have a job description for it?  
22 A. I was given no training whatsoever. In fact, if I may  
23 say, I was reluctant to take on the post. I took it on  
24 because no one else would take it and I only took it on  
25 on the basis that the lead paediatrician was present at

1 were also interviewed by the Police Service of  
2 Northern Ireland and gave them a witness statement back  
3 in 2005. Do you remember that?  
4 A. I do.  
5 Q. Your interviews are contained in documents 116-038 and  
6 116-039. Do you wish to adopt all of those written  
7 documents as part of your evidence today?  
8 A. As far as I can remember they were correct, yes.  
9 Q. You have kindly provided us with a CV. I'm not sure if  
10 you have it in front of you?  
11 A. I do.  
12 Q. If we could have it up on screen, please. 315-020-001.  
13 Your CV tells us that you graduated from medical school  
14 in 1968.  
15 A. That's correct.  
16 Q. You became a member of the Royal College of  
17 Gynaecologists in 1973 and spent a career specialising  
18 in that field, obs and gynae.  
19 A. That's correct.  
20 Q. We note that in terms of your career, much of your  
21 working life has been spent outside of this  
22 jurisdiction. You have spent a significant period of  
23 time working in South Africa.  
24 A. That's correct.  
25 Q. And you worked in the McCord Zulu Hospital. Is that

1 our joint meetings with the director of acute hospital  
2 services. My involvement with the paediatric department  
3 was very much at a distance.  
4 Q. It sounds like something of a short straw?  
5 A. I thought so.  
6 Q. Certainly that's the impression you give.  
7 A. Well, I felt that I had no knowledge of paediatric  
8 medicine and I had a full enough job to do with running  
9 obstetrics and gynae and my clinical role.  
10 Q. So you combined this --  
11 A. It was with reluctance that I took on the post with that  
12 caveat that the paediatricians were present at our  
13 meetings.  
14 Q. Yes. And you have described in your meetings, 291/1,  
15 page 2, that your duties and responsibilities as the  
16 clinical director were to coordinate the organisation  
17 and running of the obs and gynae department to see that  
18 there was organisation and running of the paediatrics  
19 department and to report to Mr Fee, who was the director  
20 of acute hospital services?  
21 A. Correct.  
22 Q. Presumably, in that role, it was at least part of your  
23 concern to establish that the services provided to  
24 patients were being conducted safely in that general  
25 sense?

1 A. I think that's probably true to say, yes. I think my  
2 involvement in both departments was to see that the  
3 organisation ran, looking after the staffing, general  
4 day-to-day running of the place, but the paediatric side  
5 I very much delegated to the lead paediatrician in the  
6 hospital.  
7 Q. Yes. We asked you some questions in your witness  
8 statement about your knowledge of some paediatric health  
9 and healthcare issues. So for example, we asked you  
10 about your knowledge of hyponatraemia in paediatric  
11 cases and you told us that you had received no advice,  
12 no training or education in this area. Is that --  
13 A. That is correct. The last time I had anything to do  
14 with paediatrics was as a very junior houseman many  
15 years ago and I'd long since forgotten.  
16 Q. Hyponatraemia as a condition, is that something you  
17 encountered in your obs and gynae work?  
18 A. Not that I remember.  
19 Q. We also asked you about fluid management in the  
20 paediatric setting, and, again, I think you told us that  
21 you'd received no advice, training or education in that  
22 area?  
23 A. That is correct.  
24 Q. We know, and we'll come on this morning to look at it,  
25 about your role as the coordinator in the review that

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1 obstetrician, neither of us had any idea as to what were  
2 appropriate fluids or volumes of fluids for children.  
3 That's why we requested that external paediatric  
4 expertise was put into the -- our information.  
5 Q. Let me broaden this out a little and bridge the gap, if  
6 you like, between fluids on the one hand and the  
7 potential for hyponatraemia on the other and ask the  
8 question in this way. In terms of the physiology or the  
9 biochemistry for the biochemical principles applicable  
10 to this whole area, would you have had any understanding  
11 that the infusion of fluids that were too low or were  
12 low in sodium could have a detrimental impact on the  
13 health of a patient?  
14 A. I had never heard of Solution No. 18. It was not  
15 something that we as adults had ever used. In the whole  
16 of my medical experience I had never used  
17 Solution No. 18. I'd never heard of it. Even when  
18 I was working in South Africa, I had no knowledge of  
19 Solution No. 18 at all.  
20 Q. But that --  
21 A. We were aware of the fact that excess of fluids in  
22 a child could be a serious problem, but we had no idea  
23 as to what were appropriate levels of fluids to any  
24 particular age group of child.  
25 Q. But Solution No. 18, just to broaden this debate out

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1 was established. It might on one view have been  
2 important to have had an understanding, at least on  
3 a general or perhaps a basic level, of what  
4 hyponatraemia was in medical terms. Did you have that  
5 understanding?  
6 A. I didn't. I was approached by Mr Fee and informed that  
7 he and I had been asked to conduct a review, and I had  
8 no training for the review, I'd had no experience of  
9 such a review. He took very much the lead role and  
10 I more or less did as I was told. I felt I was a junior  
11 partner in that coordinating.  
12 Q. I'm going to come to some of those features in your role  
13 presently, but sticking with that issue of knowledge.  
14 Clearly, whatever way the review was going to turn out,  
15 one of the focuses of the review was the fluid  
16 management of Lucy Crawford. And what I'm asking you,  
17 just to be clear, before we move forward from this  
18 position, are you telling us that in terms of the --  
19 let's start with fluids. In terms of the fluids that  
20 might be prescribed to children, depending upon their  
21 state of wellness, that was not something you had any  
22 grasp of or understanding?  
23 A. That is correct. In fact, that was why we, Mr Fee and  
24 I, when we sat down to analyse, recognised that neither  
25 of us -- he was a mental health nurse, I was an

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1 a bit, is just a fancy name for a fluid that had  
2 one-fifth normal saline in 4 per cent dextrose. Now, it  
3 was -- I hesitate to use the word, but I'll use it  
4 anyway -- fashionable at that time or common at that  
5 time to use that in paediatrics, but as the label on the  
6 bottle said, it was a low sodium fluid. In terms of the  
7 administration of that kind of fluid in a child whose,  
8 for example, gastric resources were depleted, had you  
9 any sense of what that might lead to or what problems  
10 that could cause?  
11 A. Again, on that issue, we were very heavily reliant on  
12 the advice of the external paediatrician and in his  
13 report he did not question the use of the fluid, so we  
14 didn't question it either.  
15 Q. Yes, we're going to get there. You have almost answered  
16 my question, I think. Put it in these terms: were you  
17 going to be in a position, doctor, to in any sense  
18 critique the views expressed by the external physician  
19 who was identified and used to assist in this external  
20 review?  
21 A. We didn't think we were, no, I don't think I was in  
22 a position to question his advice.  
23 Q. I used the phrase "external review" inadvertently there.  
24 A. The report that we got from Dr Quinn.  
25 Q. It was an internal review using Dr Quinn's assistance.

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1 A. Yes.  
2 Q. And he was external --  
3 A. He was external to our hospital.  
4 Q. Yes, thank you. So if I can summarise the position  
5 before we move forward. You seemed to be saying to us  
6 that in terms of the issues that were to be explored in  
7 this review by Dr Murray Quinn, you didn't have anything  
8 like approaching any expertise in this field?  
9 A. That is correct.  
10 Q. And in fact, you seem to be saying that your knowledge  
11 was at best fairly low in this whole area in the sense  
12 that you would have appreciated that children required  
13 careful fluid management and the wrong fluid might cause  
14 health problems, but you didn't have any knowledge of  
15 the detail of that?  
16 A. That is correct.  
17 Q. Could I ask you just to look at an answer that you've  
18 given to us in your second witness statement? If  
19 I could have up on screen, please, WS291/2, question 15.  
20 You can see that in the preface to question 15,  
21 doctor, we allude to an earlier answer you had given to  
22 question 53, and we can go back to that if necessary.  
23 What we're asking you is:  
24 "Arising out of that answer [where you said that  
25 at the time of the review the word 'hyponatraemia' had

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1 sodium of less than 135.  
2 A. First of all, we didn't understand the levels  
3 appropriate for a child, and secondly, that level had  
4 been available to Dr Quinn and he had stated that, to  
5 the best of my knowledge, that that was not  
6 a sufficiently low level to have caused the  
7 deterioration in Lucy's condition. So we were guided or  
8 misguided by his statement.  
9 Q. Yes, doctor, but the question isn't at this stage  
10 whether the hyponatraemia was a problem or whether it  
11 was identified as a problem. The question is whether  
12 you as one of the coordinators understood that an  
13 electrolyte reading of serum sodium in the order of 127  
14 actually amounted to by definition hyponatraemia.  
15 A. I would have known that 127 was a low level, I would not  
16 have known whether it was a dangerously low level.  
17 Q. Which is why we were puzzled and why we raised the  
18 question with you because you seem to have said that the  
19 word "hyponatraemia" wasn't a feature of Lucy's case.  
20 That seemed to be your understanding from the answer  
21 that you gave.  
22 A. Just to clarify. The answer that I gave was that the  
23 word "hyponatraemia" had not been mentioned or  
24 identified as being the cause of the sudden  
25 deterioration in Lucy's condition.

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1 not yet been mentioned, that is what you said in answer  
2 to the earlier question 53] clarify whether you are  
3 intending to suggest that those conducting the review  
4 did not appreciate that hyponatraemia was a feature of  
5 Lucy's case during the period of her treatment in the  
6 Erne Hospital."  
7 And you say:  
8 "That is correct. We did not appreciate that  
9 hyponatraemia was a feature of her case."  
10 A. That is correct. We were very much dependent on the  
11 paediatric management on the report that was provided by  
12 Dr Quinn and he certainly did not identify that  
13 hyponatraemia was a problem.  
14 Q. No, no, I'm not asking whether hyponatraemia was  
15 a problem.  
16 A. Right. It hadn't been mentioned.  
17 Q. The question was intended to focus on whether you  
18 actually appreciated that by definition Lucy had  
19 encountered hyponatraemia.  
20 A. Right. We did not appreciate that. We did not  
21 understand that that was the case. Our feeling, as far  
22 as I can remember back then, was there's a question of  
23 fluid volume as opposed to the sodium levels.  
24 Q. Yes, but you would appreciate, or perhaps you don't  
25 appreciate, that by definition hyponatraemia is a serum

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1 Q. Right. Just to get it right, you appreciated that  
2 a reading of 127 amounted to a low sodium reading?  
3 A. I appreciated it was outside of the normal range, and  
4 again we were very much guided by the paediatric opinion  
5 that we got from Dr Quinn. He did not identify that  
6 that was sufficiently severe as to cause the sudden  
7 deterioration in Lucy's condition.  
8 Q. Yes, we'll come to that in a moment. Now, of course  
9 those who contributed to the review -- Dr Auterson  
10 referred in his report to the review of a reading of  
11 127. That's what he said in his statement. And when he  
12 said that and identified that, that is in effect him  
13 saying that there was hyponatraemia present.  
14 A. He was stating a level. Again, whether that was  
15 sufficiently low as to cause a pathological outcome was  
16 not apparent to us.  
17 Q. Very well. Let me take you to the events of 12, 13 and  
18 14 April 2000. Lucy was admitted into a ward in your  
19 directorate; is that right?  
20 A. Yes, the paediatric ward, yes.  
21 Q. And that happened on the evening of 12 April.  
22 A. That's correct.  
23 Q. Her condition deteriorated overnight so that she was  
24 transferred and admitted to the Royal Belfast Hospital  
25 for Sick Children in the early morning of 13 April.

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1 A. So I understand, yes.  
2 Q. And was to subsequently die in that hospital on  
3 14 April. Now, you have told us that you got to hear of  
4 that death informally within the Erne Hospital.  
5 You have described the Erne Hospital as being a small  
6 place. Presumably, in small places, the grapevine, if  
7 you like, works effectively and you get to hear about  
8 it?  
9 A. Yes.  
10 Q. Can you recall who told you about it, first off?  
11 A. I cannot recall who told me. I do remember that I met  
12 informally with Dr O'Donohoe, and my first reaction to  
13 him was to make sure that he has got careful notes  
14 written because this has serious implications. That was  
15 an informal comment made to him by way of just  
16 a colleague's advice.  
17 Q. So he was one of the first people you remember speaking  
18 to informally; is that fair?  
19 A. That would be fair to say. Whether he was the first --  
20 but he was certainly one of the first.  
21 Q. Yes. Was he the person who told you about the  
22 catastrophic event that --  
23 A. He may well have been, I can't remember.  
24 Q. Can you remember what, if anything, he told you about  
25 the events leading to this death?

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1 A. I cannot remember which of those were intended, but  
2 certainly as a general principle the longer things go  
3 on, the more you're likely to forget, and while it's  
4 fresh in your memory, best to record it while you can.  
5 That was really not given as the advice of the clinical  
6 director to one of the people under my care, but rather  
7 as one colleague to another.  
8 Q. And so it may be of significance in terms of this  
9 inquiry. Do you think you might have been suggesting to  
10 him that it was appropriate to go back to the clinical  
11 notes to fill in any gaps in information?  
12 A. I cannot remember what the implication was at the time.  
13 I suspect it was probably that he be clear in his own  
14 mind and have a clear record of what actually happened.  
15 Q. Why did you have an instinct to say that, can I ask?  
16 Is that because there was, if you like, on the  
17 grapevine, a concern that something had gone wrong with  
18 this child's management and therefore it would be  
19 important for that clinician, Dr O'Donohoe, to get the  
20 facts straight in his own mind?  
21 A. That may have been in the back of my mind, I cannot  
22 recall, to be clear. But certainly, in what was  
23 a tragic incident, it is a general principle in medicine  
24 that we have our notes very clearly documented.  
25 Q. Was there a sense, thinking back, that this tragedy had

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1 A. I can't remember the details, suffice to say that there  
2 had been a child who had been brought in and had to be  
3 transferred to the Royal Belfast Hospital for Sick  
4 Children because she had collapsed in the middle of the  
5 night.  
6 Q. So your memory tells you it was as -- I don't mean this  
7 disrespectfully, but it was as bland as that, there was  
8 no discussion about the whys and wherefores of that?  
9 A. I cannot remember the details of the discussion.  
10 Q. Just focusing on Dr O'Donohoe for a moment and thinking  
11 about your discussion with him, this informal discussion  
12 with him appears to have taken place before you were  
13 appointed to the review.  
14 A. That is correct.  
15 Q. And your reaction to him, and perhaps to others -- were  
16 you speaking to others perhaps who'd been involved  
17 in the care?  
18 A. I cannot remember if I met with others at that time.  
19 Q. Your reaction to him was to make sure he had made good  
20 notes of the event?  
21 A. Yes.  
22 Q. Just thinking about that, were you advising him to get  
23 the clinical notes in order or were you advising him to  
24 make his own, if you like, private notes as an  
25 aide-memoire for further enquiry?

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1 started off because of some mismanagement?  
2 A. At that time I was not aware as to whether there may or  
3 may not have been mismanagement. Regardless, it is  
4 important in a general principle to have clear notes.  
5 Q. Somebody else has told us that he had an informal  
6 discussion with you. Dr Auterson was an anaesthetist,  
7 consultant anaesthetist, in the hospital at that time.  
8 Did you know him?  
9 A. He was my regular anaesthetist on my Thursday operating  
10 sessions.  
11 Q. Right. He tells us that he can recall another one of  
12 these, what you have described as informal discussions.  
13 He met you outside of theatre. You say he generally  
14 operated for you on a Thursday?  
15 A. I had a gynae operation session every Thursday and he  
16 was my regular anaesthetist for that session.  
17 Q. He says when he met you outside theatre, you were  
18 already aware of the death. Now, the death didn't occur  
19 until, I think, a Friday, on the calendar for that year.  
20 So it may not have been the day he was operating for  
21 you. Can you remember informally discussing the death  
22 with Dr Auterson?  
23 A. I have no recollection of that at all, I'm afraid.  
24 Q. None at all? Let me see if I can help you. He says  
25 that in that discussion, he may have mentioned the

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1 sudden collapse, the hyponatraemia and the subsequent  
2 transfer to Belfast. Does that ring any bells?  
3 A. He may have, but I have no recollection of that  
4 discussion.  
5 Q. He was, of course, the anaesthetist who came into the  
6 resuscitation --  
7 A. I understand so.  
8 Q. And it would not be unusual for him to be speaking to  
9 somebody such as you, clinical director, about matters  
10 of note that had happened in the hospital?  
11 A. He may have done so in my role as clinical director or  
12 just as another colleague in the hospital.  
13 Q. Could I just put one thing to you which he has said.  
14 I posed to Dr Auterson the question around the fact that  
15 you had said to the inquiry the point we've dealt with  
16 just a minute or two ago, that you had said to the  
17 inquiry that hyponatraemia was not a word that was  
18 discussed around Lucy's death, and you have explained  
19 what you meant by that when you gave evidence this  
20 morning. But he says that he can't believe that --  
21 sorry, he says he finds it difficult to understand how  
22 you would say that hyponatraemia had not been  
23 a consideration or had not been mentioned as part of the  
24 review. He finds it difficult to understand how you  
25 would have got that sense of things.

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1 contact with children and anaesthetising them.  
2 Q. Of course, that's right, not daily work, but certainly  
3 regular work.  
4 A. It would have been part of his work.  
5 Q. Yes. And we'll come on to ask you in a moment just to  
6 what extent you exploited all of the evidence that was  
7 available to you as part of the review. But it's quite  
8 clear that Dr Auterson wasn't asked to give an opinion  
9 or to express a view in relation to what had happened to  
10 Lucy; isn't that right?  
11 A. I cannot recall that we deliberately asked him  
12 specifically to give an opinion as to the cause of the  
13 poor outcome. We did ask for his account of what  
14 happened and he had opportunity, but didn't mention the  
15 fact that he thought it was related to the low sodium.  
16 Q. Let me just come back to that in a moment. Could I ask  
17 you this. In terms of clinical governance at that time  
18 in 2000, various accounts tell this inquiry that so far  
19 as the Erne Hospital was at that time, clinical  
20 governance was in its infancy and was in a developmental  
21 stage. Is that something you can comment on?  
22 A. Yes. I think that would be a fair statement. Most of  
23 us had very little knowledge of what clinical governance  
24 actually implied. As I said, I received absolutely no  
25 training in it. When I took on the role of clinical

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1 A. Again, I would say that we were very much dependent upon  
2 the paediatric opinion that we sought from Dr Quinn.  
3 Dr Auterson would have had much more contact with fluid  
4 balance in children than I would ever have had, so he  
5 might have been in a better position to form an opinion  
6 than I. As an anaesthetist they are anaesthetising  
7 children and they are obviously involved in fluid  
8 balances as part of their anaesthetic. I had no  
9 experience in that whatsoever. So his opinion would  
10 have been more clinically relevant than mine.  
11 Q. Indeed he went on to say -- this was at page 152, sir,  
12 for your reference when he gave evidence on 31 May 2013.  
13 He went on to say that he can't believe that he was the  
14 only one to have strong suspicions that there was  
15 a connection between the fluid mismanagement, as he saw  
16 it, and the cerebral oedema which ultimately was the  
17 cause of death here. But you say that was not a view  
18 you were able to come to?  
19 A. Well, if he had come to that conclusion, he didn't  
20 convey it to us, to the best of my knowledge.  
21 Q. Yes. But you have recognised that as an anaesthetist,  
22 it would have been part of his daily work to be  
23 anaesthetising children and managing their fluids for  
24 that purpose?  
25 A. Perhaps not daily work, but he would have certainly had

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1 director I was given no training for that role either.  
2 In fact, when I arrived at the hospital I didn't even  
3 get an induction into the hospital.  
4 Q. Clinical governance seems to have been a concept that  
5 was introduced into hospitals in Great Britain in the  
6 late 90s and the process of implementing it in  
7 Northern Ireland seemed to gather steam in or around the  
8 early years of this millennium, this century. Leaving  
9 that concept aside, nevertheless there was a process in  
10 place presumably by which the Erne Hospital could  
11 grapple with or review adverse incidents?  
12 A. If there was, I was not made party to it. We were not  
13 given any direction or instruction in how to carry out  
14 a review.  
15 Q. Well, leaving Lucy's case to one side, had you any  
16 understanding prior to being appointed to the review in  
17 Lucy's case about how the system was supposed to work in  
18 circumstances where you had an adverse incident?  
19 A. I had no -- I was not given any instruction along those  
20 lines at all.  
21 Q. What would your advice have been to a clinician in your  
22 directorate if they came to you to say some catastrophe  
23 had occurred?  
24 A. My initial advice to Dr O'Donoghue was to make very  
25 careful notes and be prepared, I presume, to answer

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1 questions thereon.  
2 Q. In your role as clinical director, did you see any  
3 function for yourself in instigating or suggesting that  
4 a review should be instigated once you discovered that  
5 there was this difficulty?  
6 A. No, I had -- the first I heard was within a few days  
7 when Mr Fee approached me and said that we had been  
8 asked to conduct a review. I had not initiated it  
9 before that.  
10 Q. Before looking at your appointment to the review, can  
11 I ask you this other question arising out of the  
12 governance arrangements at that time. In or about the  
13 late 1990s, the Erne Hospital became part of the Sperrin  
14 Lakeland Trust. I think it was in or about 1996, just  
15 a couple of years before you came back from  
16 South Africa.  
17 A. Mm-hm.  
18 Q. It's the view of an expert advising the inquiry,  
19 Professor Scally, that the Trust and the hospital within  
20 the Trust was accountable in management terms to the  
21 Department of Health and Social Services. It would  
22 appear on the basis of his opinion that this death and  
23 the fact that there was to be a review of the death  
24 ought to have been reported to the Department of Health  
25 in Belfast. But it apparently wasn't or at least that's

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1 and outcome of Lucy's condition and whether there were  
2 any features of our contribution to the case which may  
3 suggest the need for change in our approach to the care  
4 of patients in the paediatric department or wider  
5 hospital. Those were the terms of reference that  
6 we were given.  
7 Q. You're reading from the objectives for the review that  
8 were set out in the review report?  
9 A. Yes.  
10 Q. And who handed you those terms of reference?  
11 A. That would have been via Mr Fee, who I presume received  
12 them from Mr Mills, but I don't know.  
13 Q. Have you ever seen them in writing apart from within the  
14 review?  
15 A. I don't think I'd seen them in writing until this came  
16 up, was produced.  
17 Q. You have told us already about your lack of expertise  
18 in the whole area of paediatrics and the management of  
19 paediatric fluids, paediatric hyponatraemia. When you  
20 were asked to engage as a coordinator for this review,  
21 did you consider yourself as suitable person to be  
22 appointed?  
23 A. I would have said no, I didn't, but I didn't see that  
24 I had any choice. I was approached and was told that  
25 Mr Fee and I had been asked to do this and would

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1 what the other witnesses associated with the Trust are  
2 telling the inquiry. Have you any knowledge of whether  
3 the death was reported to the department?  
4 A. I have no knowledge of that.  
5 Q. Can you help us in terms of whether in governance terms  
6 it should have been reported to the department?  
7 A. Again, I did not know what the systems were in  
8 governance terms.  
9 Q. Very well. You were appointed to the review almost  
10 informally, is that fair, in that Mr Fee came on to the  
11 telephone to you and appraised you of the background?  
12 A. As far as I can remember, that's how it happened.  
13 Q. And he told you that he had been approached by Mr Mills,  
14 the chief executive for the Trust, and he asked that you  
15 would carry out a review of Lucy's care in the hospital  
16 to include looking at the notes?  
17 A. Yes.  
18 Q. And you were to examine whether any mistakes had been  
19 made and whether any lessons could be learned; is that  
20 fair?  
21 A. That was the terms of reference that we were given, were  
22 to see whether there was any connection between our  
23 activities and the progression and outcome of Lucy's  
24 condition, whether there was any omission in our actions  
25 and treatment which may have influenced the progression

22

1 I assist him, which I agreed to do, but I did not feel  
2 that -- I felt that we would have probably benefited  
3 from a paediatric person on our review team. But not  
4 having one, we asked for a paediatric opinion.  
5 Q. Yes. And in terms of your suitability, why did you  
6 regard yourself as not particularly suitable to be  
7 involved?  
8 A. Firstly, because I had no knowledge of paediatrics and  
9 the intricacies of what should or should not be treated,  
10 what treatment a paediatric patient should have.  
11 Secondly, that I'd had absolutely no experience in such  
12 a review.  
13 Q. Did you express those misgivings or those concerns to  
14 anyone?  
15 A. I can't remember if I did.  
16 Q. Is it fair to say that you were then entering into this  
17 review lacking in confidence in terms of whether you  
18 would be able to understand the relevant concepts?  
19 A. I think that would be a fair comment.  
20 Q. And --  
21 THE CHAIRMAN: Sorry, doctor, a moment ago you talked about  
22 the absence of a paediatrician. Did you ask for  
23 a paediatrician and were refused?  
24 A. No, I don't remember us asking for one, but I do  
25 remember we recognised at an early stage that we would

24

1 need the opinion of a paediatrician.  
2 THE CHAIRMAN: Thank you.  
3 MR WOLFE: But of course, there were senior paediatricians  
4 within the hospital who could likewise or equally have  
5 taken a position on this review?  
6 A. As far as I can remember, there were two consultant  
7 paediatricians at that time in the hospital. One was  
8 Dr O'Donohoe, who was obviously very much involved, and  
9 the other was Dr Halahakoon, who was his senior and who  
10 was part of our regular meetings with Mr Fee.  
11 I mentioned very much earlier that the reason I took on  
12 the role of clinical director for obstetrics and gynae  
13 and paediatrics was that there would be a paediatrician  
14 present at our meetings.  
15 Q. So what you're telling me is had it been thought through  
16 appropriately, there was a person with suitable  
17 expertise or sufficient expertise, Dr Halahakoon, who  
18 could have taken a position on this review?  
19 A. Dr Halahakoon would have certainly been much better  
20 qualified than I was, but I suspect, and this is  
21 speculation, that it was felt that she was too closely  
22 involved in the department and I think that was why,  
23 when we asked for an opinion, they went outside of our  
24 hospital to a neighbouring hospital.  
25 Q. But in the absence of sufficient expertise among the

25

1 A. I think so.  
2 Q. Was anybody available to you to advise you and Mr Fee  
3 about the appropriate approach to a review of this type?  
4 A. I don't know and I was never informed that there was  
5 someone who could.  
6 Q. You didn't seek any advice?  
7 A. I very much followed the lead that Mr Fee gave.  
8 I understood that he -- I understand that he had had  
9 previous experience of conducting reviews, but I had  
10 none.  
11 Q. This review was to be conducted because this was an  
12 unexplained death; isn't that right?  
13 A. That is correct.  
14 Q. And you and Mr Fee were appointed jointly as  
15 coordinators; isn't that right?  
16 A. I saw myself as an assistant, but we were, yes, the  
17 joint coordinators.  
18 Q. Well, you said in your witness statement that you were  
19 his assistant during the review.  
20 A. He very much gave the lead, but we discussed together at  
21 each stage what we were going to do. As I say, I had no  
22 experience of it, so I followed his lead.  
23 Q. How did you fall into the role of assistant when in fact  
24 you were appointed jointly to conduct the review?  
25 A. Again, Mr Fee seemed to know what we were doing, what

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1 coordinators, you have said Mr Fee was a mental health  
2 nurse, you were obs and gynae, the review process did  
3 not have among its number someone who was capable of, if  
4 you like, challenging the opinions and the views  
5 expressed by Dr Quinn?  
6 A. That is correct.  
7 Q. Or, I don't mean challenging in the sense of getting  
8 into a debate about whether he was right or wrong --  
9 A. We didn't question his opinion and we weren't qualified  
10 in our medical knowledge to question his opinion.  
11 Q. And you have told us that you had no training for the  
12 conduct of reviews; is that right?  
13 A. That is correct.  
14 Q. Had you ever carried out any similar investigation in  
15 this hospital?  
16 A. The only thing that remotely approached it -- in  
17 obstetrics and gynae, on a monthly basis, we looked at  
18 what we called a perinatal mortality meeting, where we  
19 looked at any untoward outcomes of children being born,  
20 either stillborn or born with a very low Apgar score or  
21 who died within a matter of weeks of having been born.  
22 So we did that on a regular basis, but that is the only  
23 experience that I'd had of such a thing.  
24 Q. Qualitatively, that is a different approach to what you  
25 were being asked to do here; is that right?

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1 he was doing. I was following and doing what he  
2 suggested we did.  
3 Q. But how did that happen? Or why did it happen, is  
4 perhaps the better question.  
5 A. I find that difficult to answer. I think it was just  
6 the way things turned out. I don't think I was  
7 officially the assistant. My statement was that  
8 I regarded myself as being an assistant.  
9 THE CHAIRMAN: Would it be unfair for me to interpret this,  
10 doctor, as you taking the view, "I'm a bit at sea here.  
11 Mr Fee seems to have a better idea of what the process  
12 involves, therefore I'll follow his lead"?  
13 A. That was as I saw it.  
14 THE CHAIRMAN: Thank you.  
15 MR WOLFE: You have helpfully set out what you saw as the  
16 purpose of the review. 033-102-264. Is that the  
17 document you're reading from in front of you?  
18 A. Yes.  
19 Q. The purpose of the review is threefold, (a), (b) and  
20 (c). (a) similar to (b) in the sense that what's really  
21 going on there is that the review was designed to  
22 explore whether there were any acts or omissions on the  
23 part of the clinicians and nursing staff at the  
24 Erne Hospital which may have influenced the progression  
25 and outcome of Lucy's condition.

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1 A. Yes.  
2 Q. And then (c) based on what conclusions might have  
3 emerged and (a) and (b), there was a purpose in the  
4 review to examine whether there was a need for change  
5 in the approach to caring for children in the hospital.  
6 A. Which we took as being recommendations.  
7 Q. Yes. Just in terms of those purposes, at the heart of  
8 it appears to be a concern that an act or omission may  
9 have been responsible for triggering Lucy's  
10 deterioration.  
11 A. Yes. Our understanding of that was that there was -- it  
12 boiled down to poor communication between the doctor  
13 prescribing and the nursing staff hearing what he  
14 claimed to have prescribed and administering something  
15 different in terms of the volume of fluid.  
16 Q. So that prescribing error, if you like, was identified  
17 at the start; is that right?  
18 A. That was what we identified as being the root cause of  
19 the problem. The doctor had given a verbal order,  
20 he hadn't recorded in writing his order, he claimed that  
21 he had ordered one thing, the nursing staff understood  
22 that he had ordered something else and they administered  
23 a dosage which was much higher than what he claimed  
24 he had ordered. We saw that as being the root problem  
25 of the condition. We felt she had then been

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1 being an error.  
2 Q. But you had -- I'll bring you to the document if  
3 necessary. You had a note within that file signed off  
4 by Dr O'Donohoe, who said -- it's my recollection, I'm  
5 paraphrasing here -- that, "I directed or I prescribed  
6 100 ml as a bolus to be followed by 30 ml per hour".  
7 Isn't that right?  
8 A. That's what he claimed he had prescribed.  
9 Q. Yes. So that is, if you like, what his prescription was  
10 or his direction?  
11 A. But he made the mistake of not writing it down.  
12 Q. Of course. And the nurses heard something different.  
13 A. Yes, and we were faced with two people's statements,  
14 which were conflicting, and each stuck by their  
15 statements.  
16 Q. Yes, but the upshot of that, doctor, was that this  
17 child, on the consultant's account, received fluids of  
18 a different type and at a different rate or volume than  
19 he had intended; is that fair?  
20 A. That's what we understood.  
21 Q. Yes. Moreover, did you recognise that after the child's  
22 collapse that she had received a very significant  
23 infusion of normal saline?  
24 A. We understood that normal saline was put up and was said  
25 to be running freely, so our conclusion was that the

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1 over-transfused with fluid, but we were unqualified to  
2 determine anything other than what we would need the  
3 advice of a paediatrician to decide.  
4 Q. Well, you say that yourself and Mr Fee quickly  
5 identified the need to go through the documentation.  
6 A. Yes.  
7 Q. And you did that.  
8 A. We did.  
9 Q. And what notes did you go through?  
10 A. To the best of my knowledge, we had the record -- the  
11 children's ward chart.  
12 Q. Yes.  
13 A. And the fluid balance chart.  
14 Q. Is that -- maybe just to short circuit this. Is that  
15 all of the nursing and medical notes?  
16 A. Yes.  
17 Q. And it would include, for example, the biochemistry  
18 reports, showing the electrolyte results?  
19 A. It would have included the initial and the subsequent  
20 electrolyte result, yes.  
21 Q. Can I ask you if you can help us. When you looked  
22 through those notes, did you recognise that there had  
23 been this prescribing error?  
24 A. We recognised that there had been a failure to record  
25 the volume of fluid to be administered, which we saw as

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1 child had received an overdose of fluid.  
2 THE CHAIRMAN: Is that a two part overdose? The first part  
3 is getting more than Dr O'Donohoe said he wanted her to  
4 get and the second part is receiving too much normal  
5 saline?  
6 A. I think both were applicable, yes. She had received  
7 more than he intended and then she had a further fluid  
8 load.  
9 THE CHAIRMAN: So a child who was already overloaded with  
10 fluid then received a significant --  
11 A. We weren't qualified to know how much she had been  
12 overloaded with. It was certainly more than he had  
13 intended.  
14 THE CHAIRMAN: Thank you.  
15 MR WOLFE: And looking at the notes again, you would have  
16 recognised an electrolyte derangement in the sense  
17 that -- and I'm conscious of what you have said earlier  
18 about your expertise in this field. But you'd have  
19 recognised that serum sodium had dropped from 137 to  
20 a number of 127?  
21 A. We recognised that there had been a fall. We were not  
22 qualified to know whether that fall was sufficiently  
23 severe as to cause the fatal outcome.  
24 Q. Yes. You would also have recognised, would you, that  
25 the bloods that were taken for electrolytes had only

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1 been taken after a quantity of intravenous fluid in the  
2 form of normal saline had been run in?  
3 A. I think we failed to recognise the timing of that.  
4 I think several other people also failed to recognise  
5 that that level had been taken -- the second level was  
6 taken after she had received normal saline. So I think,  
7 looking back, we now can speculate that her serum level  
8 was probably lower than 127, but we didn't know that  
9 at the time, we didn't recognise that at the time.  
10 Q. Yes. I'm just anxious to explore that a little bit  
11 more. If we can put up on the screen 027-017-057. This  
12 is a nursing note. You can see about a third of the way  
13 down the page, looking to the right-hand side of the  
14 page:  
15 "IV fluids changed to 0.9 per cent saline and run  
16 freely into IV line."  
17 Do you see that?  
18 A. Yes, I see that.  
19 Q. "Decreased respiratory effort noted at 03.20."  
20 Then it goes on to say:  
21 "Dr O'Donohoe in attendance. Repeat U&Es ordered."  
22 A. I see that.  
23 Q. Do you follow that?  
24 A. I see that.  
25 Q. Now, as we develop your evidence this morning, doctor,

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1 A. I've got another page in front of me, yes.  
2 THE CHAIRMAN: I think they're in reverse order.  
3 MR WOLFE: They're in reverse order on the file, yes. Maybe  
4 this is what you're referring to. It seems to be 02.30,  
5 large, soft, runny --  
6 A. Yes.  
7 Q. Is that what you say you had?  
8 A. That was the information we had. I cannot remember  
9 whether I actually saw that page as well. But  
10 I certainly was of the -- the information we had was  
11 that she had a large, runny stool.  
12 Q. Yes. What you seem to be saying is that you can't  
13 recall seeing the page that's up in front of you, which  
14 is the nursing note?  
15 A. That's correct.  
16 Q. And you can't recall seeing the first of the pages that  
17 I had in front --  
18 A. That is correct.  
19 Q. In fairness, I'll put up on the screen the medical note,  
20 which may well confuse the sequence or at least there's  
21 the potential for confusion if you look at this.  
22 027-017-023. You have at the top of the page the repeat  
23 electrolytes. I should orientate you by saying this is  
24 a note written by Dr O'Donohoe. Can you remember seeing  
25 that document?

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1 one of the things that we might return to, hopefully not  
2 repeatedly, is this: the notes here, on the face of it,  
3 seem to give a significant clue as to the sequence of  
4 events post-seizure; isn't that right?  
5 A. I may say that looking at this page that you have in  
6 front of me now, this is the first time I remember  
7 seeing this page. I have no recollection of seeing that  
8 page at the time.  
9 Q. That begs the question, doctor. Did you see that page  
10 in the sense --  
11 A. I have no recollection of ever having seen that page  
12 until right now.  
13 Q. Are you telling us that you didn't?  
14 A. I'm telling you that I didn't or, if I did, I certainly  
15 have no recollection of it.  
16 THE CHAIRMAN: And do I understand you to mean by that,  
17 doctor, that you think that you would have remembered if  
18 you'd seen that summary?  
19 A. I think I would. The nursing notes that I saw were on  
20 a different format and mentioned the large, offensive  
21 stool, but I do not remember having seen that particular  
22 page.  
23 MR WOLFE: The nursing notes run over two pages. I think if  
24 we can go forward a page to the next page, they start  
25 there. Doctor, do you have that?

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1 A. I don't remember seeing that document either, I'm sorry.  
2 I have no recollection. The diagram at the bottom,  
3 I have no recollection of seeing that page at all.  
4 Q. Are you saying that kind of diagram would stand out in  
5 your memory if you'd seen it?  
6 A. I'd have thought if I'd seen that before, I would  
7 recognise it, but I do not recognise it.  
8 Q. And the confusion, if I may suggest to you, between the  
9 nursing note which you say you can't remember seeing,  
10 and this note, is that on this page you have the serum  
11 electrolyte scores, if you like, and then following  
12 after that is the reference to normal saline. So if you  
13 were reading that page in the order in which it is  
14 written, I suppose the reader could be forgiven for  
15 thinking the normal saline kicked in after the  
16 electrolyte results were obtained, which seems to have  
17 been the view which Dr Murray Quinn adopted in his  
18 report, you may recall.  
19 A. Yes, I read that in his report.  
20 Q. Can I explore with you just before we leave this  
21 section, you seem to have identified for us a problem  
22 this morning, doctor, in that you were appointed with  
23 Mr Fee to coordinate a review, but you seem to be  
24 saying, if we can have this as straight as possible,  
25 that you did not have all of the relevant notes in front

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1 of you to the best of your recollection.  
2 A. That has become apparent in this last couple of minutes.  
3 It would appear to me now that I did not see all of the  
4 notes.  
5 Q. In preparation for today, can I ask you whether --  
6 I don't wish to intrude into legal advice -- you looked  
7 at file 27?  
8 A. I was given a large quantity of notes. I went through  
9 those and these pages did not appear in them.  
10 Q. I'm more interested then -- well, going back to 2000,  
11 you seem to be saying these notes did not appear?  
12 A. I have no recollection of having ever seen those pages  
13 then or now, until now.  
14 Q. You did see, you tell us, the blood electrolyte scores;  
15 is that right?  
16 A. I can remember that we were aware that the serum sodium  
17 had fallen, but --  
18 Q. I wonder, could you take a look at this? It's in the  
19 usual standard form, 027-012-031, and if we could have  
20 up on the page alongside it 032. And you would  
21 recognise that as the standard form for biochemistry  
22 results?  
23 A. That would be correct.  
24 Q. Would you have had that kind of document, do you think?  
25 A. We may well have had, I cannot remember. That would be

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1 Q. There's a word or at least an acronym in the middle of  
2 the page "Xgate".  
3 A. I see that, but I have no idea what it's supposed to  
4 mean.  
5 Q. Could it mean "investigate"?  
6 A. I don't know. I don't know what the intention was.  
7 Q. Have you seen this document before?  
8 A. Not to my recollection.  
9 Q. So having gone through the documentation that you did  
10 have at that time -- sorry, just before we leave it, can  
11 you remember who provided the documentation to you?  
12 A. I suspect that Mr Fee obtained it and that we looked at  
13 it together.  
14 Q. You sat side by side looking at it together?  
15 A. Yes.  
16 Q. And can you remember what conclusions you reached after  
17 looking at the documentation?  
18 A. My memory is that we reached the conclusion that there  
19 had been a failure of communication and that there was  
20 a fall in -- there was poor documentation of the fluid  
21 administered, it was in excess of what Dr O'Donohoe felt  
22 that he'd ordered and that we needed paediatric help to  
23 determine the significance of those changes.  
24 THE CHAIRMAN: Sorry, doctor, in forming that view would  
25 you have had in front of you the respective statements

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1 the standard format in which the lab reported.  
2 Q. And they show, plainly -- one is timed at 8.50 pm on  
3 12 April, showing the normal serum sodium. And then the  
4 later result is untimed, but it appears to have been  
5 produced following bloods going to the lab at some time  
6 after 3.30 in the morning of 13 April. And you can see  
7 the sodium had reduced by a score of 10.  
8 A. Yes.  
9 Q. Your recollection is being apprised of the numbers but  
10 not necessarily of --  
11 A. The significance. We were aware of the numbers, we  
12 recognised that we needed paediatric advice as to how  
13 significant that fall was.  
14 Q. Yes. Could I ask you to look at this further document?  
15 It's at 027-026-078. This document has been provided to  
16 the inquiry and it appears on the back of what we call  
17 file 27, but in real terms is just the collection of  
18 nursing, medical and biochemistry results that must have  
19 all been brought together at some point. This appears  
20 to be an attempt by someone to look side by side at the  
21 biochemistry test results for this child. Do you  
22 follow?  
23 A. Yes.  
24 Q. Do you recognise the handwriting?  
25 A. I don't.

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1 of Dr O'Donohoe and the nurses?  
2 A. I suspect by that stage we had, but I can't remember the  
3 exact sequence as to when we asked for Dr Quinn's.  
4 THE CHAIRMAN: Because you might not have been able to draw  
5 that conclusion unless you had the conflicting  
6 statements about what was prescribed or not prescribed.  
7 A. I assume we must have then, but I cannot remember the  
8 exact timing of it.  
9 MR WOLFE: The timing of it seems to be that fairly early  
10 in the piece, you sat down with Mr Fee to look at the  
11 notes. If we could pull up 033-102-285. This is one of  
12 the appendices to the review report and you'll be  
13 familiar with this document. It's marked "draft" for  
14 some reason, but it appears on the final review report.  
15 Halfway down the page it says:  
16 "On Wednesday 19 April Dr Anderson and Mr Fee met to  
17 review the case notes and agreed the following action  
18 plan."  
19 Do you see that?  
20 A. Yes, I see that.  
21 Q. Then various action points are made out, including at  
22 number 1:  
23 "That staff listed above and Dr Auterson would be  
24 asked to provide a factual account of the sequence of  
25 events from their perspective."

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1 Do you see that?  
2 A. Yes.  
3 Q. As it turns out, reports came in from various members of  
4 staff, and I don't mean this pejoratively, in dribs and  
5 drabs, and Dr O'Donohoe's report was addressed to  
6 yourself, doctor, under cover of a letter, I think that  
7 was dated 2 May.  
8 A. Okay.  
9 Q. So you wouldn't have had a report from the staff when  
10 you first considered the notes; is that fair?  
11 A. I think that would be fair to say. I think we  
12 recognised early on that we were going to need  
13 paediatric help.  
14 Q. And what would have given you, if you like, the big clue  
15 or the big indicator that that was this prescription  
16 problem or communication problem, as you describe it, is  
17 the note contained at 027-010-024, if we could have that  
18 up on the screen, please. And could we have alongside  
19 it 025?  
20 Do you remember seeing that document, doctor? This  
21 is a continuation of the medical notes. You can see  
22 at the bottom of the left-hand page the entry which  
23 continues on to the right in the hand of Dr O'Donohoe.  
24 He's explaining, following a telephone call from  
25 Dr Crean of the Royal Children's Hospital, just what he

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1 a report from the ward sister that there has been  
2 a problem and, at the bottom of the left-hand page:  
3 "Concern expressed about fluids  
4 prescribed/administered."  
5 Do you see that, the very last line?  
6 A. Yes.  
7 Q. Have you any recollection of seeing that document?  
8 A. I probably did, but I -- I'm almost ... I think I would  
9 have, but I cannot say that I did or I didn't.  
10 Q. Sister Traynor in formal terms seems to have been the  
11 person who put the need for a review on a formal  
12 footing.  
13 A. Right.  
14 Q. There's another side to this in that Dr O'Donohoe tells  
15 us that he made a report to Dr Kelly.  
16 A. Yes.  
17 Q. And that that led to the trigger for the review. But  
18 we have those two actions perhaps side by side. Did you  
19 ever go yourself or with Mr Fee to speak to  
20 Sister Traynor about this initial report?  
21 A. I have no memory of having spoken to Sister Traynor  
22 about it. We might have, I don't know, I can't  
23 remember.  
24 Q. You see, would it not have been an important thing to do  
25 to speak to, if you like, the originator of the concern

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1 thinks has happened here. He has prescribed or directed  
2 a certain course and Dr Crean is telling him in fact he  
3 thinks that 100 ml have been given. Did you have that  
4 document?  
5 A. I cannot remember whether I saw that document or not.  
6 I'm sorry, I can't ... I'm not recognising it. I can't  
7 say that I didn't see it, but I don't recognise it.  
8 Q. It's obviously in terms of its content fairly  
9 significant in that Dr O'Donohoe is in a sense  
10 explaining that there is a problem here?  
11 A. Yes.  
12 Q. Can I ask, if you didn't see that document, from what  
13 other source would you have been able to identify the  
14 fact that there was this, if you like, communications  
15 problem?  
16 A. I cannot remember. It may well have been from verbal  
17 communication, but I cannot remember.  
18 Q. Could I ask you about this other document? There was  
19 a critical incident form completed. 036a-045-096 and,  
20 alongside that, 097. This is a form completed by  
21 Mrs Millar.  
22 A. Yes.  
23 Q. You know Mrs Millar?  
24 A. Yes.  
25 Q. Mrs Esther Millar. As the content illustrates, it is

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1 to find out what was agitating it or what was triggering  
2 it?  
3 A. I think we relied very much on the written reports.  
4 Q. One of the actions that you took, going back to  
5 033-102-285, was to meet with staff, according to the  
6 note. It says halfway down the page:  
7 "It was confirmed on Monday 17 April 2000 that  
8 Lucy Crawford had died in hospital. The funeral was  
9 held on Sunday."  
10 The dates may not be entirely correct, it would  
11 seem, but leaving that point aside, because it says 17  
12 and 18 April, which can't be correct:  
13 "Dr Anderson and Mr Fee met with ..."  
14 And then a list of names is given. You have told us  
15 in your witness statement that you can't remember such  
16 meetings.  
17 A. That is correct, I cannot remember that. We may have,  
18 but I do not remember it.  
19 Q. At the bottom of the page it says that Dr Anderson is to  
20 speak to Dr O'Donohoe and request that he share with  
21 staff concerned, in confidence, the verbal report of the  
22 cause of death received. Do you remember whether you  
23 complied with that action?  
24 A. I know that I spoke on many occasions with Dr O'Donohoe  
25 and I cannot remember whether that was specifically part

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1 of our conversation. But I suspect that we would have  
2 discussed the ongoing developments.

3 THE CHAIRMAN: What was the report, the verbal report of the  
4 cause of death?

5 A. The cause of death was -- it depends when we're talking.  
6 I was given a preliminary pathology report, which gave  
7 the cause of death as cerebral oedema causing coning,  
8 but it also, I think, mentioned other factors like  
9 bronchopneumonia, which I don't know how relevant they  
10 were.

11 THE CHAIRMAN: Thank you.

12 MR WOLFE: One of the issues for us, doctor, is whether in  
13 fact the clinicians were the subject of a written  
14 request to give information to the review. When you  
15 answered that question in your witness statement, you  
16 referred to a number of letters that had been issued,  
17 but in pointing to those letters you were in fact  
18 pointing to the letters that were written to the nursing  
19 staff. Now, the inquiry has not been provided with the  
20 correspondence, if correspondence was sent to medical  
21 staff.

22 A. Right.

23 Q. Can I just explain our interest in that, doctor, is not  
24 simply to see whether a request was made in writing, but  
25 rather our interest is in seeing whether the medical

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1 through his secretary who wrote the letters. If  
2 I communicated to the doctors, it would have been  
3 verbally, but I don't remember writing letters to them.

4 THE CHAIRMAN: Do you remember seeing any letters which were  
5 sent to the doctors which are in any way comparable to  
6 the letters which were sent to the nurses?

7 A. I have no memory of it, sir.

8 THE CHAIRMAN: Thank you.

9 MR WOLFE: We see from your contribution to the police  
10 service when they interviewed you, where you said to the  
11 best of your knowledge Mr Fee wrote out to those parties  
12 and we considered the reports which we received. For  
13 his part, Mr Fee thinks it was you, doctor, who linked  
14 with the medical staff, and he doesn't recall whether  
15 reports were ever made in writing or requests for  
16 reports were ever made in writing.

17 A. I have no memory of it, I'm afraid, I'm sorry.

18 Q. Is that a satisfactory situation, doctor, where we can't  
19 account for how the key personnel, the key medical  
20 personnel, were asked to provide evidence? We can't  
21 work out, first of all, how they were asked to provide  
22 evidence or what evidence they were asked to provide.

23 A. All I can tell you is that I cannot remember whether  
24 I wrote letters or not. Obviously they were  
25 communicated with by virtue of the fact that they

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1 staff were asked to express their views on particular  
2 issues. Let me give you an example of that from the  
3 nursing side. One of the persons who received a letter  
4 was Nurse McManus. If we could have up on the screen,  
5 please, 033-120-299, and if we could put up the page  
6 alongside it.

7 Within this letter at the bottom of the left-hand  
8 page, Sister McManus, as she's referred to here, is  
9 asked to provide:

10 "A factual account of the sequence of events  
11 in relation to Lucy's care where you were involved.  
12 I would be particularly interested in your comments on a  
13 range of issues around the prescription and the  
14 administration of IV fluids."

15 And then there's a set of specific issues  
16 identified. Do you see that?

17 A. I see that.

18 Q. We're interested to know, doctor, if you can help us  
19 with whether the medical staff would have received  
20 correspondence and whether the correspondence was  
21 focused and specific to the fluid issue which clearly  
22 had emerged.

23 A. I have no memory of writing any of the letters. I may  
24 have, but I don't remember. I did not have a secretary.  
25 Mr Fee had. To the best of my knowledge, it was he

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1 responded. I cannot remember who wrote to them or  
2 what was said.

3 Q. We touched on whether you met with any of the  
4 clinicians, and you can't remember in specific terms  
5 whether you met with them and, in particular terms,  
6 whether you met with Dr O'Donohoe to ask him to speak to  
7 the staff in confidence about the verbal notification of  
8 the cause of death. Could I ask you to assist us with  
9 this. Dr O'Donohoe gave evidence. At page 143, sir,  
10 for reference, in his transcript of 6 June, he,  
11 referring to the note that we had up on the screen about  
12 you and Mr Fee meeting with him, he says that he doesn't  
13 believe that that meeting ever happened.

14 A. I cannot remember.

15 Q. Moreover, he tells us that he doesn't believe that  
16 he was ever formally informed about who was conducting  
17 the review. Can you help us with that? In terms of the  
18 fact that you were appointed to conduct the review,  
19 would he have known that, do you think?

20 A. I cannot answer for what he knew.

21 Q. Well, maybe I put it in these terms. Did you tell him  
22 that you were conducting the review?

23 A. I can only assume that we did, but I cannot swear to it.

24 Q. And indeed, he tells us that the report which he sent in  
25 to you, he didn't realise that that was a contribution

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1 to the review. Your demeanour suggests that you find  
2 that surprising.  
3 A. Yes.  
4 Q. Why do you find that surprising?  
5 A. Well, I read it as being his contribution. I am  
6 surprised that he didn't realise that it was  
7 a contribution.  
8 Q. He went on to tell the inquiry when he gave evidence  
9 that he would recognise that he had more information to  
10 give, more to say about the whole sequence of events  
11 surrounding Lucy's care, but he didn't feel inclined to  
12 give that because he didn't realise that he was  
13 preparing a report for the review. He thought he was  
14 preparing a report for your information. If I could  
15 just add a further caveat to a long question, he thought  
16 that you were a man who preferred concise reports rather  
17 than long, complicated reports.  
18 A. I don't know how to comment on that. That's what he  
19 said.  
20 Q. Let me try and break it down.  
21 THE CHAIRMAN: There's nothing wrong with preferring concise  
22 reports, is there?  
23 A. Well, so long as a concise report contains the relevant  
24 factors.  
25 MR WOLFE: Yes. But could I have your comments on whether

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1 needed a paediatric opinion, which we sought and which  
2 we accepted, and on which we made recommendations.  
3 Q. And that led to the appointment of Dr Quinn?  
4 A. Yes. That happened when I was on holiday and I had no  
5 communication with Dr Quinn at all personally.  
6 Q. Yes. We'll come to Dr Quinn just in a moment. When you  
7 sat down with Mr Fee, was there any attempt on the part  
8 of either of you to seek to identify all of the relevant  
9 sources of evidence that would be available to you?  
10 A. To my memory, we went through the people who we thought  
11 were involved and we wrote to them.  
12 Q. Well, one of the key set of people who were involved  
13 were the clinicians at the Royal Belfast Hospital.  
14 A. We understood our remit was to look at what happened  
15 within the Erne Hospital. We did not understand that  
16 we were directed to look at what happened subsequently.  
17 Q. Yes, and that's the point. You weren't investigating  
18 how she was cared for at the Royal, and that would be  
19 very understandable. But do you recognise any substance  
20 in the point that there were clinicians who had treated  
21 the child in the Royal Belfast Hospital who could have  
22 assisted you in your review in terms of giving evidence  
23 about what they thought had happened to her?  
24 A. We did not recognise that at the time.  
25 Q. Was it discussed?

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1 you think it's -- well, could I ask you to comment on  
2 whether you have any recollection when you asked for  
3 a report from Dr O'Donohoe, what you might have told him  
4 was its purpose?  
5 A. I cannot recollect what I would have said, I'm sorry.  
6 As you're aware, it's 13 years ago. My memory is not  
7 what it used to be and I'm sorry, but I'm telling you  
8 the truth, I can't remember.  
9 Q. Can I ask, from your perspective, were you looking for  
10 a report from the clinicians in order to assist with  
11 your review?  
12 A. We were trying to establish what happened, what their  
13 involvement was and what happened on the evening.  
14 Q. Yes. In terms of the work of the review which was being  
15 carried out by yourself and Mr Fee, we have it then that  
16 you considered the notes and you've mentioned some  
17 issues about that this morning, and you realised that  
18 there were certain issues. You talked to the staff and  
19 you asked for reports. Now, can I ask you whether  
20 yourself and Mr Fee discussed beyond that the strategy  
21 that you would be taking in terms of gathering evidence?  
22 A. My understanding was that we looked at the notes, we  
23 read the reports that were sent to us by the staff  
24 involved, and we decided that we were not qualified to  
25 judge on the significance of the events and that we

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1 A. No, not to my knowledge.  
2 Q. You knew that a pathologist was involved?  
3 A. We knew that there was -- we had a post-mortem report,  
4 a preliminary post-mortem report, so therefore we knew  
5 that a pathologist had been involved.  
6 Q. And at some stage you would have discovered, as  
7 I understand it, that the pathologist had met with the  
8 parents of Lucy Crawford?  
9 A. I think we discovered that subsequently, yes.  
10 Q. Was there any consideration given to approaching the  
11 pathologist for his view?  
12 A. Not in my memory.  
13 Q. Another source of evidence that would have been  
14 available to you was the parents themselves. Was any  
15 consideration given, as you started off in this process,  
16 to approaching them?  
17 A. I have no memory of us having discussed involving the  
18 parents.  
19 THE CHAIRMAN: If you were trying to get a factual account  
20 of what happened that night in the Erne, would Mr and  
21 Mrs Crawford not have been two obvious people to  
22 approach?  
23 A. I think looking back now, one could say yes, but we did  
24 not consider that at the time.  
25 MR WOLFE: And then in terms of strategy, doctor, we know

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1 that you asked for reports from the various clinicians,  
2 leaving aside whether those requests were made in  
3 writing or orally, and you realised then that in  
4 response to those requests you would be getting reports  
5 in. A decision had to be made in terms of what to do  
6 with those reports once they came in. Was there any  
7 discussion about whether staff would be the subject of  
8 follow-up interview or questioning?  
9 A. I cannot remember such a discussion.  
10 Q. In fact, we know that no such interviews took place with  
11 those who had provided reports; isn't that fair?  
12 A. None that I can remember.  
13 THE CHAIRMAN: No interviews involving this doctor?  
14 MR WOLFE: Isn't it correct to say that neither yourself nor  
15 Mr Fee interviewed any staff member who provided  
16 a written report?  
17 A. I can only speak for myself, I can't speak for Mr Fee,  
18 but I have no memory of having had interviews with the  
19 nursing staff involved.  
20 Q. And you didn't interview the medical staff?  
21 A. My discussions with the medical staff, I think, were all  
22 informal. But I have no recollection of a formal  
23 interview with them.  
24 THE CHAIRMAN: Sorry, what's the difference, doctor? I'm  
25 not sure I get the point. When you are talking about

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1 Q. Let's just look briefly at each of these reports so that  
2 I can ask you about this point. If we could have up on  
3 the screen Dr Auterson's report, please, 033-102-316.  
4 This report was produced a week after the incident.  
5 I think he's one of the first members of the team to  
6 produce a report. Did you see it, doctor?  
7 A. I have read it. Again, in my memory, I presume I must  
8 have read it at the time, but I can't swear that I did  
9 or I didn't. I assume I must have.  
10 Q. You would recognise, doctor, that it would have been  
11 within your job description, or within your obligations  
12 as a coordinator to the review to read it?  
13 A. I presume we did, yes.  
14 Q. I don't think we need to go through it, but apart from  
15 reflecting on the fact, on the first page, if memory  
16 serves me, that this child was in receipt of intravenous  
17 fluids -- yes, halfway down the page:  
18 "There was a cannula in the right hand or arm, and  
19 IV fluids were being administered."  
20 A. Yes.  
21 Q. Apart from that, Dr Auterson, the anaesthetist with an  
22 expertise in fluids, that you acknowledged earlier,  
23 wasn't troubled, it seems, to elaborate upon that;  
24 is that fair?  
25 A. Well, he didn't elaborate on it, yes.

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1 formal and informal, we're not talking about the  
2 difference between a police interview and a discussion.  
3 So if you had an informal discussion with Dr Auterson or  
4 Dr O'Donohoe, how would that be different from a formal  
5 discussion?  
6 A. What I mean by that is we may have been just in the  
7 course of conversations talking about what had happened,  
8 as opposed to me sitting down and saying, "Now we want  
9 to hear or follow up on your report. You said this,  
10 what did you mean by this?", et cetera.  
11 MR WOLFE: Well, it's that point which I want to focus on.  
12 I'm conscious, in case anybody's thinking it, that  
13 Mr Fee did carry out an interview with Sister Traynor  
14 and Nurse Swift. Sister Traynor wasn't asked to provide  
15 a report or a statement. Nurse Swift was asked before  
16 the interview to provide her statement, as I understand.  
17 But leaving those two aside, it seems to be clear from  
18 the records available to this inquiry that, as you say,  
19 you didn't carry out any interviews after receiving  
20 reports with any of the medical staff.  
21 A. That is my memory.  
22 Q. Was that a deliberate strategy or a deliberate decision?  
23 A. I don't think that was a deliberate strategy, I think we  
24 worked on the premise that we had received their reports  
25 and we wanted to have a professional expert opinion.

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1 Q. He didn't elaborate on it, that's right. But you're  
2 coordinating the review, doctor. The purpose of the  
3 review, as we understand it, was to seek to work out  
4 whether there were any acts or omissions on the part of  
5 your staff that caused this child's death; isn't that  
6 right?  
7 A. And we, having read all the reports, came to the  
8 conclusion that there was poor communication, probable  
9 excess of fluid given, and we needed further help to  
10 decide the significance of that.  
11 Q. In order to work out the significance of what had  
12 happened, you obviously had Dr Quinn, and that's no  
13 doubt of some assistance to the review. But you also  
14 had this well of evidence available to you in terms of  
15 the clinicians who treated the child; isn't that right?  
16 A. The clinicians had provided factual reports. To my  
17 memory, we didn't push them as to what their feelings  
18 were on the cause of the collapse. I think there was  
19 a general feeling that they were uncertain, I think  
20 Dr O'Donohoe communicated to us that he was at a loss as  
21 to know why the child had deteriorated.  
22 Q. Let's start with Dr Auterson. He came into the ward or  
23 into the side room at the point of resuscitation. He  
24 tells us that he had information available to him in  
25 terms of the amount of fluids that the child had

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1 received, the type of fluids the child had received and  
2 the appropriateness of those fluids. You would have  
3 expected him to have had that kind of information,  
4 wouldn't you?  
5 A. I don't know what was communicated to him when he  
6 arrived.  
7 Q. But he's going in to treat a child, doctor, in an  
8 emergency situation. You would expect such a doctor to  
9 brief himself about what had gone before in order to  
10 precipitate this situation?  
11 A. I would suspect that he and Dr O'Donohoe would have had  
12 a conversation about it.  
13 Q. And you would have asked him in terms, I suspect, to  
14 provide an account of all that he knew?  
15 A. I cannot remember what we exactly asked him to say, but  
16 I suspect it was to tell us what had happened.  
17 Q. He produced a report to you which said nothing about the  
18 fluids.  
19 A. Okay, he didn't say anything about the fluids.  
20 Q. And you would have recognised that if you had read the  
21 report?  
22 A. Right.  
23 Q. And so this review was deprived of his view of what had  
24 happened in terms of the fluid management of this child.  
25 A. I think that's the conclusion that you've drawn, yes.

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1 Q. And presumably, given that this investigation or review  
2 was focused on the issue of fluids because that's the  
3 primary issue that you'd asked Dr Quinn to focus upon,  
4 you would have seen an omission in Dr Malik's report to  
5 deal with that issue?  
6 A. What we did recognise was that there was an excess of  
7 the fluid that was intended. We didn't see that that  
8 was -- we felt that we had the information that we had  
9 requested. What fluids were administered, it turned out  
10 that there was confusion over how much had been  
11 administered against what had been ordered. It was in  
12 excess of what had been intended. And our conclusion  
13 was we need to have some professional help as to what  
14 the significance of that was. That was why we asked  
15 Dr Quinn for his opinion.  
16 Q. Tell me this, doctor, just to pick one example. Did  
17 Dr Quinn know how much normal saline had been  
18 administered after the collapse?  
19 A. Did he ... I was not party to any of the communication  
20 with Dr Quinn. I only received his report.  
21 Q. You read his report?  
22 A. Yes.  
23 Q. What did he say about the administration of normal  
24 saline after the collapse?  
25 A. He made a calculation of the total amount of fluid that

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1 Q. Well, is it a fair conclusion?  
2 A. Yes, if he had come to conclusions it would have been  
3 helpful if he had appraised us of them.  
4 Q. Well, of course it would. Why didn't you go back to him  
5 and say, "This report isn't sufficient, you should deal  
6 with the fluid issue", or alternatively ask him  
7 questions about the fluid issue?  
8 A. I think we relied entirely on the report from Dr Quinn.  
9 Q. Dr Malik provided a report. Can we have that up on the  
10 screen, please? It's at 033-102-281. You would have  
11 recognised, doctor, from the note that you had  
12 considered, the clinical notes, that Dr Malik admitted  
13 the child.  
14 A. Yes.  
15 Q. Had summoned Dr O'Donohoe to assist with IV  
16 administration at or about 10.30 in the evening?  
17 A. Yes.  
18 Q. And then was present and was responsible for changing  
19 the fluids after the collapse; isn't that right?  
20 A. That's correct.  
21 Q. And Dr Malik provides a report that makes no mention at  
22 all of the fluids.  
23 A. Right.  
24 Q. And presumably, you read his report?  
25 A. I presume we did, yes.

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1 had been given orally in the initial administration of  
2 the Solution No. 18 and then the amount of saline that  
3 was given and he came to the conclusion of the total  
4 volume. So therefore, from that, he must have worked  
5 out how much had been given of the normal saline.  
6 Q. Yes. Well, in his report, doctor, which you would have  
7 seen, said:  
8 "I am not certain how much normal saline was run in  
9 at the time, but if it was suspected that she was  
10 shocked then perhaps up to 20 ml per kilogram could have  
11 been given."  
12 The reference, sir, is 033-102-273.  
13 Now, he's expressing in his report the view that  
14 he's not sure how much has been given. He's saying that  
15 20 ml per kilogram could have been given. That would  
16 have been a safe amount to give. That's 180-odd ml as  
17 a bolus. What was this child given?  
18 A. From what I understand, it was anything from 250 to 500  
19 ml.  
20 Q. And you're not sure?  
21 A. Well, reading over these notes in the last couple of  
22 days, I saw both figures.  
23 Q. You have just told us a minute ago that you thought you  
24 had all the facts.  
25 A. We had the facts that were available to us.

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1 Q. So the facts aren't the facts if you're saying it was  
2 anything from 250 to 500 ml.  
3 A. That's what I've read in the last couple of days.  
4 Q. Of course. The point is, doctor, and I don't wish to  
5 prolong this with you, you and Mr Fee deprived  
6 yourselves of valuable evidential material by failing to  
7 go back to Dr Malik to ask him how much normal saline,  
8 just to take that example, was run into this child.  
9 Isn't that correct?  
10 A. We had a note that it was running freely and, yes, we  
11 did not go back and establish from Dr Malik exactly how  
12 much, that is correct.  
13 Q. And moreover, it was Dr Quinn's concern that too much  
14 normal saline may well have been -- could be a factor in  
15 this child's deterioration; isn't that right?  
16 A. And we felt that -- our feeling was that there had been  
17 an excess of fluid.  
18 Q. Yes. We'll come back to Dr Quinn's conclusion  
19 presently, but if we could have up on the screen  
20 briefly, to finish this sequence, 033-102-293. This is  
21 the report which you'll remember, Dr O'Donohoe provided  
22 to you in May 2000. Again, doctor, looking at the  
23 second paragraph he tells you in that paragraph what he  
24 described; isn't that right, in terms of fluid  
25 management?

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1 Q. He doesn't tell you the time at which her pupils became  
2 fixed and dilated?  
3 A. Not in the report that's in front of me, no.  
4 Q. Or elsewhere, doctor?  
5 A. There was a record somewhere, I can't remember where it  
6 was, stating that the pupils were fixed and dilated.  
7 I think it might have been Dr Auterson's report.  
8 Q. Well, was it not the purpose of your request to these  
9 clinicians for them to provide you with all of the  
10 material, all of the information known to them?  
11 A. I think putting it all together we got a more complete  
12 picture than what each individual stated in their  
13 report.  
14 Q. Can you explain to us, doctor, why an investigation  
15 would deprive itself of the opportunity of going to  
16 these clinicians to ask them to specify how this fluid  
17 mismanagement occurred?  
18 A. There was no deliberate decision to do that. We perhaps  
19 very simplistically got the information that was  
20 provided to us, we recognised as a result of that  
21 information that there was a problem with the fluid --  
22 communicating of the fluid that should have been  
23 prescribed, the fluid that was prescribed, and that the  
24 outcome from the report was that the child had developed  
25 cerebral oedema, and as a result of that information we

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1 A. He described what he thought he had -- claims that he  
2 had prescribed or thought that he had prescribed.  
3 Q. Yes. He didn't tell you what he knew had been  
4 prescribed. Sorry, he didn't tell you what he knew had  
5 been delivered to the child, did he?  
6 A. Not in that document, no.  
7 Q. In any other document?  
8 A. I cannot remember.  
9 Q. He didn't tell you --  
10 A. We had a fluid balance chart, which showed that a lot  
11 more had been prescribed than he had suggested there.  
12 Q. Yes. He didn't tell you anything about the  
13 appropriateness of providing the child with fluid  
14 outside of his prescription?  
15 A. I cannot recollect him having said that to me.  
16 Q. Well, he doesn't.  
17 A. He doesn't in that report.  
18 Q. His report is silent on that issue.  
19 A. Yes.  
20 Q. He didn't tell you anything about the fluid that was run  
21 in after the collapse?  
22 A. No.  
23 Q. He doesn't tell you the time at which blood was taken  
24 for the repeat electrolytes?  
25 A. Correct.

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1 asked for a professional expert opinion.  
2 THE CHAIRMAN: But if the information which you gather, then  
3 the report that Dr Quinn provides can't be accurate;  
4 isn't that right?  
5 A. All I can say in response to that is that we -- neither  
6 of us were paediatricians and we didn't recognise that  
7 we needed to go further. And on that issue, yes, we  
8 perhaps -- well, we didn't go into it in as detailed  
9 a fashion as has subsequently been gone into.  
10 MR WOLFE: Well, it's actually worse than the chairman  
11 suggests. Isn't it the case that these reports weren't  
12 even given to Dr Quinn?  
13 A. I don't know. I was not involved in any of the  
14 communication with Dr Quinn. I don't know what he  
15 received.  
16 Q. And indeed, his requests -- I'll put it in other terms.  
17 Where you can see in his report that he is unsure about  
18 certain things such as the amount of normal saline that  
19 had been given post-collapse, there doesn't appear to  
20 have been any attempt to further investigate that.  
21 A. Again, I had no communication at all with Dr Quinn. We  
22 received his report, we took it at face value and we  
23 concluded our review on that basis.  
24 Q. Tell me this, doctor. When these reports came in, did  
25 you sit with Mr Fee to analyse them?

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1 A. To the best of my knowledge, we sat down and we read  
2 through them together.  
3 Q. And what was the purpose of that?  
4 A. The purpose was to appraise ourselves of what had  
5 happened and to decide where we went from there.  
6 Q. Did you tool yourself with the following approach: we  
7 must look at these statements to see if all relevant  
8 information has been given?  
9 A. I cannot remember if we ... All I remember was that we  
10 felt that we needed some help.  
11 Q. Let me move on to the appointment of Dr Quinn.  
12 THE CHAIRMAN: We'd better take a break for a few minutes.  
13 Doctor, we'll back in ten minutes.  
14 (12.00 pm)  
15 (A short break)  
16 (12.15 pm)  
17 MR WOLFE: Doctor, we were moving on to look at the  
18 appointment and role of Dr Quinn. As I understand your  
19 evidence so far, it was upon considering the medical and  
20 nursing notes and records that yourself and Mr Fee  
21 identified a fluid mismanagement issue, but your  
22 uncertainty was in relation to the implications of that?  
23 A. That is correct, yes.  
24 Q. So you saw the issue, but you didn't know whether that  
25 had caused the child any particular harm?

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1 conversation between the pair of them, and the issues  
2 that he's asked to address are threefold. The  
3 significance of the type and volume of fluid  
4 administered, the likely cause of the cerebral oedema,  
5 the likely cause of the change in the electrolyte  
6 balance, was it likely to be caused by the type of  
7 fluids, the volume of fluids used, the diarrhoea or  
8 other factors.  
9 A. Yes.  
10 Q. By this stage, just looking at point 2, the likely cause  
11 of the cerebral oedema. This fact that there had been  
12 a cerebral oedema had been communicated to the Erne via  
13 the preliminary autopsy report; is that correct?  
14 A. To the best of my knowledge, that was part of the  
15 autopsy report that there was cerebral oedema, yes.  
16 Q. And this briefing note was drafted by Mr Fee, you tell  
17 us?  
18 A. That's correct.  
19 Q. It clearly poses the question whether the -- in terms,  
20 you can correct me if I'm wrong, but it appears in terms  
21 to pose the following question, whether there was fluid  
22 mismanagement, whether that contributed or caused the  
23 electrolyte imbalance and whether that was relevant to  
24 the cerebral oedema.  
25 A. Yes.

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1 A. We wanted to know the relationship between that fluid  
2 discrepancy, from what was ordered to what was given,  
3 and the outcome.  
4 Q. And it was going to be Dr Quinn's role, you tell us, so  
5 far as you envisaged, to give you and Mr Fee  
6 a professional input into the actual management of the  
7 fluids in terms of the drugs used, the quantities, the  
8 volume and the implications of all of that?  
9 A. I was not actually involved in any of the discussion  
10 with Dr Quinn. I was still involved before I went on  
11 leave. We recognised that we needed paediatric expert  
12 help to interpret the facts as they were presented to us  
13 by the reports.  
14 Q. Dr Quinn was sent a briefing. If we could have a brief  
15 look at it with you, doctor. It's 033-102-296.  
16 THE CHAIRMAN: Doctor, can you clarify for me how long you  
17 were on leave for and approximately when?  
18 A. I can't remember how long it was.  
19 THE CHAIRMAN: Okay. But you weren't away for a month or  
20 something?  
21 A. Oh no, the only time I had leave for a month was after  
22 I retired.  
23 THE CHAIRMAN: Thank you.  
24 MR WOLFE: This is the letter that went out to Dr Quinn from  
25 Mr Fee, 21 April, it followed upon a telephone

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1 Q. There's that logic to it; isn't that right?  
2 A. Yes.  
3 Q. Had you anything to do with the formulation of those  
4 issues?  
5 A. I didn't have anything to do with the letter at all.  
6 Q. You described for us the fact that you were by no means  
7 expert in this field and Mr Fee was by no means expert.  
8 A. Correct.  
9 Q. Have you any sense at all about how these issues came to  
10 be identified and formulated in that way if the two of  
11 you, if you like, were non-experts in the field?  
12 A. Well, we were not experts in the field, but we could see  
13 that the field that was administered was not the  
14 intended dosage as prescribed or as intended to be  
15 prescribed by Dr O'Donohoe, so we recognised, first of  
16 all, that there was a problem there. Secondly, we  
17 recognised that there was a free flowing drip of normal  
18 saline and that there was cerebral oedema. We knew  
19 enough to know that cerebral oedema usually comes as  
20 a result of excess fluid.  
21 Q. Yes. You've told the police, doctor, that just in terms  
22 of Dr Quinn that you'd never met the man or ever seen  
23 the man and never had any contact with him at all.  
24 A. To my knowledge, no. Interestingly, I read in his  
25 report that he worked in Durban for a couple of years.

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1 Q. Yes.  
2 A. And he says we might have met socially, but I don't  
3 remember that. I wasn't aware of that fact until I read  
4 that a couple of days ago.  
5 Q. You worked in the McCord Zulu Hospital in Durban through  
6 the mid-70s forward?  
7 A. Mid-70s until 1998.  
8 Q. And you would have been there at the same time as  
9 Dr Quinn was working at the King Edward VIII Hospital in  
10 Durban?  
11 A. Correct.  
12 Q. And he says in his witness statement that he may have  
13 met you at social functions during that period.  
14 A. I don't -- I can't imagine which social functions he had  
15 in mind. The King Edward VIII Hospital was a major  
16 university hospital. His department and my department  
17 had no gatherings together. If we met, I have no  
18 recollection of it at all.  
19 Q. Dr Quinn has told the inquiry, indeed has told the  
20 police during interview, that in terms of his input to  
21 the review he was expressing certain restrictions or  
22 certain reservations. He wasn't going to be  
23 interviewing staff, he wasn't going to want to meet  
24 parents, he wasn't going to be preparing a report or  
25 getting involved in any complaints procedure or

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1 2 May. Let's look at the note of that. It's  
2 033-102-287. The context for this meeting, doctor, it  
3 seems, is that Dr Quinn had been provided with the  
4 medical notes and records.  
5 A. Yes.  
6 Q. And this was, if you like, a preliminary conversation  
7 with him on the telephone, obviously, and it appears to  
8 be Mr Fee's note of it. Is this a note that you would  
9 have seen?  
10 A. I'm not aware of having seen that.  
11 Q. As the appendix number on the top right suggests, it was  
12 included as one of the appendices on the review report  
13 that was put together by Mr Fee to which you  
14 contributed.  
15 A. If it was, then that could be the case. I cannot swear  
16 that, yes, I saw it or, no, I didn't see it.  
17 Q. Just before leaving this, you will see as one reads  
18 down, certain conclusions and/or certain questions. So  
19 number 1 hasn't been posed as a question, but it  
20 reflects an uncertainty:  
21 "Difficult to get a complete picture of the child."  
22 Then a more definite conclusion at 2:  
23 "Type of fluids appeared appropriate. The amount  
24 given would be dependent upon the level of  
25 dehydration ..."

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1 medico-legal procedure. As I understand it, those kinds  
2 of reservations were not expressed to you?  
3 A. I was unaware of those.  
4 Q. In any event, it seems that he wasn't being asked to  
5 perform any of those tasks; is that fair?  
6 A. I was not aware of what he was being asked to do other  
7 than what I've read and the pages in front of us.  
8 Q. Is it fair to say, doctor, that you didn't have any  
9 sense of how Dr Quinn was going to perform his tasks on  
10 behalf of the review?  
11 A. All I knew was that Mr Fee and I had requested that  
12 we have expert opinion. The next thing I knew was that  
13 we had this report from Dr Quinn.  
14 Q. So the fact that he didn't receive the reports from the  
15 staff such as they were --  
16 A. I was unaware of that.  
17 Q. Myself suggesting that to you this morning, is that the  
18 first --  
19 A. I was unaware of what information he was given. I was  
20 just -- I went on leave, us having made the request that  
21 we needed paediatric expert help. And when I returned,  
22 I was presented with Dr Quinn's report.  
23 Q. And you don't know how he had performed his task?  
24 A. I had no communication with him at all.  
25 Q. There was a meeting between Mr Fee and Dr Quinn on

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1 Then number 3 is an issue that we will explore with  
2 Dr Quinn:  
3 "When the fluids are divided over the length of  
4 stay, the child received approximately 80 ml per hour."  
5 But not to go through all of them because it's not  
6 a document you recall seeing. It appears clear, doctor,  
7 that there were some uncertainties on the part of  
8 Dr Quinn:  
9 "7. Did the child have a seizure or was it rigid,  
10 a symptom of coning?"  
11 When we draw all this together and I take you  
12 through the various stages of this process, the question  
13 of what happened at or about 3 o'clock and thereafter  
14 remained uncertain. So the question is raised here,  
15 what happened at 3 o'clock, and that's a point that's  
16 still left unresolved by the time of his final report.  
17 It was an issue that might have been addressed with the  
18 mother of the child, who was with the child at the  
19 material time. Can you recall, doctor, whether, in your  
20 discussions with Mr Fee, this issue was discussed?  
21 A. I don't remember us discussing it. We recognised that  
22 there was some seizure, for want of a better word, had  
23 happened. The significance of it, Dr Quinn identified  
24 in some things that I've read, could have been either as  
25 a result of coning or some other factor. We were not

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1 qualified to know the significance of whether it was  
2 a seizure or whether it was a fit, whether it was  
3 a rigidity, we didn't know the significance of the  
4 differences.  
5 Q. One of the issues might have been whether what happened  
6 at 3 o'clock was akin to a febrile convulsion and  
7 whether what happened thereafter led to hypoxia, which  
8 might have had an impact on the brain, coupled with the  
9 infusion of this very significant amount of normal  
10 saline. That was an issue that appears to have been  
11 posed.  
12 A. I have read that subsequently, but the significance of  
13 that would have been lost on us.  
14 Q. Perhaps we'll come back to it. The other issue at  
15 number 9 he's posing as a question:  
16 "Was the resuscitation adequate?"  
17 In other words, did she get sufficient oxygen in  
18 time, I suspect, is what lies behind that question.  
19 Again, that is something that might have been resolved  
20 by going to the doctors.  
21 A. I would suspect that the doctors would have said they  
22 did everything that was within their power to do.  
23 Q. How much normal saline was run in, number 10. If 500 ml  
24 was given, this may have affected the level of cerebral  
25 oedema experienced at post-mortem, number 11. I'm

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1 more than the 20 ml per kilogram, which might have been  
2 appropriate if there was shock?  
3 A. Again, we -- our memory of it was we thought she had had  
4 an excess of fluid.  
5 Q. At the bottom of the page you'll see a footnote, which  
6 purports to answer the question, but there remains  
7 a question in terms of whether that was reported to  
8 Dr Quinn, whose report, as I say, ultimately expresses  
9 uncertainty about the amount of normal saline run in.  
10 THE CHAIRMAN: Doctor, you see the footnote at the bottom of  
11 the screen?  
12 A. Yes.  
13 THE CHAIRMAN: That appears on the face of it to be  
14 a footnote added after the conversation between Mr Fee  
15 and Dr Quinn.  
16 A. Mm-hm.  
17 THE CHAIRMAN: And if that's right and if Mr Fee obtained  
18 that advice from nursing staff, is there anybody else  
19 who he might have asked about how much normal saline was  
20 administered to Lucy between 3.15 and 4 am?  
21 A. From what I can see from having just re-read the notes  
22 in the last few days given to me, one person says it was  
23 running freely, Dr O'Donohoe said that it was almost  
24 completely run in, so there seems to have been some  
25 confusion in the amount that had actually been

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1 raising these issues with you now, doctor, because  
2 you'll see when we go all the way round the circle to  
3 the final report that some of these issues remain  
4 unresolved.  
5 A. We were of the opinion that probably the child had been  
6 given too much fluid.  
7 Q. Yes. And if she had been given 500 ml, this may have  
8 affected the cerebral oedema is what we have here. We  
9 know from the record that you say you hadn't seen, we  
10 know for example from what Dr O'Donohoe was able to put  
11 into his coroner's statement or deposition in 2003 that  
12 500 ml had been run in. And yet, as again we'll  
13 probably come on to this in a bit more detail in  
14 a moment -- but yet in the final report, this issue  
15 that's raised here is left unresolved in the final  
16 report. And I'm asking you, was this an issue that ever  
17 troubled you?  
18 A. I think, again, I can only repeat that we felt that the  
19 child had received an excess of fluid.  
20 Q. But it doesn't answer the point, doctor, that she may  
21 well have received an excess of fluid, but was it so  
22 excessive this doctor, Dr Quinn asked was it so  
23 excessive in terms of its volume that it might have  
24 affected the cerebral oedema. So what appears to be  
25 being asked here is: did she get 500 ml, did she get

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1 administered at that point.  
2 THE CHAIRMAN: Yes. And people who might contribute to that  
3 discussion would include Dr Malik and Dr O'Donohoe.  
4 A. I seem to think that Dr Malik said he was involved in  
5 dealing with other patients elsewhere at that stage.  
6 I can't remember exactly.  
7 THE CHAIRMAN: But it's not an issue that only nursing staff  
8 could advise on?  
9 A. Dr O'Donohoe would have been there.  
10 THE CHAIRMAN: Yes, thank you.  
11 MR WOLFE: The next stage in this, doctor, is for the views  
12 of Dr Quinn to be considered further at a meeting, which  
13 took place between Dr Kelly and Mr Fee on 21 June when,  
14 as I understand it, you were on leave.  
15 A. Yes.  
16 Q. And if we could have up on the screen, please,  
17 036c-004-007. We've been advised yesterday,  
18 Mr Chairman, that this note of this conversation which,  
19 as we understand, was compiled by Dr Kelly, was intended  
20 by -- let me maybe put it another way. Dr Quinn would  
21 say that the report that he eventually provided in  
22 writing was intended to supplement what he had said  
23 orally at this meeting. And yet this note of the  
24 meeting, Dr Anderson, would not appear to have been  
25 added, in fact it wasn't added to the group of

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1 appendices that formed the back of the review report.  
2 Do you follow all that?  
3 A. Yes.  
4 Q. So there is a list of appendices that supplement the  
5 report that yourself and Mr Fee produced. They include  
6 the telephone conversation with Dr Quinn on 2 May but  
7 don't include this record of the meeting.  
8 A. Right.  
9 Q. You weren't at the meeting?  
10 A. No.  
11 Q. We know that Mr Fee supplied you with a draft report and  
12 the appendices. Did he provide you with this note of  
13 the 21 June meeting?  
14 A. I don't recognise it, so I don't -- I can't say that he  
15 did.  
16 Q. And reading through the note, he says:  
17 "The choice of fluid is correct. Resuscitation  
18 volume higher than normal."  
19 That appears to be a reference to what came after  
20 the collapse situation, the normal saline, as we've  
21 discussed.  
22 Then Dr Quinn outlines a number of figures in terms  
23 of what fluid replacement should have been given. So he  
24 calculates 40 ml for maintenance and then combining --  
25 we take it from this note -- combining maintenance with

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1 Q. But the problem is, and perhaps you have missed the  
2 point, that Dr O'Donohoe would say that his prescription  
3 was 100 ml of normal saline as a bolus, followed by  
4 Solution No. 18 at 30 ml per hour.  
5 A. I'm sorry, I understood that he had prescribed  
6 Solution No. 18, 100 ml as a bolus and 30 ml per hour.  
7 Q. That wasn't his evidence to the General Medical Council?  
8 A. Wasn't it? I don't know. That was my understanding of  
9 what he had prescribed.  
10 THE CHAIRMAN: So you didn't understand there was any  
11 difference between the initial bolus fluid which he  
12 prescribed for Lucy and the hourly fluid which she was  
13 to receive thereafter?  
14 A. The nurses obviously thought it was the same fluid.  
15 There was no question from anything that we read that  
16 the drip was changed from one solution to another.  
17 THE CHAIRMAN: It wasn't.  
18 MR WOLFE: Then as we read through it, doctor, again we're  
19 coming back to the point of the normal saline halfway  
20 down the page:  
21 "Dr Quinn notes that there was further fluids  
22 administered after the resuscitation, 250 ml normal  
23 saline."  
24 Which, read in those terms, would suggest that  
25 he had been given confirmation of precisely the amount

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1 her needs for replacement when she was dehydrated. If  
2 she was dehydrated at 10 per cent, then the combined  
3 total on his calculations would have read 80 ml per  
4 hour.  
5 It's a point for Dr Quinn to address, Dr Anderson,  
6 but where he says that the choice of fluid is correct,  
7 clearly that's an issue which the experts, which  
8 Dr MacFaul for the inquiry begs to differ with. He  
9 would say that the appropriate fluid for replacement  
10 purposes in the case of a dehydrated child is normal  
11 saline, 0.9 per cent. Is that something you would have  
12 appreciated?  
13 A. That was the very reason why we asked for the paediatric  
14 opinion. As I had stated earlier, I had never come  
15 across Solution No. 18 before. I had no idea what it  
16 contained or what was appropriate. We had Dr Quinn's  
17 report that he said it was appropriate.  
18 Q. And you weren't in a position to challenge that?  
19 A. Why would we have challenged it?  
20 Q. Is it something that you could have addressed with your  
21 own paediatrician, Dr Halahakoon?  
22 A. Well, it was prescribed by one of our own  
23 paediatricians, Dr O'Donohoe, and it was confirmed by  
24 Dr Quinn that it was an appropriate fluid. We accepted  
25 those two opinions.

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1 of normal saline run in, but which -- I'll show you in  
2 a moment. That seems to be inconsistent, this note  
3 seems to be inconsistent with his final report, and I'll  
4 bring you to that in a moment.  
5 Moving on to the next sentence:  
6 "Choice of fluid by anaesthetist was reasonable but  
7 volume high."  
8 Again, that appears to reflect the mistake on the  
9 part of those at the meeting that it was the  
10 anaesthetist Dr Auterson, who prescribed the normal  
11 saline when in fact it was Dr Malik.  
12 A. My understanding was that it was Dr Malik.  
13 Q. And he's raising the point, or the point is raised:  
14 "Could after a hypoxic incident this amount of  
15 normal saline have produced the cerebral oedema? Events  
16 remain unclear."  
17 So if I can pose this point to you, doctor. You  
18 seem to have read Dr Quinn's report not having seen this  
19 note as giving the fluid regime a clean bill of health.  
20 A. I was not -- I did not have possession of this note.  
21 Q. Whereas -- and obviously we'll hear from Dr Quinn this  
22 week -- what this note seems to suggest is that events  
23 remain unclear. In other words, he is posing a question  
24 with regard to, at the very least, the use of the normal  
25 saline, and wondering whether this could have produced

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1 or contributed to the cerebral oedema.  
2 A. I think he was questioning the volume of normal saline  
3 as opposed to the choice of normal saline.  
4 Q. Yes. The fact is or the suggestion is that the use of  
5 normal saline in excess can produce a fluid overload and  
6 may contribute to the cerebral oedema?  
7 A. I think a choice of any fluid in excess could produce  
8 cerebral oedema.  
9 Q. And again, he asks or at least somebody asks another  
10 question. Could there have been earlier seizures  
11 resulting in hypoxia for 20 to 30 minutes prior to the  
12 catastrophic seizure event, and so it goes on.  
13 Could we turn to his report, just to bring this all  
14 together, and raise some issues with you in relation to  
15 that, because that was a document you did see.  
16 033-102-270. Tell me, doctor, when you received this  
17 report, was it read in an analytical way or a critical  
18 way in order to determine whether what he was saying  
19 made sense or the alternative appears to be whether you  
20 just accepted the report as a given?  
21 A. My memory is that we accepted it as a given.  
22 Q. So if there were factual inaccuracies in it, they  
23 weren't going to be challenged by you?  
24 A. If there were, they weren't recognised.  
25 Q. If we go to page 271, please. At the top paragraph,

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1 it. I did not feel that I was a very well qualified  
2 person doing this review and if we made mistakes, yes,  
3 we did. We did it in ignorance.  
4 Q. Well, you're a professional man, no doubt of some  
5 intelligence, doctor. When it comes to briefing anybody  
6 to analyse a problem, surely the first thing to be got  
7 right is to give that person the best opportunity to  
8 arrive at safe conclusions by establishing the facts?  
9 A. The facts that we had established were that there was  
10 a miscommunication, there was an excess of fluid, the  
11 significance of it we did not know, and we asked for an  
12 opinion.  
13 Q. With due respect, doctor, that's not the answer to my  
14 question. The question being posed here is: in this  
15 context where Dr Quinn has got it wrong in terms of his  
16 interpretation of the notes, that is something that in  
17 a sense is unforgivable because you could have  
18 established the facts had you sought from the relevant  
19 clinicians a breakdown of just what had happened?  
20 A. Again, I was not aware of what documentation was made  
21 available to Dr Quinn at all.  
22 Q. Could we go over the page to 273, please? This was the  
23 point I have perhaps been drumming on about too much  
24 this morning, but this is closing the circle on it.  
25 He's saying during resuscitation it obviously became

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1 Dr Quinn is setting out the background to the history.  
2 He refers to the use of the diazepam, how there was  
3 a bowel motion and he suspects that the diazepam was  
4 then expelled. Then he says:  
5 "On reviewing the child's electrolytes in and around  
6 that time, it was decided that because the sodium was  
7 low that normal saline should be given."  
8 Do you see that?  
9 A. I see that.  
10 Q. Do you see any problem in that?  
11 A. I think it has subsequently been recognised that the  
12 normal saline had been given before the electrolyte was  
13 rechecked, so that I think we now know that the serum  
14 sodium had probably been lower than 127, but we did not  
15 recognise that at the time.  
16 Q. And do you accept the significance of that omission?  
17 A. Absolutely.  
18 Q. And it's the point I think I was making to you much  
19 earlier this morning, that had you and Mr Fee set off in  
20 a more systematic approach of obtaining from the  
21 evidential well at your disposal a chronology of what  
22 happened, you would have been in a better position to  
23 brief Dr Quinn?  
24 A. Can I remind you that we were untrained in what we were  
25 meant to be doing? It was the first time we'd ever done

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1 apparent that the child's sodium dropped to 127 and  
2 potassium down to 2.5. He's repeating the mistake of  
3 earlier, but it's the next sentence:  
4 "I am not certain how much normal saline was run in  
5 at that time, but if it was suspected that she was  
6 shocked then perhaps up to 20 ml/kilogram could have  
7 been given."  
8 And this is the point I wanted to put to you. It  
9 appears that he hasn't been able to conclude that 250 ml  
10 has been given, you know the footnote that we looked at  
11 earlier.  
12 A. Mm-hm.  
13 Q. It would appear that if he had that information, he  
14 certainly should have included it. But having read that  
15 report, doctor, and if you had known how much normal  
16 saline had been given, or Mr Fee had known, that would  
17 have been the kind of information you should have been  
18 going back to him with; isn't that right?  
19 A. Yes. Again, we failed to recognise that the repeat  
20 electrolyte test was done after a significant amount of  
21 saline had been given.  
22 Q. Yes. And his point, as we saw earlier, at the earlier  
23 notes of the telephone meeting, was that if 500 ml had  
24 been given, this might have affected the cerebral  
25 oedema. And that in fact was what was given according

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1 to a number of accounts.  
2 A. I would have thought that 500 ml of fluid to a child of  
3 that age would have been excessive and could have caused  
4 cerebral oedema.  
5 Q. And the point is that it appears that that wasn't  
6 sufficiently clarified for Dr Quinn.  
7 A. Well, my recollection was that he had the same  
8 information that we had.  
9 THE CHAIRMAN: Yes, which was -- he's saying if you look at  
10 the last sentence in the top paragraph:  
11 "I am not certain how much normal saline was run in,  
12 but if it was suspected that she was shocked then  
13 perhaps up to 20 ml/kilogram could have been given."  
14 She's a bit of 9 kilograms, so that gives you 180.  
15 Some say 180, 200 an hour.  
16 A. So she had received an excess of fluid.  
17 THE CHAIRMAN: Yes.  
18 A. Which we knew.  
19 THE CHAIRMAN: But he doesn't know. He doesn't say he  
20 knows. In fact, he says he doesn't know.  
21 A. Right.  
22 THE CHAIRMAN: So if he doesn't know, how can he give this  
23 report?  
24 A. Again, I was not aware of what documents were sent to  
25 him.

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1 in relation to the information gap. Do you follow?  
2 A. We did not pick up that discrepancy.  
3 Q. You've read Dr MacFaul's report?  
4 A. Yes.  
5 Q. He remarks critically, doctor, about the fact that you  
6 were not as engaged in this review process as you might  
7 have been.  
8 A. I think that's probably a fair comment. As I say, it  
9 was the first time I'd been involved in such a thing.  
10 I had no previous experience, I had had no training or  
11 direction in it. I followed the lead by Mr Fee.  
12 Q. It's the case that you had no contact at all with  
13 Dr Quinn; isn't that right?  
14 A. That's correct.  
15 Q. The key person who was going to advise the Trust on what  
16 happened to this child, you didn't see to it that you  
17 engaged with him?  
18 A. But my colleague had spoken to him and met with him.  
19 Q. But you weren't in a position, because you didn't engage  
20 with him at any point, you weren't there in a position  
21 to grapple with or understand what he was saying?  
22 A. That's correct.  
23 Q. You were left in a position of simply having to accept  
24 the report as it stood?  
25 A. I did, yes.

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1 THE CHAIRMAN: Okay.  
2 MR WOLFE: If you read that, doctor, he's saying the  
3 appropriate volume to give if a child is shocked is  
4 20 ml per kilogram and that totals about 180. Yet it  
5 was capable of being discovered that she had been given  
6 500 ml very quickly, and this is a report from which the  
7 Trust drew considerable reassurance and indeed  
8 demonstrated to the family or it was used to demonstrate  
9 to the family that adequate care had been given. Yet  
10 there was this information gap that could well have been  
11 filled by either yourself or Mr Fee. Can you explain  
12 why this clear call for clarification from Dr Quinn  
13 wasn't addressed?  
14 A. No, I cannot explain.  
15 Q. Is it fair to say that you simply read the report -- if  
16 we can go back to 272 of this sequence where he says  
17 at the top of the page, and here he's referring to the  
18 fluids given pre-collapse, where he's saying:  
19 "I would therefore be surprised if those volumes of  
20 fluid could have produced gross cerebral oedema, causing  
21 coning."  
22 That seems to be the main conclusion seized upon by  
23 the Trust; is that fair?  
24 A. That's correct.  
25 Q. But it ignores what he's saying at the end of his report

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1 THE CHAIRMAN: Would it also be fair to say, doctor, that  
2 although this wasn't your field, the issue about fluid  
3 management wasn't your field, that from your medical  
4 training and your general experience you might have some  
5 better idea about it than Mr Fee would have had?  
6 A. Yes, I suppose that's true, but --  
7 THE CHAIRMAN: I don't want to push that too far because  
8 you've made clear your very limited experience in  
9 paediatrics since you were a junior house doctor. But  
10 you would have some better general idea than Mr Fee,  
11 wouldn't you?  
12 A. I knew enough about paediatrics to know that dosages  
13 were very important in children, but I wouldn't have  
14 known what the specifics were.  
15 MR WOLFE: And it's fair to say, doctor, that you didn't  
16 attempt to exert any influence on the shape of this  
17 review, so for example you didn't seek to push the idea  
18 that the clinicians should be interviewed, you didn't  
19 seek to push the idea that Dr Quinn should be furnished  
20 with reports from these doctors or statements from these  
21 doctors?  
22 A. That would be correct. I think I played a very passive  
23 role in the review.  
24 Q. Do you think that's acceptable?  
25 A. I was in a learning process.

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1 Q. You moved, doctor, from passivity to some activity when  
2 you provided a short report to Mr Fee; isn't that right?  
3 A. My memory was that Mr Fee sent a draft report to me to  
4 read and to comment on and to make recommendations, and  
5 the recommendations were those that I produced.  
6 Q. If we could have up on screen 033-102-261. This is  
7 Mr Fee writing to you, 5 July. He is providing to you  
8 with this document his draft report; isn't that right?  
9 A. That's correct.  
10 Q. He reflects upon a number of things. He knows that  
11 Dr Kelly met with Dr O'Donohoe on 28 June to give him  
12 feedback on our meeting with Dr Quinn. So before the  
13 ink is dry on the review report, Dr Kelly is meeting  
14 with Dr O'Donohoe to apprise him of Dr Quinn's view;  
15 isn't that right?  
16 A. That's what I understand, yes.  
17 Q. And what Mr Fee is suggesting in the next sentence is:  
18 "Beyond the completion of this report, a meeting  
19 should be arranged again with the family to give further  
20 feedback. This meeting would probably best be attended  
21 by address, Dr O'Donohoe and Sister Traynor."  
22 A. I'm not sure that I've got the right page in front of  
23 me.  
24 Q. You should have if it's on the screen. It's the next  
25 sentence:

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1 undertaken by the Trust was identified. And it was only  
2 much later again, in January 2001, that a version of the  
3 review report, and not the final version that we have in  
4 front of us, was provided to the Crawford family.  
5 Could I ask you this, doctor: we have  
6 a recommendation that the family should be contacted.  
7 Why didn't that happen?  
8 A. I know that I passed on that recommendation to higher  
9 authorities. I suspect that I expected that to be  
10 arranged at a higher authority and I did nothing further  
11 about it myself.  
12 THE CHAIRMAN: Sorry, I'm not sure what you mean. When you  
13 say you passed on a recommendation to higher  
14 authorities, does that mean that you spoke to somebody  
15 or you wrote to somebody?  
16 A. No, the report that we made was passed from myself to  
17 Mr Fee, who then passed it on, I presume, to the  
18 chief executive officer.  
19 THE CHAIRMAN: Right. So when you say you passed on the  
20 recommendation, you're referring to finalising your  
21 report and sending it to Trust management?  
22 A. Yes.  
23 THE CHAIRMAN: Okay.  
24 MR WOLFE: As we saw a moment ago at the start of this  
25 sequence, Mr Fee was saying to you in his memo that you

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1 "We would suggest ..."  
2 The third paragraph.  
3 A. Sorry, with you now, yes.  
4 Q. This is Mr Fee suggesting that beyond the completion of  
5 the report, a meeting with the family should be arranged  
6 to give further feedback. This meeting would be  
7 probably best attended by yourself. Do you see that?  
8 A. I see that.  
9 Q. Could I maybe deal with the issue of the family now  
10 rather than having to come back to it. In the report  
11 that was finally produced after you had made certain  
12 recommendations -- and I want to deal with those in  
13 turn, but I'm taking a circuitous route. If I could  
14 have on the screen 033-102-266. One of the  
15 recommendations is that it would be appropriate for  
16 another meeting with the family to appraise them of all  
17 of the knowledge and opinions that we have at this  
18 point. This is in a meeting dated 31 July. That  
19 meeting was never arranged, was it?  
20 A. Certainly I had no knowledge of it and I had no part in  
21 it at all.  
22 Q. In fact, on 22 September 2000, some five months after  
23 Lucy's death, Mr Crawford wrote a letter of complaint to  
24 the Trust, and it was only then, according to his  
25 correspondence, that the idea that a review had been

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1 should attend the meeting.  
2 A. Yes.  
3 Q. You were the head of the directorate?  
4 A. Yes.  
5 THE CHAIRMAN: When you passed on that recommendation, was  
6 that on the basis that it was for others to meet Mr and  
7 Mrs Crawford or that you would be one of the ones to  
8 meet Mr and Mrs Crawford?  
9 A. I didn't specify who would be there, but my  
10 recommendation was that someone from the Trust should be  
11 meeting with the family.  
12 THE CHAIRMAN: Did you think it was appropriate that you  
13 would be one of the people to meet them since you were  
14 the lead in the department in which Lucy was treated and  
15 since you had played a role in the review?  
16 A. I think I expected it to be the paediatric team talking  
17 with them.  
18 THE CHAIRMAN: Thank you.  
19 MR WOLFE: So your answer is, doctor, it was for somebody  
20 else to arrange this meeting, you put down  
21 a recommendation on paper and it was up to the powers  
22 that be to facilitate that?  
23 A. I think that was my understanding, yes.  
24 Q. And nobody contacted you to say, "We're now going to  
25 facilitate this"?

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1 A. That would be correct.  
2 Q. And whose responsibility was it to facilitate it, so far  
3 as you're concerned?  
4 A. It had been passed to Trust management and I suppose  
5 naively I expected they would do something. I knew that  
6 contact had been made by health visitors and  
7 Dr O'Donohoe with the family and I presume that  
8 I expected that they would continue, but I acknowledge  
9 that that was an area in which I failed.  
10 Q. Certainly Dr MacFaul in his report would say that the  
11 onus was on you to sort this out.  
12 A. Right, well, I acknowledge that I failed in that.  
13 Q. You provided a short report in response to Mr Fee's  
14 request. If we could have a brief look at that, doctor.  
15 It's at 033-102-262. In order to put this short piece  
16 together, doctor, back to Mr Fee, what work did you  
17 carry out?  
18 A. I think I read the report which the -- the draft report  
19 which he had sent to me.  
20 Q. And you didn't seek to cross-reference it with the  
21 medical notes and records?  
22 A. Not that I can remember, no.  
23 Q. You set out a brief history of the child's situation and  
24 then you say that you found that the report by Dr Quinn,  
25 whilst helpful in the sense that it ruled out any

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1 in that the child received fluids that weren't intended  
2 for her by her treating clinician; isn't that right?  
3 A. Yes.  
4 Q. That point wasn't made in your report, was it?  
5 A. I think I should probably have concluded from Dr Quinn's  
6 report that there was no obvious gross mismanagement  
7 because he failed to -- he identified that or failed to  
8 identify that the wrong fluid was being used and he  
9 didn't ... His report was not critical of the  
10 clinicians involved, other than the failure to document.  
11 Q. You make a number of recommendations around  
12 communication issues and the importance of proper  
13 documentation; isn't that right?  
14 A. We thought that that was a very obvious conclusion to  
15 make in that I think in -- had that been done in the  
16 first place, we may not have run into the problems that  
17 we did. If the doctor involved had written his  
18 prescription, the child would have received a much lower  
19 dosage.  
20 Q. You didn't make a recommendation, doctor, in respect of  
21 the need for further investigation or enquiry into this  
22 case.  
23 A. No. I think we felt that we were passing on our report  
24 and it would be then taken to -- the fact that the cause  
25 of death had not been explained would be further looked

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1 obvious mismanagement on the part of your medical and  
2 nursing staff at the hospital, was also evidence of the  
3 fact that there was no clearly obvious explanation for  
4 the child's sudden deterioration. That's the conclusion  
5 that you drew or the inference that you drew from the  
6 report?  
7 A. That was the inference that I drew from the report.  
8 Q. And as we've established earlier, you didn't recognise  
9 that within that report were a number of, if you like,  
10 calls for further clarification?  
11 A. That is correct.  
12 Q. So you moved from a position where you were satisfied  
13 that the report hadn't established a causation between  
14 mismanagement and the child's deterioration to making  
15 a certain number of recommendations?  
16 A. My experience from my career in the past had been that  
17 in any such circumstances we were looking to see what  
18 could be done to improve the way in which we worked.  
19 The two things that became obvious to me were that there  
20 had been a failure to write down the prescription and  
21 there did not appear to be a standard protocol which  
22 would recognise that they were outside of the normal  
23 protocol.  
24 Q. Could I just pose this point to you, doctor: there was,  
25 of course, evidence of mismanagement in this case

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1 at by higher authorities, Trust management. We thought  
2 that we had taken it as far as we were capable of taking  
3 it.  
4 Q. Well, you were aware, doctor, upon reading the report of  
5 Dr Quinn that he wasn't able to establish a satisfactory  
6 or obvious explanation for the child's sudden  
7 deterioration; isn't that right?  
8 A. Yes.  
9 Q. You were also aware, doctor, that this in many respects  
10 was a limited investigation; isn't that right?  
11 A. Yes.  
12 Q. It was limited in the sense that Dr Quinn wasn't going  
13 to be speaking to your clinicians or nursing staff?  
14 A. I was not aware of that.  
15 Q. You knew from all the materials that he hadn't spoken to  
16 them presumably?  
17 A. I'm not aware that I knew whether he had or hadn't.  
18 Q. Is that right?  
19 A. Yes.  
20 Q. So you weren't aware as coordinator of this review that  
21 Dr Quinn hadn't had access to the staff?  
22 A. My colleague might have known that, but I was unaware.  
23 Q. You were also aware that there were other sources of  
24 evidence out there such as the parents, the clinicians  
25 at the Royal Victoria Hospital?

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1 A. To the best of my memory, we had not considered that.  
2 Q. Dr Asghar was another source of evidence that wasn't  
3 tapped into, if you like, as part of this review?  
4 A. Dr Asghar, I think, wrote his letter of complaint to  
5 Dr Kelly and I was copied in on that.  
6 Q. Mr Mills.  
7 A. Was it to Mr Mills? Okay. I was aware of the fact that  
8 Dr Asghar and Dr O'Donohoe had a very poor working  
9 relationship.  
10 Q. Yes.  
11 A. As a result of that, his allegation against  
12 Dr O'Donohoe, I spoke with Dr Halahakoon, who was the  
13 senior to both of them, and I was reassured by her that  
14 she felt that Dr Asghar was trying to harm Dr O'Donohoe,  
15 that she did not feel that Dr O'Donohoe was incompetent.  
16 I knew that it was then being taken up by Dr Kelly, who  
17 in turn took it on to the Royal College to examine  
18 Dr O'Donohoe's competence, and that included the case of  
19 Lucy Crawford.  
20 Q. You were aware that Dr Asghar was making the allegation  
21 that this child in the context of having a cerebral  
22 oedema had been given too much fluid?  
23 A. I can't remember the exact details of his allegation,  
24 but I was aware of the fact that he was critical of  
25 Dr O'Donohoe's management.

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1 A. I think looking back, I would say that that is probably  
2 the case, but I did not recognise that at the time.  
3 MR WOLFE: And then it would be appropriate for another  
4 meeting with the family, which is the recommendation  
5 that found its way into the final report, which I'm  
6 going to move on to now. But doctor, apart from taking  
7 steps to adjust the documentation around prescriptions  
8 for fluid management, which I understand was addressed,  
9 two of the key recommendations from this report, which  
10 might have involved having to talk out loud about what  
11 happened, didn't take place.  
12 A. I think that's probably the case, yes.  
13 Q. And was there any sense, doctor, that there was  
14 a reluctance to talk out loud about this case for fear  
15 of what it might reveal?  
16 A. I'm not aware whether there was a reluctance or not.  
17 Q. Can you explain how these two important recommendations  
18 didn't find their way into being activated?  
19 A. All I can say is I think we failed.  
20 Q. Can you explain why you failed or why the organisation  
21 failed?  
22 A. I think it probably reflects my reluctance to get very  
23 involved with the paediatric department and my  
24 reluctance to have been involved in this review in the  
25 first place.

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1 Q. Yes. In terms, doctor, however, you were left with  
2 uncertainty about the cause of this child's death. You  
3 were aware that there was further evidence out there  
4 that could have been tapped into, but you felt it wasn't  
5 within your line of responsibility to make  
6 a recommendation for further investigation?  
7 A. I was aware of the fact that my knowledge of the  
8 paediatric management concerned was limited, that  
9 I had -- we had asked for an opinion and which  
10 simplistically or naively we took at face value.  
11 Q. If we could perhaps go over the page. You made two  
12 further recommendations, doctor, outside of the  
13 communications prescription protocol issue. One was  
14 that all team members involved in the care of the child  
15 on the night in question would benefit from a joint  
16 meeting and discussion of this report and findings. Did  
17 that meeting take place?  
18 A. I was aware of the fact that the paediatric department  
19 had regular weekly meetings and that ... I assumed,  
20 perhaps incorrectly, that that would be discussed at  
21 that, having made the recommendation.  
22 THE CHAIRMAN: Would it not have been entirely appropriate  
23 for you as the head of that department, at least by  
24 being present, to signify the importance of that  
25 meeting?

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1 Q. The review went higher up the chain to the management  
2 hierarchy, isn't that right? It was sent to Mr Mills;  
3 is that correct?  
4 A. I assume that. I passed it on to Mr Fee and I was  
5 unaware of what happened to it after that. I assume  
6 that it went to the Trust management.  
7 Q. Did you receive any feedback from them?  
8 A. I didn't.  
9 Q. There does seem to be -- and we can look at this with  
10 each of the witnesses, but there does seem to be this  
11 black hole into which this report entered. I'm not  
12 aware of any description of what happened to the report  
13 in terms of discussion of it after it left your desk or  
14 after it left Mr Fee's desk. Hopefully I haven't  
15 mischaracterised the position. But can you help me at  
16 all or help the inquiry at all in terms of what happened  
17 to the report after it left the desk of you or Mr Fee?  
18 A. I can't help you because I don't know. I was asked to  
19 make my recommendations, which I did, I passed it back  
20 to Mr Fee and after that I heard nothing. I was aware  
21 of the fact that there were ongoing developments at  
22 a higher level with the medical director, the  
23 chief executive officer and various people in the  
24 Western Health Board, but I was not involved in any of  
25 them and I was not contacted any further.

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1 MR WOLFE: Sir, I see the clock. I think I have probably  
2 about 20 minutes to 30 minutes.  
3 THE CHAIRMAN: Doctor, I hope you don't mind coming back.  
4 We'll adjourn until 2 o'clock and have your evidence  
5 finished fairly soon thereafter.  
6 (1.20 pm)  
7 (The Short Adjournment)  
8 (2.00 pm)  
9 (Delay in proceedings)  
10 (2.10 pm)  
11 MR WOLFE: Good afternoon, doctor. Could I take you almost  
12 finally to the actual report that was produced. The  
13 cover page is 033-102-264. In terms of the drafting of  
14 that report, doctor, it contains the recommendations  
15 that formed part of your short report: isn't that right?  
16 A. That's correct.  
17 Q. But otherwise, is the report the work of Mr Fee?  
18 A. My memory of it was that that was produced by Mr Fee,  
19 passed on to me, with a request that I look at it, make  
20 any amendments that I thought needed to be made and make  
21 any recommendations, most of which I think I drew out of  
22 the report itself.  
23 Q. So in that way then the report became, if you like, the  
24 joint authorship of yourself and Mr Fee?  
25 A. Yes. It was drawn up by Mr Fee, I was asked to comment

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1 having been understood or misunderstood. We felt that  
2 had Dr O'Donohoe written what he intended, that  
3 Lucy Crawford probably wouldn't have died, and therefore  
4 we concluded that we had identified the main problem.  
5 THE CHAIRMAN: I'm sorry, doctor, I don't understand that.  
6 I don't understand how -- well, what was the root cause  
7 of Lucy's death?  
8 A. We felt that it was -- we understood that Dr O'Donohoe  
9 thought that he had ordered a certain regime. That  
10 regime was misunderstood by the nursing staff and was  
11 not adhered to, as a result of which Lucy's condition  
12 deteriorated and she subsequently had this episode and  
13 died.  
14 THE CHAIRMAN: Is that what Dr Quinn concluded? If Dr Quinn  
15 didn't conclude that, how did you and Mr Fee conclude  
16 it?  
17 A. I think that was my thinking.  
18 THE CHAIRMAN: But does Dr Quinn say that the root cause  
19 is that Lucy received too much fluid?  
20 A. I can't remember whether that was what he said.  
21 My thinking was that Lucy had received too much fluid.  
22 We, I think, subsequently know that she received too  
23 much of the wrong fluid, but we did not know that.  
24 THE CHAIRMAN: No, in fact he said on the contrary, he said  
25 the fluid was appropriate.

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1 or adjust as I thought necessary.  
2 Q. Tell me, before finalising the report, what work, if  
3 any, did yourself and Mr Fee carry out in terms of  
4 discussing the overall findings?  
5 A. I cannot remember what we would have done. I'm not sure  
6 that we met after that was drawn up. Although we did  
7 have regular monthly meetings as a matter of routine in  
8 our ongoing management positions.  
9 Q. You don't seem to be able to recall, doctor, and correct  
10 me if I'm wrong, any meeting at which you and Mr Fee sat  
11 down and sifted through the evidence and highlighted any  
12 points that might have been of concern or any issues  
13 that needed to be followed up.  
14 A. I cannot remember us having done that. We may have, but  
15 I can't remember.  
16 Q. Dr MacFaul in his report criticises the apparent absence  
17 of analysis between the two of you, between yourself and  
18 Mr Fee. In other words, he's saying if this has been  
19 coordinated properly, you should have sat down together  
20 and, given all the evidence, discussed any  
21 inconsistencies or any issues that might have emerged?  
22 A. I can only say that I think we were ill-equipped to do  
23 the report in the first place. We thought we had  
24 identified the root cause of the problem and that was  
25 the failure to communicate and the wrong prescription

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1 A. Yes.  
2 THE CHAIRMAN: So he was advising you that she had received  
3 the appropriate fluid. Is that right?  
4 A. He also though, I think, did identify that there was  
5 a problem with the amount of fluid given, although there  
6 was this confusion over the exact amount.  
7 THE CHAIRMAN: You see, if we bring up 033-102-272, and  
8 Mr Wolfe took you to this this morning, if we look  
9 at the top of the page, three lines down:  
10 "I would therefore be surprised if these volumes of  
11 fluid could have produced gross cerebral oedema causing  
12 coning."  
13 A. Yes.  
14 THE CHAIRMAN: So where does Dr Quinn say in his report that  
15 the root cause of the problem is that Lucy received too  
16 much fluid?  
17 A. Perhaps we misunderstood it, but my understanding was  
18 that Lucy had died because there was a miscommunication  
19 between the consultant and the nursing staff, as  
20 a result of which Lucy did not receive the fluid that  
21 Dr O'Donohoe had intended. That was my understanding.  
22 And as a result of that, we produced the recommendation  
23 that in future prescriptions should be written down and  
24 balanced against recognised protocols.  
25 THE CHAIRMAN: I don't have any difficulty with that because

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1 I understand that it is a clear recommendation that from  
2 now on, there should be clearer communication of  
3 prescriptions and that they should be written by the  
4 likes of Dr O'Donohoe so that there's no mistaking what  
5 the prescription is. That's one thing and that's an  
6 entirely appropriate recommendation. But I don't see  
7 anywhere in Dr Quinn's report that he attributes Lucy's  
8 death to this inadequate communication between doctor  
9 and nurse.  
10 A. Well, that was my understanding. It may not have come  
11 from his report, but --  
12 THE CHAIRMAN: Can you see anywhere in his report where he  
13 says anything like that? He seems to be saying in this  
14 page that's on screen that the volume of fluids that she  
15 received, he doesn't think they could have produced the  
16 cerebral oedema.  
17 A. That statement certainly confused and misled us because  
18 we thought it was the volume of fluid that had caused  
19 the cerebral oedema. That was my understanding.  
20 I thought that it was the volume of fluid that she had  
21 received that had caused the cerebral oedema.  
22 MR WOLFE: If I can take that up. You have said in your  
23 report back to Mr Fee, we looked at this earlier, that  
24 Dr Quinn had ruled out any obvious mismanagement on the  
25 part of nursing and medical staff. That was your

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1 talking about you, it was the volume of fluid that  
2 caused the problem?  
3 A. Right. If you had taken me aside and pinned me down and  
4 said, "What do you think caused Lucy's demise?", I would  
5 have replied, "As far as I can see, it looks like the  
6 volume of fluid". Now, that was not corroborated by  
7 Dr Quinn's report, so therefore I could not change or  
8 did not change what we had said. But my own personal  
9 thinking was that I thought it was the volume of fluid.  
10 Q. And presumably you shared your, if you like, your  
11 instinct or suspicion with Mr Fee?  
12 A. I presume -- I'm sure we would have.  
13 Q. And did he share his with you?  
14 A. I can't remember the details of our conversations, but  
15 I would have thought that we probably did agree that,  
16 but I can't speak for what he was thinking.  
17 Q. Well, put it this way. If he said back to you, "You're  
18 talking nonsense, Dr Anderson, I really think that's  
19 a far-flung idea", it would have jarred with you?  
20 A. It would have jarred, yes.  
21 Q. And you don't have that sense of that jarring?  
22 A. No.  
23 THE CHAIRMAN: Let me put it more gently than that. If  
24 he had said to you, "I can understand why you think  
25 that, but we went to Murray Quinn because he's

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1 understanding of what Dr Quinn was saying.  
2 A. Yes.  
3 Q. But what you're telling us is that yourself and Mr Fee  
4 had a significantly contrary view, which was that the  
5 fluids were the underpinning cause of the death?  
6 A. Well, I can't speak for Mr Fee, but that was my  
7 thinking, was that it was the volume of fluid. I did  
8 not know enough about the type of fluid, but my thinking  
9 was that the volume of fluid was the major factor.  
10 THE CHAIRMAN: So although Dr Quinn appears to say to the  
11 contrary and although you've told me earlier that you  
12 accepted Dr Quinn's opinion, because you had gone to him  
13 for this expert opinion in the first place, your view  
14 remained that Lucy died because she received excessive  
15 fluid?  
16 A. Well, I was in no position to disagree in a report with  
17 what Dr Quinn had said because I didn't have the  
18 qualifications, but my own thinking was that the volume  
19 of fluid was the major factor. But since Dr Quinn had  
20 not identified that or corroborated that, I did not  
21 therefore include that in -- or change the report that  
22 Mr Fee passed on to me.  
23 MR WOLFE: Sorry to push you on this, doctor, but if you can  
24 be specific, please do. What do you mean when you say  
25 it was so far as you were concerned, and we're just

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1 a paediatrician and he says that's not what caused it,  
2 therefore we have to go with him", according to what  
3 you have just told me, if that's the sort of  
4 conversation that you had, then you and Mr Fee would  
5 have been providing a report on your review, based on  
6 Dr Quinn's report, with which each of you instinctively  
7 disagreed?  
8 A. I would have said that while that was my thinking, I was  
9 unqualified, so therefore I had to bow to the expert  
10 opinion of Dr Quinn, who did not imply that that was the  
11 problem. So therefore, I would have concluded that  
12 I was wrong, but that was my initial thinking, that the  
13 volume of fluid was the problem.  
14 THE CHAIRMAN: Thank you.  
15 MR WOLFE: Did you consider whether you had any obligation  
16 to report your thinking to the coroner?  
17 A. No, I did not have such a view at all. We were not --  
18 I don't even know that we considered the coroner being  
19 involved because the patient had died in the Royal  
20 Victoria Hospital and our understanding was it was they  
21 who notified the coroner. But, no, we did not think of  
22 doing that.  
23 Q. Well, the thoughts that you have shared with us this  
24 afternoon in terms of the fluids being to blame, did you  
25 discuss that with anybody else in the hierarchy at the

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1 Trust? For example, the medical director, Dr Kelly had  
2 a contribution to make to this review. Was he informed  
3 of your view?  
4 A. No. That was purely my thinking, which I assume I would  
5 have shared with Mr Fee. We felt that we were -- our  
6 initial conclusion was not corroborated by Dr Quinn, so  
7 therefore we didn't push it any further.  
8 Q. Could I ask you about a number of portions of the report  
9 that was produced. Could I take you to  
10 page 033-102-266. Under the heading "Level of  
11 Description of Event":  
12 "Retrospective notes have been made by nursing and  
13 medical staff."  
14 And we know that, that information formed part of  
15 the appendix to the review. It says:  
16 "With the exception of Nurse McCaffrey's report,  
17 little detailed descriptions of the events are recorded  
18 and no account appears to be in existence of the  
19 mother's description, who was present and discovered  
20 Lucy in this state."  
21 Do you see that?  
22 A. Yes.  
23 Q. Why was this report finalised, recognising that there  
24 was this information gap, when in fact something quite  
25 easily could have been done to remedy that, the parents

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1 paragraph 2 is that there is little detailed description  
2 of the event and no account of the mother's description,  
3 do you really need hindsight to say, "We should have  
4 asked Mrs Crawford"?  
5 A. I think our thinking at the time was that the damage had  
6 already been done by then.  
7 THE CHAIRMAN: Then why does the level of description of the  
8 event matter? If the damage has already been done, why  
9 does the description of the event after the damage has  
10 been done matter a jot?  
11 A. Um ... I don't think we considered the implications of  
12 the details. We recognised that there was something  
13 drastically wrong at that stage, the child had had some  
14 sort of a seizure, I think we took that as it was given.  
15 MR WOLFE: But it matters, doctor, because when Dr Quinn  
16 compiled his report, and the reference is 033-102-272,  
17 it matters because he says that it's very difficult to  
18 say what happened in or around 3 o'clock:  
19 "It is certainly possible [he said] that she had  
20 a seizure and may even have had a period of time when  
21 she was hypoxic before medical attention was drawn to  
22 the fact that she was unwell."  
23 And he says he cannot say that this is the case.  
24 He says:  
25 "It may be that the mother informed the ward staff

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1 could have been approached?  
2 A. Yes. I can't account for that, that we did not discuss  
3 that and we did not seem to consider it.  
4 Q. This is one of the issues that Dr Quinn had raised as  
5 far back, I recall, as the telephone meeting as 2 May,  
6 and it comes up again in his final report, what exactly  
7 happened around the 3 am mark.  
8 A. Yes. Well, as you know, I was not involved in that and  
9 Mr Fee did not communicate to me, to the best of my  
10 memory, that there was a serious doubt about the exact  
11 happening. We assumed -- I think we took it as read  
12 that the child had had some sort of a seizure.  
13 Q. But you'd have read this report and identified this  
14 issue, presumably?  
15 A. I read this report, yes.  
16 THE CHAIRMAN: Doctor, let me just spell this out. When you  
17 were asked by Mr Wolfe about why this issue hadn't been  
18 raised with the mother and you say, "I can't account for  
19 that", in terms are you accepting that it was wrong not  
20 to speak to Mrs Crawford?  
21 A. Looking back, yes, I think it was. We didn't consider  
22 at the time. With the benefit of hindsight, we could  
23 have learnt more.  
24 THE CHAIRMAN: But since this paragraph is "Level of  
25 Description of Event", and the point which is made in

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1 immediately she noted the problems."  
2 So in terms of getting clarity on exactly what the  
3 child -- what deterioration process she went through,  
4 this is one of the issues that he was raising.  
5 A. Which we failed to highlight and pursue further.  
6 Q. Could we move over the page, please, to 267? Under  
7 the heading "Communications", the point is made:  
8 "The main communication issue identified within this  
9 review was the confusion between all those concerned  
10 in relation to the intended prescribed dosage of  
11 intravenous fluids. The record shows that  
12 Dr O'Donohoe's intention or recollection was that ...  
13 While the nursing staff held a clear view that the  
14 expressed intention was to give 100 ml hourly until Lucy  
15 passed urine. Furthermore, this was considered by the  
16 nursing staff interviewed to be a standard approach in  
17 such circumstances."  
18 And I think what is meant by that, doctor, and you  
19 explain this in a police interview -- I should say,  
20 sorry, Mr Fee had spoken to Sister Traynor, isn't that  
21 right?  
22 A. I understand that he did.  
23 Q. And she has been recorded as saying, albeit she  
24 vehemently disagrees with the accuracy of the recording,  
25 that 100 ml per hour in a child of that condition would

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1 not be unusual. Do you follow?  
2 A. Yes.  
3 Q. So what seems to be said here is that although there was  
4 a fluid error in that the child got more than what the  
5 prescribing clinician intended, it was all okay because  
6 she was only getting what would have been quite common  
7 to give anyway. Is that the sense that we are to make  
8 out of that?  
9 A. Yes. And I seem to remember that we found that  
10 confusing.  
11 Q. Well, is it not confusing on a number of levels? First  
12 of all, if this child was getting -- if the prescription  
13 was to give the child 100 ml an hour until she passed  
14 urine, you would have seen evidence in the notes that  
15 she did pass urine shortly after the intravenous fluids  
16 commenced.  
17 A. I did not see that evidence. We saw that she had had  
18 a loose, watery stool.  
19 Q. On the fluid balance chart, she was recorded as having  
20 a damp nappy at about 11 o'clock.  
21 A. Which I thought was due to the -- my understanding was  
22 that we thought it was due to the diarrhoea that the  
23 child was having.  
24 Q. In any event, doctor, I know you can't comment on the  
25 exchange between Sister Traynor and Mr Fee because you

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1 "A number of issues arose in respect of our link  
2 with the regional services in this case."  
3 And that's a reference to the Royal Belfast  
4 Hospital, I think. Is that right, doctor?  
5 A. I presume so.  
6 Q. "These included the arrangements to support the transfer  
7 of such patients, the need for greater communication  
8 between the local hospital and the regional hospital in  
9 respect of feedback which is to be given to parents in  
10 such instances."  
11 Could I just stop there. If this was being  
12 identified as a problem, what feedback is being given to  
13 parents? What was to stop you or Mr Fee from postponing  
14 the publication or finalisation of your report and going  
15 back to the Royal to establish with greater clarity or  
16 with some clarity just what was being said to the  
17 parents in terms of feedback?  
18 A. Well, all I can say is I don't think that we considered  
19 that.  
20 Q. Moreover, doctor, the report at that section bemoans the  
21 significant time delay in getting access to the final  
22 post-mortem report. Do you see that?  
23 A. Yes.  
24 Q. That's a post-mortem report that was available at the  
25 time of the conclusion of this report; isn't that right?

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1 weren't present, but what appears to have happened  
2 is that a view has been taken from her to justify the --  
3 or to otherwise mitigate the fluid error so that what is  
4 originally classed as a mistake becomes not so much of  
5 a problem because it was, according to what is suggested  
6 here, a standard approach in the circumstances.  
7 A. And yet Dr O'Donohoe himself recognised that the fluid  
8 that was given was excessive.  
9 Q. Yes.  
10 A. So therefore that would conflict with what  
11 Sister Traynor is reported to have said, which she  
12 didn't say to me.  
13 Q. And that's the point I would come back to. As one of  
14 the authors of the report, somebody, and that's Mr Fee,  
15 saw fit to go to Sister Traynor, who wasn't responsible  
16 for caring for this child, to seek an explanation, yet  
17 nobody saw fit to go to the prescriber to seek to  
18 understand whether this was a standard approach in the  
19 circumstances.  
20 A. I think it would have been a standard approach, he would  
21 probably have acknowledged that, but he vehemently  
22 claimed he prescribed a lower dosage.  
23 Q. Could I move over to the next page of the report,  
24 please. Under the heading "Linkage with the Regional  
25 Centre":

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1 A. I'm not sure what you're asking.  
2 Q. It was available. The final post-mortem report was  
3 available to be read by you at the time just before the  
4 conclusion or the publication of this report.  
5 A. I can't remember, but, yes, if you say so, I can't argue  
6 with that.  
7 Q. Yes, in fact you say, doctor, that while you recognise  
8 that the post-mortem report was available, you haven't  
9 seen it. Why didn't you make it your business to read  
10 the post-mortem report if you were analysing, as  
11 I assume you were, what happened to cause this child's  
12 death?  
13 A. I cannot remember whether I was given verbal information  
14 it, but if I said I didn't see the report, I didn't see  
15 the report. I may have had it reported to me verbally.  
16 Q. If we could have on the screen, please, 033-102-262.  
17 This is your report back to Mr Fee. You say in the  
18 first sentence:  
19 "Having read through the review, including all of  
20 the reports received, I do not have the final report of  
21 the post-mortem and therefore have not seen it."  
22 But Mr Fee had notified you that the report was  
23 available.  
24 A. I can't remember the ...  
25 Q. And I think you've told us already, doctor, that after

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1 submitting this report, you neither sought feedback or  
2 obtained feedback from management who --  
3 A. That is correct.  
4 Q. -- it was sent to. Could I ask you about some  
5 developments briefly that happened after the publication  
6 of this report or the service of this report to  
7 management. You were aware through your contacts with  
8 Dr Kelly that the Royal College of Paediatrics and Child  
9 Health were going to carry out a review in respect of  
10 Dr Jarlath O'Donohoe's conduct?  
11 A. Yes.  
12 Q. And that was sparked in many respects by the complaint  
13 that had been raised by Dr Asghar?  
14 A. Yes.  
15 Q. Now, you have told the inquiry that you didn't receive  
16 the Royal College report.  
17 A. That is correct.  
18 Q. Is that correct, doctor?  
19 A. Well, I do not recall having seen it.  
20 Q. Could I have up on screen, please, 116-038-004 and 005.  
21 This, doctor, is one of your interviews with the PSNI,  
22 and towards the bottom of the left-hand page, you are  
23 discussing this whole sequence of events leading up to  
24 the Asghar letter. You say:  
25 "In this Lucy Crawford case [and three other

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1 A. But I can't remember what was the understanding at the  
2 time.  
3 MR WOLFE: Sir, I have no further questions.  
4 THE CHAIRMAN: Mr Quinn, no? Any questions from the floor?  
5 No?  
6 Doctor, thank you very much for your time. I'm  
7 grateful to you for coming along. You don't have to say  
8 anything more and you shouldn't feel any obligation to  
9 do so, but if there is anything more you want to finish  
10 with before you leave the witness box, you're free to do  
11 that.  
12 A. Sir, my only other comment was that I have tried to  
13 answer every question as honestly as I can. I have not  
14 attempted to hold anything back. I apologise that my  
15 memory is not as clear as it would have been many years  
16 ago. At the time, we thought that we had carried out  
17 our review. It had obviously transpired, very obviously  
18 today, that we could have done a lot better.  
19 I came across a statement by my colleague, Mr Fee,  
20 which I agree with entirely, when he was asked did we  
21 think that we had done it correctly, and he said:  
22 "I am not now satisfied with the review we conducted  
23 or the conclusions we reached, given the findings of the  
24 inquest. On reflection, we should have involved the  
25 family at the outset. The review should have been

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1 patients were mentioned] I recall discussing it with  
2 Dr Kelly and he decided to call in the Royal College and  
3 I agreed. They were brought in by Dr Kelly. I got  
4 a copy of the report hereafter but was not present at  
5 any of the interviews with those concerned."  
6 A. Right, I had forgotten that, I'm sorry.  
7 Q. Right. There were two Royal College reports.  
8 A. I understand so.  
9 Q. And the second of their external reviews involved  
10 interviewing people. So did you get both the first and  
11 the second reports?  
12 A. I cannot remember.  
13 Q. Can you recall the conclusions of the reports being  
14 discussed with you?  
15 A. I can recall the fact that Dr O'Donohoe was not  
16 considered to have been incompetent to the point that he  
17 should have been suspended from work. That's the only  
18 detail that I can remember.  
19 Q. Can you recall any discussion in relation to what the  
20 Royal College was saying about what might have caused  
21 Lucy's death?  
22 A. I cannot remember the details. I think I have  
23 subsequently read that they were concerned with fluid  
24 management.  
25 Q. Yes.

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1 conducted using a more systematic approach, such as root  
2 cause analysis. The team selected would probably have  
3 been benefited from the inclusion of a paediatrician and  
4 an experienced paediatric nurse and perhaps the medical  
5 director. We probably relied too much on the external  
6 opinion without having the expertise to examine the  
7 opinion offered. The case should probably have been  
8 jointly reviewed or investigated by the two hospitals  
9 involved in Lucy's care."  
10 And I would agree entirely with what Mr Fee has said  
11 there.  
12 THE CHAIRMAN: Thank you very much indeed, doctor. You are  
13 free to leave. Thank you for your time.  
14 (The witness withdrew)  
15 DR IAN CARSON (called)  
16 Questions from MS ANYADIKE-DANES  
17 MS ANYADIKE-DANES: Good afternoon, Dr Carson.  
18 A. Good afternoon.  
19 Q. Can I just ask you if you have your curriculum vitae  
20 there, please?  
21 A. Yes, I have.  
22 Q. Thank you. Before we come to that, I'm going to ask you  
23 if in relation to the statements that you have made in  
24 this part of the inquiry's investigation, that is  
25 relating to Lucy, whether you adopt them as your

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1 evidence, subject to anything else that you may say now  
2 to the chairman.

3 You have previously provided three statements to the  
4 inquiry. Just so that we have those, they're series 77.  
5 The first is 077/1, dated 8 July 2005. That is I think  
6 the first one you have provided. That was largely, if  
7 I may put it that way, to do with departmental matters.

8 A. Correct.

9 Q. Then you made a statement dated 14 May 2012 in Adam's  
10 case, and that was 077/2. And you made a statement  
11 dated 19 January 2013 relating to issues in Adam and  
12 Claire's cases together, and that is 077/3.

13 In relation to this part, Lucy's part, you have made  
14 two statements for the inquiry. They are both bearing  
15 the series 306. The first is dated 13 December 2012 and  
16 the second is dated 3 May 2013. And in relation to  
17 those two, do you wish to adopt them as your evidence,  
18 subject to anything else you may say?

19 A. I'm happy to adopt them.

20 Q. Can I ask you, have you discussed Lucy's case or any  
21 element of these cases, really, with anyone prior to  
22 giving your evidence here today, apart from your legal  
23 team?

24 A. No.

25 Q. Thank you. Then if we go to your curriculum vitae, and

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1 clinical director at the Royal from April 1990  
2 to March 1993?

3 A. Correct.

4 Q. And so that would span the admission of all these  
5 children, really? Sorry, I beg your pardon, it doesn't.  
6 It doesn't at all. It's the next one we want, which is  
7 the medical director.

8 A. Yes.

9 Q. That was you being clinical director in anaesthesia and  
10 intensive care.

11 A. Yes.

12 Q. And then you were medical director and deputy  
13 chief executive, this is the one I meant, March 1993  
14 to July 2002.

15 A. Correct.

16 Q. And you've been or were deputy chief medical officer  
17 from August 2002 to January 2006?

18 A. Correct.

19 Q. You did also chair one of the specialty advisory  
20 committees, CMO advisory committees. Did you do that as  
21 a result of your position as the deputy chief medical  
22 officer?

23 A. Yes. It would have been if the CMO was not available,  
24 I would have frequently chaired specialty advisory  
25 committees, yes.

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1 you may already have gone through some of this before  
2 when you gave evidence earlier, there are some elements  
3 I'd like to pick up for the purposes of today.

4 306-088-001. if we can pull up alongside that 002?

5 A. I should say that this CV was an abbreviated format that  
6 I made initially available. When I saw that other CVs  
7 were more extensive, I submitted another one. I'm happy  
8 to work off this one.

9 Q. Then just briefly, you have been a doctor since 1968?

10 A. Yes.

11 Q. And you had a period of time when you were an assistant  
12 professor at Stanford University Medical School, 1974 to  
13 1975?

14 A. Yes.

15 Q. And then I think you were first a consultant, consultant  
16 anaesthetist, in the cardiac surgical unit in the Royal  
17 Victoria Hospital in 1975?

18 A. Correct.

19 Q. Was that your first consultancy position?

20 A. Correct.

21 Q. And you were a member of the Intensive Care Society, are  
22 you still?

23 A. Not any longer, no.

24 Q. And you were a clinical director at a relevant period  
25 for the purposes of the inquiry's work, you were the

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1 Q. I wonder if we can just pull up -- I'm trying to see if  
2 I can get the terms of reference for them. If we pull  
3 up 320-110-001. That holds true for all of the special  
4 advisory committees, does it?

5 A. I presume so.

6 Q. And the one that you chaired, at least the record that  
7 I've got of you chairing it, is anaesthetics. But would  
8 you have chaired others?

9 A. No, I would have -- I attended -- during my period as  
10 deputy CMO, I would have attended whatever specialty  
11 advisory committee was meeting on that particular  
12 occasion. If the chief medical officer wasn't there,  
13 I would have chaired the meeting. However, before  
14 I became deputy CMO, I was a member of SAC anaesthetics  
15 for a period of time.

16 Q. Thank you.

17 A. So I would have attended that in my own right as  
18 a clinician before I ever had any association with the  
19 department.

20 Q. Thank you very much. I was going to ask you that.  
21 Can you remember roughly when you did become a member of  
22 it?

23 A. I honestly can't remember. I'm sure I could find that.

24 Q. Thank you. If that wouldn't be too difficult, that  
25 might be useful. But in any event, were you a member of

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1 it at the same time or at least for some part of the  
2 time you were medical director, which would be 1993 up  
3 to 2002?

4 A. I can't answer that. I don't have that information.  
5 I'll look at my fuller CV and it just says I was  
6 appointed a member of SAC anaesthetics. There's no  
7 dates attached to it, so I'm not sure whether I would  
8 have attended. I doubt it. I think it probably  
9 preceded my period of appointment as medical director.

10 Q. I see. I had asked Dr Hicks the extent to which she  
11 thought that these special advisory committees, given,  
12 as we see their terms of reference -- perhaps  
13 particularly advising the CMO on strategic policy  
14 in relation to health matters and then if we see the  
15 second one, the quality of the service provision with  
16 specific reference to agreed quality standards, and then  
17 the fifth one, really, to advise and consider the  
18 implications of advances, if I can summarise them  
19 in that way.

20 So I had asked Dr Hicks whether she thought these  
21 committees could be a forum or could have been a forum  
22 for discussing some of the issues that were raised by  
23 the children's deaths that the inquiry is investigating,  
24 and her view was that she thought they could have been.  
25 Would you share that?

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1 ourselves, ourselves in the Department of Health, and  
2 the Court Service in relation to changes, potential  
3 changes in Northern Ireland. I think I was hinting at  
4 that time in 2002 that that work was ongoing.

5 Q. Now that you raise the possibility that part of what it  
6 might have been looking at is the outworking of reviews  
7 going on in the rest of the United Kingdom, did this  
8 provide a useful forum for doing that, for a means of  
9 getting on to the agenda things that happened in the  
10 rest of the United Kingdom with a view to seeing what  
11 benefit there might be in this jurisdiction?

12 A. I think if you look at the SAC meetings overall, the  
13 agenda was largely a departmental agenda, sharing of  
14 emerging issues, issues around staffing, funding,  
15 developments of services. But if there were new policy  
16 initiatives emerging from the Department of Health, one  
17 of the places that the department might have tested the  
18 viability or the feasibility or potential difficulties  
19 introducing a new policy would, first of all, to have  
20 been aired to the clinicians who had attended the  
21 specialty advisory committee, and if there was benefit  
22 in that, it might well have gone to a higher level, to  
23 central medical advisory committee, which was one level  
24 above the specialty advisory committee. And this was  
25 part of the intelligence gathering that departmental

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1 A. There was nothing to prevent an issue, a clinical issue  
2 of concern, being raised. If the clinician attending  
3 the Specialty Advisory Committee felt that there were  
4 wider issues, there was nothing to prevent a clinician  
5 submitting that as a potential agenda item at an SAC  
6 meeting.

7 Q. Yes. I went through a number with her, and I don't  
8 propose to go through them all with you, but there's one  
9 that might be of significance. If we pull up -- this is  
10 the minute of the meeting for 1 October 2002.  
11 If we pull up 320-114-006. If you see there, this is  
12 one that you particularly have referred to. It's  
13 a review of coroners. Can you remember what that was  
14 about?

15 A. Yes. Spelt incorrectly, I note. The agenda was usually  
16 drawn up by the Department of Health prior to the SAC  
17 meetings and would have been circulated to the  
18 attendees. Offers would have been made to members  
19 attending if they wished to put anything on the agenda.  
20 The secretary who would be handling the particular SAC  
21 would have made that offer available. There was, as  
22 you're aware, at that time a number of reviews of the  
23 coronial system taking place. The LUCE review in  
24 England, Wales and Northern Ireland. There was also  
25 a further review, a joint review taking place between

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1 officials would have used. But yes, anything could have  
2 potentially been discussed within that forum.

3 Q. But it could be two way?

4 A. Yes.

5 Q. It could be the department wishing to ventilate  
6 something to see whether it would get any traction to  
7 get the local clinicians' input as to the potential  
8 benefits of it, but could it not also be the local  
9 clinicians and managers bringing something to the  
10 attention of the department that perhaps you felt needed  
11 to be dealt with in a sort of broader way than just  
12 Trust by Trust?

13 A. There was an opportunity for that to happen, yes.

14 Q. One example that I put to Dr Hicks, and I think she  
15 agreed that it was the place where one could discuss  
16 that, is in the meeting at reference 320-049-012, there  
17 was an issue of establishing a standard age for transfer  
18 from paediatric to adult services.

19 A. Mm-hm.

20 Q. Now, that is something that might have benefited from  
21 a regional position, otherwise you will have the  
22 possibility that, as in fact was the case, different  
23 hospitals, different trusts have different standards, so  
24 you might be in a paediatric ward in one hospital and  
25 not in another, and if you're going to be transferred

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1 from one to the other, that may cause its own  
2 difficulties?  
3 A. Yes.  
4 Q. So that's the sort of thing you could discuss?  
5 A. It was an ideal forum at which issues of a regional  
6 implication could be explored with the profession or by  
7 the profession with the department. It was a two way  
8 process, you're right in saying that.  
9 Q. I did also ask Dr Hicks how effective a forum she  
10 thought it was. So while she's conceded it was possible  
11 to discuss all these sorts of things, her view was it  
12 wasn't a terribly effective forum, or at least it wasn't  
13 as effective as it might have been. Just so that I'm  
14 not misrepresenting her, it's in the transcript for  
15 7 June at page 22. She gave the impression that there  
16 might well be quite a bit of talk and you might think  
17 that you got something that might go somewhere, but it  
18 didn't always.  
19 A. I would respond by saying that some of the SAC  
20 committees were much more effective than others.  
21 I think that would be recognised by departmental  
22 officials. I think it probably is also reflected by the  
23 clinicians who attended them, whether they felt there  
24 was a lot of benefit in the dialogue and exchange that  
25 took place. A lot depends on the calibre of clinician

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1 They differed in size.  
2 Q. If she's doing that, Dr Carson, then there shouldn't  
3 have been an issue about calibre. She presumably will  
4 be selecting the people who can most contribute to the  
5 exchange she wants and assist her or him with that, so  
6 why wasn't it operating effectively for this exchange of  
7 information and possible dissemination of learning?  
8 A. I am not in a position to say whether they were  
9 effective or not, I'm just saying that there was  
10 a variation across the different specialty advisory  
11 committees and I'm not in a position now to recall how  
12 effective paediatric SAC was, I cannot recall that  
13 detail. What I do know is that in the current advisory  
14 system, the SACs no longer exist. So does one imply  
15 that the department receives advice on specialty issues  
16 by a different means? Have they decided that they have  
17 served their purpose and that they no longer do so? I'm  
18 not really in a position to comment on that, except that  
19 when I chaired individual SAC meetings, I know that one  
20 would come away from a meeting and say, "That was  
21 a really good meeting, we achieved a good outcome. We  
22 covered the whole of the agenda. We benefited in the  
23 department." One of the clinicians says, "That was  
24 really useful, thank you", and others were less  
25 successful".

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1 who's contributing to the discussion, how close they are  
2 to the issue that's being -- how relevant it is to their  
3 field of -- because remember within these, within one  
4 specialty you'll have a range of different  
5 paediatricians of different ... And if you're talking  
6 about a particular subset of that then maybe not  
7 every -- and maybe not everybody is represented and  
8 certainly not every Trust would have been represented at  
9 an SAC.  
10 Q. It may be something that we'll take up more in the  
11 department. But given that you actually sat on this,  
12 not just as a member but chaired it from time to time,  
13 saw its operations from that point of view, wanting it  
14 to be effective, I presume, that's really why I'm  
15 starting the enquiry here with you. And if it could  
16 have been a useful forum, I presume the CMO wanted it to  
17 be a useful forum, that's why she had them in the first  
18 place, and it was recognised by Dr Hicks as potentially  
19 being a useful forum, in your view what was stopping it  
20 from being one? If I add to that question, you talked  
21 about the membership. Who selected people to be on it?  
22 A. That's a good question. I think the members were  
23 appointed by the chief medical officer to the best of my  
24 recollection. I can't recall the exact constitution of  
25 it because they did differ from specialty to specialty.

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1 THE CHAIRMAN: I think we can move on, doctor, because it's  
2 just in the nature of committees that sometimes  
3 committees work better than at other times and sometimes  
4 some committees work better than others.  
5 A. Correct.  
6 THE CHAIRMAN: Let's move on.  
7 MS ANYADIKE-DANES: If I ask you, as I did Dr Hicks, and  
8 given that you have indicated that you could sometimes  
9 have some very good exchanges, what was the mechanism  
10 for integrating any of what was discussed and agreed at  
11 those SAC meetings into practice, let's take into the  
12 Children's Hospital?  
13 A. This would probably be the area where the SAC meetings  
14 were least effective, I think, and it's a generalisation  
15 I'm making now and I'm not specifically referring to SAC  
16 paediatrics. But I think the information that was  
17 shared by the department with the specialists would  
18 have -- there was potential for that to be discussed  
19 within the specialty. Whether that was at training  
20 committee level in the postgraduate council or whether  
21 it had relevance to a particular service development in  
22 a hospital or a Trust -- and that could apply to the  
23 Royal Belfast Hospital for Sick Children. I'm  
24 struggling to give an overall assessment of their  
25 effectiveness and how the clinicians viewed that. But

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1 in general terms, my personal view is that they did not  
2 feed into the local Trust development's policy,  
3 thinking, management.  
4 Q. That was actually what I was getting at. You had helped  
5 me by saying it's very difficult to work out why you  
6 didn't think they were particularly effective or even to  
7 have an informed view of how effective they were.  
8 I understand that. What I'm trying to see if you can  
9 help us with now is that the things that were being  
10 introduced there, how did that find its way, what would  
11 be the mechanism for using that to improve or modify  
12 practice in the Children's Hospital? That's what I'm  
13 trying to see. It's a process question, really.  
14 A. Well, again, I can't reflect -- I was the Trust medical  
15 director, I hadn't particular specific sole  
16 responsibilities within the Children's Hospital. An  
17 attendee at a specialty advisory committee could raise  
18 issues from the most recent SAC meeting at a clinical  
19 directorate meeting, be that paediatrics, be it surgery,  
20 be it anaesthetics, general medicine. Do you understand  
21 what I'm getting at?  
22 Q. Yes.  
23 A. And it could have been that a well-run directorate would  
24 have had as a standing item on its agenda a report from  
25 the most recent specialty advisory committee or a report

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1 taking place, I was not aware of the agenda items at  
2 these meetings. That information, which was held within  
3 the department, was not shared with Trust management.  
4 These were meetings of clinicians with the officials in  
5 the Department of Health.  
6 Q. Then if I move on from the special advisory committee  
7 meetings and just ask you more generally how, as medical  
8 director, you sought to make best use of the varying  
9 sources of information that came to your clinicians,  
10 whether it's because they regularly attended the  
11 Intensive Care Society or any of their professional  
12 bodies or guidelines coming out. What was the route for  
13 making use of that? I'll tell you why I'm asking in  
14 particular. At your CV, 306-088-002, you have  
15 summarised a little of what your role as a medical  
16 director was.  
17 In there, I'm looking at the first substantive  
18 paragraph under that title, you say that part of your  
19 role was the maintenance of standards of professional  
20 performance, then the development of teaching and  
21 research, the development of external relations with the  
22 Northern Ireland Department of Health and Social  
23 Services, the health boards and GPs, and the liaison  
24 with the tertiary centres and the GMC and so on.  
25 So you have a sort of an external relations element

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1 from the central medical advisory committee.  
2 Q. But as medical director, would you have wanted there to  
3 be a way in which that kind of information could be, in  
4 a more systematic way, considered and introduced if  
5 appropriate into -- now, let's not confine it to the  
6 Children's Hospital, as you had a broader remit than  
7 that, into the Trust?  
8 A. Sorry, the question is?  
9 Q. When you were medical director, did you not want to see  
10 whether there was a more systematic way of introducing  
11 anything that was appropriate to be introduced into  
12 practice for the Trust as a whole, from the special  
13 advisory committees to the Trust? Because at the moment  
14 it seemed a bit ad hoc. Somebody could just raise that  
15 at a directorate meeting and we could get a discussion  
16 and see what would happen. I'm trying to see with your  
17 medical director's responsibilities whether you thought  
18 to institute something a little more systematic than  
19 that.  
20 A. I didn't during my tenure as a Trust medical director  
21 attempt to do that. I think these were very ... That  
22 could have been done, that could have been achieved.  
23 Whether it would have achieved any more effective  
24 outcome, I'm not in a position to judge. But as a Trust  
25 medical director, I did not know what SAC meetings were

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1 to your role, and what I'm seeking to find out is how  
2 you used that to bring into the Trust the information  
3 that your own clinicians, and maybe managers as well  
4 attending conferences, were obtaining.  
5 A. Given the breadth of the remit, it's very difficult, and  
6 that was one of the challenges of the post. I had no  
7 idea what individual clinicians were gaining from  
8 international conferences and so on. This is all about  
9 keeping your ears, listening, antennae, connections,  
10 networking with senior officials in the department. One  
11 of the challenges of the role of Trust medical director  
12 is to be able to balance this breadth and width of  
13 responsibility and at the same time be a clinician.  
14 Q. Yes, I'm sure that's so, and I don't for a minute think  
15 that it wasn't challenging. But I'm not suggesting that  
16 you should on any given day know that a clinician from  
17 the Royal is attending a particular conference and that  
18 conference might be helpful. I'm, as I said, looking at  
19 processes and structures. What mechanism might you or  
20 did you set up to ensure that the Trust took best  
21 advantage of those contacts that it had developed? I'll  
22 give you one particular example.  
23 THE CHAIRMAN: Let me ask you, doctor. If there were  
24 important developments in paediatrics from conferences  
25 or published journals or whatever, did you expect and

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1 did it occur to paediatricians working in the  
2 Children's Hospital that this should lead to changes in  
3 practice or improvements in practice? Did you expect  
4 the lead from that to come up from the paediatric  
5 directorate?

6 A. Absolutely, and the main conduit for that intelligence  
7 would have been through the clinical director. There  
8 were two opportunities, just to follow on from that, so  
9 far as the Trust was concerned. Operationally, the main  
10 focus of systems was the hospital council, chaired by  
11 the chief executive, at which all of the clinical  
12 directors attended and other non-clinical directors.  
13 That was the main operational function, forum, within  
14 the hospital. In addition to that, I chaired a medical  
15 committee, which consisted solely of the clinical  
16 directors, and that was an opportunity for clinical  
17 directors to raise with me, as medical director, issues  
18 that were pertinent to their specialty, to their  
19 directorate, and also at the same time for me to explore  
20 and develop some of the policies and procedures that  
21 I was trying to take across the Trust to try and get  
22 their support. Because the main role of clinicians  
23 involved in management is one of leadership, it's  
24 trying -- and I spent a lot of time, I think last time  
25 I attended the inquiry, trying to illustrate the

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1 you, because it was an example I had given Dr Hicks, is  
2 Dr Taylor in his evidence, his first witness statement  
3 in relation to Adam, said that he was a member of the UK  
4 Paediatric Intensive Care Society, and that he would go  
5 regularly to those meetings and he recalls that there  
6 was a whole day meeting devoted to the issue of optimum  
7 fluid regimes for children, and that was in October  
8 1999.

9 Now, fluid regimes in 1999 may well have been  
10 a topic of some interest. There had been some papers,  
11 as you may have been aware, published just slightly  
12 before that, and that might have been an issue. So if  
13 she's got a structure, which I presume is what you're  
14 suggesting should happen, so that she would know about  
15 those developments, then to the extent that she sifts  
16 that and thinks that's something that could be brought  
17 to the hospital as a whole, you would expect that to  
18 percolate its way up into that meeting you have with the  
19 clinical leads?

20 A. That would be my expectation, that that would be  
21 a useful and maybe the primary channel through which  
22 developments within a specialty would be made known to  
23 hospital management, yes.

24 Q. And how was the effectiveness of that regime monitored  
25 and evaluated, how did you know it was working properly?

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1 difficult culture that it was for doctors who got  
2 involved in management, and we don't need to go over  
3 that again.

4 The main function that I saw as a medical director  
5 involved in hospital management was one of leadership,  
6 leading by example, leading by maintaining personal high  
7 standards in the way in which you conducted your role.  
8 But those two committees, the hospital council, that was  
9 an opportunity for a clinical director, for example, to  
10 say face-to-face to the chief executive, "There's  
11 an issue in paediatrics or in obstetrics", and also  
12 at the medical committee where the focus was more likely  
13 to be on professional issues, professional standards,  
14 whereas the hospital council inevitably at that time, in  
15 particular, focused on financial issues, performance  
16 issues, I mean in terms of output, productivity, waiting  
17 times, waiting lists, number of operations done, et  
18 cetera, et cetera.

19 MS ANYADIKE-DANES: So does that mean, therefore, to the  
20 extent that there was a structure for doing that, that  
21 it was really for the directorates to bring that up to  
22 you at the meetings that you had with the clinical leads  
23 and you could see to what extent you had at that more  
24 macro level got something that should feed its way into  
25 a change in policy? The example I was going to give

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1 A. I'm not sure. Difficult to -- I think a lot depended  
2 on, if you like, the ... Obviously when we put in place  
3 appraisal for clinicians, I as medical director  
4 appraised the clinical directors, I personally carried  
5 out their own individual appraisal. But also, in the  
6 Trust, we did introduce -- and I can't remember the  
7 exact dates of this. We did introduce a performance  
8 management system, at which myself as medical director,  
9 the director of performance and planning, and the  
10 director of finance, if you like, three senior  
11 executives of the Trust, sat on one side of the table,  
12 and on the opposite side of the table would have  
13 attended the clinical director, their business manager  
14 and their nurse manager. So here was probably the most  
15 penetrating assessment or evaluation of the  
16 effectiveness of that directorate.

17 Q. We have heard from some of those who were working in  
18 paediatric intensive care, that they were  
19 under-resourced in terms of personnel and it put  
20 tremendous strain and stress on the system. What  
21 you have just described, is that a place where you  
22 would -- if you hadn't already heard, where you would be  
23 expecting to hear that and discussing how that could be  
24 addressed?

25 A. In those performance management accountability reviews,

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1 I think we called them, the issue of finance was a major  
2 one. The issue of contractual compliance in terms with  
3 the contracts that we had with the commissioning boards  
4 would have been an issue, and clinical governance was  
5 also. So I as medical director, as part of that  
6 tripartite forum, was wanting to say, "How well are you  
7 achieving against junior doctors' hours? Have you been  
8 able to put in place your appraisal arrangements? How  
9 many of your consultants have complied?". So that was  
10 a very effective mechanism that was put in. It would  
11 probably be around 2000, but I'm not sure. I can't  
12 confirm that.

13 Q. Can I ask you about that point you have just mentioned  
14 there because that's likely to come up again. As you  
15 know -- well, you probably know that the inquiry has  
16 retained the services of Professor Gabriel Scally --

17 A. Yes.

18 Q. -- to look at the relationship between the Trust and the  
19 boards. And you just mentioned there an important issue  
20 that was the subject of those meetings, which is your  
21 contractual compliance with the boards. Can you explain  
22 a little more about what you mean by that?

23 A. Obviously, each year, in advance of the commencement of  
24 each financial year before 1 April each year, there  
25 would have been contractual negotiations between the

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1 Am I understanding you to say that the meetings, the  
2 forum that you've just described there is where  
3 a decision like that could have been discussed?

4 A. It could have been, it tended to be retrospective,  
5 looking at previous years' outcomes and performance.  
6 There would have been separate planning discussions with  
7 the commissioning boards, regional consortium, by the  
8 director of planning, who -- I can't remember whether it  
9 was a Mrs Gordon or a Mr Hugh McCarthy(?). It was there  
10 was a executive director of the Trust, they were  
11 responsible for agreeing the quantitative and the  
12 qualitative and the financial components of a contract.

13 Q. So is this how governance came into those discussions  
14 because you would have to address them on the extent to  
15 which you had discharged your contractual obligations to  
16 quality as well as quantity?

17 A. I have to say, the introduction of the quality agenda as  
18 part of governance was much later, it was post-1999.  
19 At the time of Adam Strain's case in the mid-1990s, the  
20 issue around the quality standards for a service such as  
21 paediatric nephrology would have been discussed between  
22 the commissioning board and the planning side of the  
23 hospital. It was much less of a clinical -- it hadn't  
24 reached the stage of development in clinical governance  
25 that emerged in the late 1990s and early 2000s.

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1 Trust and the four health boards, and in the context of  
2 paediatrics, because there were so many paediatric  
3 specialties that were of a regional nature, the four  
4 health boards had a Regional Medical Services  
5 Consortium. So a representative from that. If we take  
6 paediatric transplantation as an example, which was of  
7 interest to the inquiry. That subject could have been  
8 raised in contractual terms with the Trust. "We want to  
9 provide you with the following resources to enable you  
10 to carry out up to 20 or 30 paediatric renal  
11 transplants." Or the area that I was mostly closely  
12 involved in as a clinician was cardiac surgery. "How  
13 many coronary artery bypasses are we going to do next  
14 year? Here's the money to do it."

15 Q. Can I just ask you in this way, because this is  
16 something we were trying to grapple with previously.  
17 That is at some point in time, a decision was made to  
18 take the paediatric renal transplant service from the  
19 Belfast City Hospital to the Children's Hospital.

20 A. Yes.

21 Q. And Adam was one of those whose surgery was conducted  
22 under that different regime, and we were trying to  
23 explore how those decisions were made and where that  
24 would be discussed. It seemed to us that that was  
25 a service change from one hospital to the other.

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1 Q. But in the early 2000s, am I understanding you that you  
2 were discussing the quality of service with the boards?

3 A. That would have taken place as part of the contractual  
4 negotiations between the Trust and the boards, GPs also  
5 as well at that time.

6 Q. Thank you. And then if I come closer to home in terms  
7 of trying to ensure that one is discharging the  
8 obligations in the hospital. You, I'm aware, are aware  
9 that during the course of the inquest into Adam's death,  
10 a statement was produced. We'll have it up quickly for  
11 you now. It's witness statement 091/1, page 2.  
12 I should pull up the statement first before I pull that  
13 up. The statement itself is to be found at  
14 011-014-107a.

15 A. These are witness statements from?

16 Q. Sorry, I'll just tell you. The witness statement that  
17 you see on the left, that's a witness statement from  
18 the coroner, Mr Leckey, that was made in the course of  
19 Adam's case. What you see here on the right-hand side  
20 is a draft statement, I'm sure you've been asked about  
21 this before, that was provided by Dr Taylor to  
22 the coroner in the course of Adam's inquest. It's  
23 a statement which the paediatric consultant  
24 anaesthetists had all seen, as had Dr Murnaghan.  
25 The part that I wanted particularly to direct you to

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1 is, if you see in that middle paragraph, it says:  
2 "All anaesthetic staff will be made aware of these  
3 particular phenomena and advised to act appropriately."  
4 So that's a statement being made to the coroner as  
5 to what is going to happen back at the hospital  
6 in relation to these sorts of issues. The chairman has  
7 heard evidence that actually nothing happened about  
8 that, that statement essentially went nowhere, it didn't  
9 appear to get itself translated into anything to travel  
10 further than its authors.  
11 THE CHAIRMAN: It's worse than that. Dr Crean said  
12 he wasn't aware of that commitment that was given to  
13 the coroner that the anaesthetic staff would be made  
14 aware of these particular phenomena and advised to act  
15 appropriately. In fact, his evidence last week was  
16 he was unaware that was in the final draft.  
17 The concern obviously, doctor, about that is this is  
18 a document that was put before the coroner towards the  
19 end of the inquest into Adam's death to give the coroner  
20 some reassurance about what would happen in the future.  
21 We've heard from Dr Chisakuta, who was not in the Royal  
22 at the time of Adam's death and he was unaware of this,  
23 and Dr Crean said that he wasn't aware of the obligation  
24 which had been effectively undertaken by the paediatric  
25 anaesthetists. That's obviously highly unsatisfactory

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1 made on behalf of the hospital to the coroner?  
2 A. Yes.  
3 Q. Well, I'm going to ask you in a minute -- let's assume  
4 that happened -- how that would get itself translated so  
5 far as you're concerned. But the coroner goes a little  
6 bit further than that in terms of what he believed  
7 he was being told, if I can put it like that. So the  
8 witness statement from him on the left-hand side, that's  
9 his first witness statement for us in the Adam case. We  
10 ask him, as you can see, what his understanding was  
11 following the inquest. He says:  
12 "My understanding was that so far as the  
13 Children's Hospital was concerned, the hospital would  
14 learn from what had happened to Adam. As far as I can  
15 recall, no specific commitment was given in relation to  
16 the future fluid management of children."  
17 So that was his first point. We asked him a little  
18 bit more about that and he produced a second witness  
19 statement for us. If we can pull up 091/2, page 4. So  
20 we see this is really asking him what he thought was  
21 going to happen, and then if you see in his answer to 4:  
22 "I had assumed that the Royal Belfast Hospital for  
23 Sick Children would have circulated other hospitals in  
24 Northern Ireland with details of the evidence given  
25 at the inquest and, possibly, some best practice

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1 and I'm pretty sure that the coroner would be very taken  
2 aback to learn that the assurance which was given to him  
3 was not honoured. I think what we're really asking you  
4 is: how would you have expected that that undertaking  
5 would in fact be honoured?  
6 A. It could only be honoured if it was approved and  
7 authorised and discharged by myself or the  
8 chief executive.  
9 MS ANYADIKE-DANES: That was going to be my question.  
10 Firstly, how would you expect a decision like that to be  
11 made such that that statement could be conveyed to  
12 the coroner? What would have to happen?  
13 A. It would have had to have been brought to my attention.  
14 There would probably have had to have been a pretty high  
15 level meeting, including the clinical director. And I'm  
16 not sure whether we're talking here about paediatric  
17 anaesthetists or anaesthetists in general. Let's  
18 disregard that for the moment.  
19 Q. Yes.  
20 A. I would have expected the clinical director for  
21 anaesthetics, the clinical director for paediatrics,  
22 myself, the chief executive, Dr Murnaghan, and possibly  
23 others to have been signatories, almost, to that  
24 decision.  
25 Q. Because this is going to be a commitment that's being

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1 guidelines."  
2 Who could have had authority to give him that  
3 understanding or, rather, let me put it slightly  
4 differently. If anyone was going to give him that  
5 understanding, how would they gain that authority?  
6 A. The coroner would have to speak to the chief executive  
7 or the medical director in the Trust.  
8 Q. So if anybody was going to purport to give the coroner  
9 that understanding, that is the route by which they  
10 would have to get that authority?  
11 A. Absolutely, and I think I'm on record, either in witness  
12 statements or at the previous -- in my nine or ten years  
13 as Trust medical director, the coroner never spoke to me  
14 directly about the outcome of any of the inquests that  
15 took place.  
16 Q. Let's assume that he believes he's speaking to a source  
17 that has the authority to give him that impression, if  
18 I can put it in those terms. So if anybody was going to  
19 have that kind of authority, what would have to happen  
20 within the hospital structure for that person to have  
21 that authority?  
22 A. His main channel for communication to the Trust was  
23 through Dr Murnaghan's office who provided services on  
24 behalf of the coroner. That had been custom and  
25 practice for a number of years and before we even became

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1 a Trust. Set that aside. To get the authority and the  
2 onus that you're looking for and expecting, and I think  
3 he was expecting, he would need to have communicated  
4 directly, I think initially with the chief executive,  
5 but potentially maybe through the medical director to  
6 the chief executive. Either of those routes.  
7 THE CHAIRMAN: I see another route here, doctor, which is  
8 that Adam's inquest is coming to an end, the statement  
9 on the right-hand side of the screen is put before the  
10 coroner.  
11 A. Yes.  
12 THE CHAIRMAN: And the coroner might then at least assume  
13 from that that the anaesthetic staff in the  
14 Children's Hospital are going to be made aware of these  
15 phenomena in order to improve their awareness and  
16 therefore their handling of similar circumstances in the  
17 future. Now, if he made that assumption on the basis of  
18 the end of paragraph 2, that would be an entirely  
19 reasonable assumption, wouldn't it?  
20 A. That's the assumption I would have taken out of that  
21 statement.  
22 THE CHAIRMAN: If you were in Mr Leckey's position, you  
23 would have assumed on the basis of the statement put  
24 before you on behalf of the Trust that there were going  
25 to be steps actively taken within the Children's

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1 A. I was not aware.  
2 Q. I'm trying to find out what would have had to happen.  
3 So assuming that, what actually would have to be put in  
4 place so far as you're concerned within the  
5 Children's Hospital to enable this statement to  
6 the coroner to be made good?  
7 A. I would expect that after every inquest the coroner's  
8 verdict, the coroner's findings and any recommendations  
9 that the coroner makes following an inquest, that that  
10 would be brought to the attention of the  
11 chief executive, the medical director, and the  
12 clinicians within the directorate where the deceased  
13 patient had been treated.  
14 Q. Sorry, I probably didn't make myself clear. I'm going  
15 at it slightly differently. This is not to see what  
16 recommendations the coroner is making. This is the  
17 hospital through the statement being provided by  
18 Dr Taylor telling the coroner, "This is what we're going  
19 to do. All anaesthetic staff will be made aware of  
20 these phenomena and advised promptly" so I'm asking you  
21 to assume that that has gone through the correct  
22 channels in the hospital. If that's the case, what  
23 would you as medical director require to be instituted  
24 in the hospital so that that could be made good?  
25 A. If it was specific to one directorate, I would expect

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1 Hospital, at least the Children's Hospital --  
2 A. Yes.  
3 THE CHAIRMAN: -- to improve for the future.  
4 A. Yes.  
5 THE CHAIRMAN: I'm not entirely sure, if we go to the  
6 left-hand side of the screen, where he gets his  
7 assumption that the Children's Hospital would have  
8 circulated other hospitals, apart from him thinking  
9 perhaps that would be a good idea.  
10 A. And I do not recall any exchange from any hospital in  
11 either direction, either from other trusts to the Royal  
12 or vice versa in relation to outcomes from inquests.  
13 I don't recall any sharing of lessons learnt or changes  
14 to good practice emerging from -- not that I can recall.  
15 I may be wrong, but I don't recall. It doesn't feature  
16 in my recall as being even a rare occurrence, let alone  
17 a common practice.  
18 THE CHAIRMAN: Thank you.  
19 MS ANYADIKE-DANES: I'll come to that. So assuming then  
20 that the coroner believes that whatever internal  
21 processes have been gone through to enable a statement  
22 like that to be made to him authoritatively, and  
23 assuming that those processes have been gone through, so  
24 for example you are aware that this statement is to be  
25 made and it has whatever imprimatur is required --

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1 the clinical director and the directorate management  
2 system, nursing, administrative, to ensure that changes  
3 were put in place within the directorate, and if it  
4 applied to more than one directorate then, likewise,  
5 another directorate, paediatrics and anaesthetics, for  
6 example.  
7 Q. And how would you monitor that? Because this is  
8 a significant thing, the coroner has been told  
9 a particular thing is going to happen. What is the  
10 system for monitoring that?  
11 A. The systems for monitoring were not good, as we know.  
12 But what could have happened, for example, if it was --  
13 and if we move, for example, on to an area which the  
14 chairman will be very familiar with, around the time of  
15 the human organ inquiry, there were things that needed  
16 to be put in place. Part of the accountability reviews,  
17 for example, would have been, "Do you have all the right  
18 consent forms in place? Do you have post-mortem request  
19 forms?" So in the accountability reviews that we had  
20 latterly, situations like that could be monitored, but  
21 there was no routine follow-up, I think, in the way that  
22 you are expecting.  
23 Q. Let me put it in a slightly different way then, if there  
24 wasn't a routine follow-up. Dr Hicks said that  
25 induction courses --

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1 A. Yes.  
2 Q. And that the training element is something that was led  
3 by the medical director. We don't need to pull it up,  
4 but she said it in her evidence on 7 June at page 29.  
5 The reason I'm asking you that, apart from because one  
6 might see this as something that would find its way into  
7 a training programme or a teaching programme, is when  
8 I asked Dr Chisakuta and Dr Hanrahan about training and  
9 induction, they had no knowledge whatsoever about that  
10 kind of thing being included in any induction and  
11 training. So is Dr Hicks correct to say that induction  
12 courses and training are led by you or come under your  
13 remit?  
14 A. Programmes of induction -- induction commenced --  
15 induction courses commenced probably before we became  
16 a Trust. They focused primarily, initially, on newly  
17 qualified doctors, people who were graduating from  
18 medical school and commencing their first hospital  
19 appointments as pre-registration house officers. That  
20 was where induction started. This was the transfer from  
21 the university environment to the hospital environment.  
22 So that was where induction started. That would have  
23 happened whenever I commenced. In 1968/69, I would have  
24 had an induction.  
25 Q. Yes, but were you responsible for it when --

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1 coroners -- the responsibility of the doctor in relation  
2 to coroner's activities would have been included in that  
3 day. I don't have a copy of the programme, but I know  
4 that for example even Trust solicitors had in the past  
5 attended those induction days, sharing issues around  
6 things like clinical negligence, the role of  
7 the coroner.

8 So those activities did take place and every doctor  
9 was required to attend those induction days. May I just  
10 emphasise that these were corporate induction, high  
11 level induction? You cannot convey all of the policies,  
12 all of the procedures, all of the requirements of  
13 a doctor who has just joined the staff of a hospital.  
14 And we were very dependent on extended induction taking  
15 place within directorates, and even going beyond that  
16 within a clinical team. If a new doctor joined  
17 a paediatric surgical unit or a paediatric ICU unit,  
18 their first start day, there would have had to have been  
19 a process of induction for that newly appointed doctor.

20 Can I refer to witness statement 077/2, 86, and also  
21 possibly 97? These are extracts from the document that  
22 I published in the Trust in 1997, entitled "Medical  
23 Excellence". There is reference in this document to the  
24 requirements that induction processes were in place and  
25 that we were also dependent on that being delivered

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1 A. There's no such thing as a Trust medical director in  
2 1968/69.  
3 Q. By the time you were medical director, were you  
4 responsible for it?  
5 A. Ultimately, I would be responsible for the induction of  
6 medical staff, yes, that is correct, that would have  
7 fallen under my extensive job description.  
8 Q. Yes. And if you were responsible for it, then if you  
9 knew that that kind of commitment, if I can put it that  
10 way, had been given to the coroner, would it not be  
11 a matter for you to ensure that that gets into the  
12 induction courses?  
13 A. Possibly, but I wasn't making a link between this draft  
14 statement and general induction of doctors in the Trust.  
15 Can I just elaborate further?  
16 Q. Yes.  
17 A. We moved from newly qualified doctors, we then extended  
18 the induction process to other grades of junior doctors,  
19 SHOs, registrars, senior registrars. During my time as  
20 Trust medical director, if you like, taking  
21 responsibility for induction of new members of staff, we  
22 did actually move to include all new consultants who  
23 were taking up posts in the Trust, whether they were  
24 local graduates or graduates from overseas. In that  
25 induction day, that corporate induction day, issues like

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1 through the clinical directorates.  
2 THE CHAIRMAN: Okay. Could you bring up for me again  
3 page 97?  
4 MS ANYADIKE-DANES: Do you see the second bullet there,  
5 Dr Carson, at the top of the page? "Induction  
6 programmes for new staff". Is that what you mean?

7 A. Maybe the page before that. Would you try page 96 then:  
8 "The Trust is committed to providing safe and  
9 effective care for patients. Ensuring the performance  
10 of individual doctors is essential to achieving this  
11 commitment. Appropriate measures to promote and  
12 maintain professional performance have been put in  
13 place. These include: recruitment and section  
14 procedures; induction programmes for new staff."

15 So these were in place and that document "Medical  
16 excellence" was shared, not just to clinical directors,  
17 but to every member of staff, and they had to sign and  
18 date that they had noted it and received it, and they  
19 had to communicate that through to my personal  
20 secretary.

21 Q. Can I just ask you then, so I'm clear about the system,  
22 in terms of the actual induction, directorate by  
23 directorate, is that something that you left to the  
24 directorate lead? They would do that?

25 A. Yes.

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1 Q. But what you have sent them is a direction that that is  
2 what you want to happen? You want to have induction  
3 programmes put in place for new staff and these  
4 bulleted matters addressed? So that's your  
5 introduction to them?  
6 A. Yes.  
7 Q. They then need to institute that?  
8 A. Mm-hm.  
9 Q. And one of the ways they do is that the new staff sign  
10 off that they've received this booklet and presumably  
11 there is some communication back from the directorate  
12 lead to you that programmes have been instituted and  
13 that they are ensuring compliance. Is that how it works  
14 so far as you're concerned?  
15 A. This was newly introduced in 1997 and that was my  
16 expectation, that that would be followed through.  
17 Q. And so for the satisfaction for you, they would be  
18 having to come back to you and say that they had  
19 complied with what you had required them to do?  
20 A. They were to sign individually, individual doctors were  
21 required -- it says:  
22 "I have read and understand the procedure for  
23 reporting concerns about the conduct, performance and  
24 health of colleagues."  
25 Q. Yes. Now, in terms of the actual content of those

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1 (4.00 pm)  
2 MS ANYADIKE-DANES: Dr Carson, one of the things I was still  
3 trying to have you explain to us is once these matters  
4 have devolved down to the directorate in terms of  
5 putting in place induction courses and so forth, how did  
6 you, given that you've acknowledged it was within your  
7 remit, ensure that those matters were being dealt with  
8 satisfactorily? How were they monitored and evaluated?  
9 A. They weren't monitored formally in the sense that there  
10 was a requirement to achieve something by a certain date  
11 to a certain degree of compliance.  
12 Q. And not evaluated?  
13 A. Seldom. But I would have to say that, for example, the  
14 medical committee, if there were issues that -- if  
15 I knew, for example, that one directorate was slow at  
16 complying, then that would be addressed at a medical  
17 committee meeting.  
18 Q. I can quite understand you would do that, but from the  
19 point of view governance operates, surely it's not done  
20 to the ad hoc thing that it's come to your attention  
21 that somebody isn't complying. There's a system in  
22 place, or at least there should be a system in place to  
23 alert you to whether things are not going as you wish  
24 them, standards are not being met and so forth and then,  
25 when you have that information, you go back down and you

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1 induction programmes, who satisfied themselves that they  
2 were appropriate?  
3 A. I think this is professional judgment and it was largely  
4 based on guidance, for example, that the GMC would have  
5 issued. It was left up to individual directorates to  
6 build an agenda, if you like, and the content within  
7 that.  
8 THE CHAIRMAN: There's an overarching induction by the Trust  
9 itself, which is followed by more direct and relevant  
10 induction for paediatricians in their directorate,  
11 cardiologists in that directorate, and so on?  
12 A. The clinical director would have been responsible for  
13 the content of directorate inductions.  
14 THE CHAIRMAN: Thank you.  
15 A. And there would have been a responsibility for an  
16 individual consultant if he had junior medical staff  
17 working in a ward that the appropriate arrangements for  
18 an emergency call, for recording of blood results, et  
19 cetera, et cetera, that should be shared at induction  
20 with all new staff.  
21 THE CHAIRMAN: Thank you. We'll just take a break for a few  
22 moments. The stenographer has been going since just  
23 after 2 o'clock.  
24 (3.45 pm)  
25 (A short break)

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1 see what needs to be done to improve it. What I'm  
2 trying to find out from you is: what was your system?  
3 A. It would be recognised that those systems were not  
4 robust at that time. They have strengthened  
5 significantly since 2003 when the statutory duty of  
6 governance came into being. Prior to that, there was no  
7 requirement to do that. It was loose, it was  
8 professional commitments, professional obligations. But  
9 for example, my role as an executive director on the  
10 Trust as medical director, that has changed since 2003.  
11 The medical director now has an executive function,  
12 delivering compliance in relation to governance, whereas  
13 that didn't --  
14 Q. I appreciate that, but you could have instituted that?  
15 A. One could have, yes.  
16 Q. If we pass on from the induction day, another thing that  
17 could be done is a programme of seminars as part of the  
18 clinicians' continuing professional development,  
19 perhaps, or as part of the hospital ensuring that  
20 minimum standards were met in terms of topics you wanted  
21 to have covered. That would be possible?  
22 A. That would be possible, yes.  
23 Q. Did the Trust have such a programme of seminars and  
24 lectures?  
25 A. The Royal Group of Hospitals was a university teaching

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1 hospital. There was responsibility to communicate  
2 knowledge and developments across the whole framework of  
3 the Trust. We had a very close working relationship  
4 with universities, postgraduate Royal Colleges. This  
5 was part and parcel of the daily work of a teaching  
6 hospital, yes.

7 Q. And in that, it would be possible, would it not, to  
8 include the very thing that the coroner had been told  
9 would be done, which is teaching on fluid balance,  
10 teaching on electrolyte imbalance, the use of low sodium  
11 fluids, those sorts of things that had arisen in the  
12 course of Adam's inquest, it would have been possible to  
13 use that series of lectures and seminars to disseminate  
14 or teach that information?

15 A. That is possible, yes.

16 Q. I want to ask you, so far as you're aware, because  
17 I understand from your CV that all this research and  
18 training and education and so forth comes within your  
19 remit, to what extent did you have a way of ensuring  
20 that the up and coming new issues, new clinical points,  
21 were being disseminated or taught to the trainees  
22 through the teaching sessions and seminar sessions?

23 A. Teaching across the Trust would have been largely the  
24 responsibility of what were called clinical tutors or  
25 regional advisers, appointed either by the

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1 "Lectures on fluid balance were given by an  
2 anaesthetist and the lecture on abnormal biochemical  
3 tests, including electrolyte disturbance, by our  
4 clinical biochemist."

5 And then if we pause there. So they had a system  
6 for addressing issues that might be arising in the  
7 context of fluid balance, electrolyte disturbance and so  
8 forth. Did the Children's Hospital have an equivalent  
9 to that?

10 A. I can't answer that, I don't know. You'd need to ask  
11 that question of the clinical director at the time in  
12 paediatrics or, more likely, the clinical tutor in the  
13 paediatrics in the Children's Hospital.

14 Q. Does that mean that although the training and research  
15 and so forth came within your scope, you wouldn't  
16 necessarily see what they were -- the content of what  
17 they were training?

18 A. Absolutely. I wouldn't have had the time or the  
19 capacity to cover every issue that was being covered in  
20 every specialist --

21 Q. You would have needed a system to satisfy yourself that  
22 it was adequate?

23 A. Well, the way you test the effectiveness of teaching and  
24 training is largely through college visitations, who  
25 approve the hospital for training of either SHOs or

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1 Northern Ireland Council for Postgraduate Medical and  
2 Dental Education or by tutors and advisers who were  
3 appointed by the respective Royal College, be that the  
4 Royal College of Paediatrics and Child Health, for  
5 example. They would have designated trainers and  
6 educational advisers. Those were in place in virtually  
7 every specialty across the Trust. A lot of the  
8 professional education was driven largely by a college  
9 or university agenda.

10 Q. Altnagelvin, that's a teaching hospital as well, isn't  
11 it?

12 A. Correct.

13 Q. Let me give you an example of the sort of thing I mean.  
14 If we can pull up 316-004e-001 and 002 alongside it.  
15 This is a letter that is being written by the consultant  
16 paediatrician at Altnagelvin and he's writing to the  
17 postgraduate dean. It's really prompted by issues that  
18 arise out of the hyponatraemia, and he is communicating  
19 what they do. Under "Whole Hospital Training":

20 "From 1995 there have been teaching sessions  
21 timetabled each year on fluid balance and electrolyte  
22 disturbance within the medical division teaching and  
23 training programme."

24 And then he goes on to say how those programmes are  
25 delivered:

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1 specialist registrars. It's the responsibility of the  
2 college to approve the hospital.

3 THE CHAIRMAN: In other words, if each Royal College  
4 approves the Royal as a teaching and training hospital,  
5 then you can take that as an assurance that you are  
6 providing your junior doctors with the necessary  
7 continuing education and training?

8 A. That would be my primary -- and that would be what  
9 I would have relayed to either hospital council or to  
10 the Trust board, that we had received approval.

11 THE CHAIRMAN: Can I ask you this then: you've drawn the  
12 distinction that Mr McKee, I think, drew our attention  
13 to, that the system changed in 2003 when each Trust was  
14 made responsible for the quality of care they provided,  
15 not just for providing services. So what was the  
16 different before 2003, compared to after 2003, if it  
17 wasn't just approval by the Royal Colleges? What more  
18 did you do after 2003 that you hadn't done before?

19 A. Probably nothing, but at the end of the day the  
20 chief executive was accountable for it.

21 THE CHAIRMAN: Okay.

22 MS ANYADIKE-DANES: And can I ask you, how often did  
23 you have a visit to validate your courses?

24 A. It varied from specialty to specialty, but visitations  
25 for basic or specialist medical training were usually

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1 every three or every five years. It varied from college  
2 to college. But normally, I think they were every three  
3 years there would have been a visit.

4 Q. In the course of --

5 A. And they were managed by -- sorry. They were  
6 coordinated by the Northern Ireland Council for  
7 Postgraduate Medical and Dental Education.

8 Q. Can we just look down under the paragraph that starts  
9 "in 2002"?

10 "In 2002, following our own case of hyponatraemia  
11 and cerebral oedema [that's Raychel], Dr Geoff Nesbitt  
12 prepared a talk specifically on this topic and has  
13 presented this widely as per his own response to the  
14 inquiry."

15 Let's just deal with that. So Altnagelvin had an  
16 incidence of death in which hyponatraemia and low sodium  
17 fluids were implicated so far as they were concerned,  
18 and their response to that was to deliver a talk  
19 addressing that specifically to get that message out, if  
20 I can put it that way.

21 Now, the Children's Hospital also had its own  
22 experience with deaths and, for all we know, near misses  
23 as well. Is there any evidence that the  
24 Children's Hospital responded in a similar way to  
25 Altnagelvin?

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1 timetabling of these regular, usually lunchtime, but not  
2 always, sessions where the teaching took place in  
3 Altnagelvin. One can see in every year that they do  
4 indeed have fluid management talks and they also have  
5 a talk in relation to the coroners, they have a talk --  
6 I will put this up by way of example. 316-004e-015.

7 This is obviously the year before Lucy, and you see  
8 under the Wednesday talk at 7.30 pm, 27 October:

9 "Reporting deaths to the coroner."

10 By Professor Jack Crane. State pathologist,  
11 of course.

12 So they were targeting certain areas that they  
13 thought were likely to be beneficial and important to  
14 their trainees. And what we haven't seen is anything  
15 like this from the Royal. So far as you know, were  
16 there programmes like this?

17 A. There definitely were, yes.

18 Q. Thank you. So that's just a matter of us being more  
19 pointed in our requests to the DLS?

20 A. In every specialty I would suspect this was normal and  
21 again there were quite often either lunchtime meetings  
22 or 5 o'clock meeting or even sometimes early morning  
23 meetings, grand rounds or whatever. The programmes  
24 would have varied and covered case presentations, would  
25 have covered issues such as reporting deaths to

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1 A. I don't know. I know that they had their morbidity  
2 meetings, which have been looked at during the course of  
3 the inquiry. I don't know what other teaching took  
4 place within the Children's Hospital.

5 Q. Would you have expected them to have approached it in  
6 a similar way?

7 A. I didn't know that the child had died until --

8 THE CHAIRMAN: In fact, doctor, this is easy because the  
9 undertaking or the assurance to Mr Leckey in 1996 was  
10 that there would be teaching and training.

11 A. Right.

12 THE CHAIRMAN: So if that teaching and training -- now,  
13 I gather, if this isn't unfair, that you were a bit  
14 disturbed before the break to see that this assurance  
15 had been given to Mr Leckey without you knowing about it  
16 and, secondly, to hear that it may not have been  
17 followed up on. But if that assurance -- well, that  
18 assurance was given and, that being the case, it was  
19 then up to the relevant directorate to follow up the  
20 assurance to the coroner by giving the training.

21 A. Absolutely.

22 THE CHAIRMAN: On exactly the same basis as Altnagelvin  
23 seems to have followed up on Raychel's death in 2002.

24 A. I would agree with that.

25 MS ANYADIKE-DANES: We have actually been provided with the

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1 the coroner. I would have expected that to have taken  
2 place across the hospital.

3 Q. In addition, the Children's Hospital produced a text  
4 called "Paediatric Medical Guidelines". I will pull up  
5 the front page of it so you see it, 319-067A-001. That  
6 was July 1999, second edition, so current for Lucy's  
7 admission. Were you aware of that, that that was being  
8 published and made available?

9 A. I was aware that there were a number of what I would  
10 call primers.

11 Q. Yes.

12 A. That would have been used by junior medical staff,  
13 mostly prescribing. I can't say now with absolute  
14 conviction that I was aware of this particular document  
15 at that particular time, but I knew these were in  
16 existence.

17 Q. If we call them primers, were these part -- the  
18 provision of them, did they also come under your remit?

19 A. No, they would have been the responsibility of the  
20 clinicians within the Children's Hospital.

21 Q. Sorry, I mean the fact that you are generally in charge  
22 of training and education and so forth. Does that mean  
23 this is all under the umbrella of that part of your  
24 work?

25 A. I was responsible for training at the highest level

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1 within the organisation. If you remember the structure  
2 that we put in place in 1998/99, I had a director of  
3 postgraduate medical education who had more direct  
4 responsibility for overseeing the totality of the  
5 education and research agenda within the Trust.

6 Q. I understand.

7 A. I think at that time it was Professor Gary Love.

8 Q. Yes, Dr Carson, I wasn't presuming to suggest that you  
9 were going down there and telling them what ought to go  
10 into their primer. But at a higher level you would be  
11 expecting to be told in the same way as you would want  
12 to know that there were induction sessions, there was  
13 a training programme, and that in some way it was all  
14 operating in a satisfactory fashion, this is all part of  
15 that; is that correct?

16 A. Issuing guidelines like that to assist junior doctors  
17 and medical staff would add to the quality of the  
18 service delivered in the directorate.

19 Q. Yes. And to the extent that one saw it appropriate to  
20 have guidelines more generally on other areas, the whole  
21 question of guidelines, protocols, practices, albeit  
22 they might be confined to particular directorates, but  
23 ultimately they all came under your remit to make sure  
24 that these things were adequate, they were appropriate,  
25 and that they were being maintained in a way that made

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1 directorate to do?

2 A. Yes, and I would have expected that within the  
3 paediatric directorate there would have been doctors  
4 with specific responsibilities for training, either  
5 paediatric surgery, paediatric medicine, paediatric  
6 intensive care. They had a large number of staff.

7 MS ANYADIKE-DANES: My question to you was slightly  
8 different. It's not that you would be doing that, but  
9 in terms of governance you would need to make sure that  
10 each directorate, if it was putting out protocols and  
11 guidelines, that it had established systems to ensure  
12 the adequacy of those and that they were being monitored  
13 and evaluated, not that you would be doing the  
14 monitoring and evaluating, but you would be requiring  
15 them to have a system to do that?

16 A. How I would respond to that is by saying that the  
17 monitoring and the evaluation of that was probably not  
18 robust. I would suggest it probably wasn't robust  
19 anywhere. We were very heavily dependent on guidance  
20 from medical Royal Colleges and other specialist bodies  
21 in terms of developing good guidelines. And certainly  
22 not every directorate -- let me put it this way. The  
23 Children's Hospital did produce a formulary with  
24 Paediatric Medical Guidelines. I'm not quite sure what  
25 happened in other directorates like anaesthetics, and

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1 them current? Would that be fair?

2 A. It's a very sweeping statement. It's a huge  
3 generalisation and a huge responsibility on one person  
4 to ensure that all the educational requirement was up to  
5 scratch. I couldn't carry --

6 Q. I presume you gave people tasks to ensure they were  
7 doing that at the lower levels, but ultimately it comes  
8 under you; is that right?

9 A. I am responsible to keep the board informed that systems  
10 like that are in place, yes, that's correct.

11 Q. Thank you.

12 A. But I'm in no position to oversee the content or to  
13 quality-assure the content to ensure that its current  
14 or up-to-date. I have too many other things to do.

15 Q. Of course, and I realise that you wouldn't be able to do  
16 that. But you would, would you not, be wanting to  
17 satisfy yourself that somebody is doing that, so if the  
18 directorate feels it appropriate to put out paediatric  
19 medical guidelines, would you not want to say, "I would  
20 like to know that you have a system to ensure that those  
21 guidelines are current, they're adequate and  
22 appropriate"?

23 A. That level of assurance or compliance did not happen.

24 Q. No, but -- well, should it have?

25 THE CHAIRMAN: That's what you expect the paediatric

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1 I was a practising anaesthetist, or in ENT. I cannot  
2 assure the inquiry at this moment in time that  
3 equivalent primers were in existence everywhere because  
4 the way in which education and training differed from --  
5 one of the significant aspects of paediatric training  
6 was that there were two cohorts of doctors coming  
7 through the Children's Hospital.

8 There were those people who were coming for one or  
9 two years with a view to going into general medical  
10 practice, and they wanted a little bit of paediatric  
11 experience along with maybe some obstetric experience,  
12 some general medicine experience. Then there were those  
13 doctors who had chose to have a specialist career in  
14 paediatrics. Now, the type of training for those  
15 individuals, I understand, was -- although at the  
16 earlier stages it would be difficult to separate them,  
17 but the end product was eventually going to be  
18 different. And these paediatric medical guidelines,  
19 I understand, or understood that these lent themselves  
20 much more to that general medical trainee type of junior  
21 doctor as distinct to the person who was progressing  
22 through paediatrics, and maybe subspecialties within  
23 paediatrics, paediatric neurology, paediatric  
24 nephrology. So the purpose of these guidelines, whether  
25 it's paediatric or other guidelines that might have been

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1 present in the maternity hospital or in cardiac surgery,  
2 might have been different.

3 Q. Yes. I wasn't asking you about the content, I have  
4 asked Dr Hicks about those. If I move on to ask you  
5 about a different point, which is really to do with the  
6 possibilities of outreach for the Children's Hospital,  
7 if I can use that term. If I preface it in this way so  
8 you have the context of it. Dr Crean's evidence to the  
9 inquiry when he gave evidence last week, I think it was,  
10 was he and others, as paediatric anaesthetists at the  
11 Children's Hospital, realised that paediatricians in the  
12 district hospitals perhaps were not as familiar, as  
13 current with issues to do with fluid management, and  
14 particularly those to do with low sodium, and that he  
15 said from time to time he would see the result of that.  
16 So a child would be transferred and it would be clear to  
17 he or his colleagues that that child's fluid management  
18 in the transferring hospital had been less than  
19 satisfactory, and when that happened he would contact  
20 the consultant and discuss the fluid regime in a way to  
21 assist, if I can say it in that way.

22 I had asked Dr Hicks in the transcript on 7 June at  
23 page 19 whether, if that were the case, that the  
24 paediatric anaesthetists did have that view that they  
25 had an expertise and experience that others in the

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1 called CREST, which I have referred to in my previous  
2 submissions, the Clinical Resource and Steering Group,  
3 that developed guidelines regionally across  
4 Northern Ireland.

5 Q. When was that established?

6 A. That was established before we were a Trust. I can't  
7 remember. It's in my -- one of my ...

8 Q. Don't worry. If you've given us a date, we'll pull it  
9 up from there.

10 A. I think it's in 077/3, I'm not sure, but I have made  
11 reference to it. That was a regional committee set up  
12 by Central Medical Advisory Committee of the department.  
13 If you like, that was the tier above specialty advisory.  
14 They were responsible -- the CMAC or Central Medical  
15 Advisory Committee was responsible for resourcing,  
16 funding and assisting with the work of CREST. So that  
17 was the channel through which the majority of regional  
18 guidelines were developed in Northern Ireland.

19 Q. If that was a channel to do things regionally and not  
20 just trust by trust, do you think that was sufficiently  
21 or even adequately used, its potential?

22 A. I think they have a reputation for having produced  
23 a large number of very good guidelines.

24 THE CHAIRMAN: Sorry, doctor, just to give me an  
25 illustrative example off the top of your head, can you

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1 district hospital didn't have, whether that was not  
2 something that the Children's Hospital could approach in  
3 a more systematic way instead of just Dr Crean  
4 responding on a case-by-case way and communicating, that  
5 that kind of outreach dissemination of your clinician's  
6 specialist knowledge is something that could be done, as  
7 I say, in a more systematic way. Now, I put that to  
8 Dr Hicks and she said that it could have been. Then  
9 I asked her whether she didn't think that that,  
10 in relation to IV fluids, could have happened before  
11 IV fluids actually got on the SAC agenda, which it did  
12 ultimately after Raychel, and she said that could have  
13 happened.

14 So the point that I want to put to you is: did you  
15 regard, when you were medical director, the  
16 Children's Hospital as having that role or being capable  
17 of performing that role for the district hospitals?

18 A. It was certainly capable of doing it. I'm not sure that  
19 as a Trust or the Children's Hospital within the Trust  
20 saw it as being their responsibility to do it in the way  
21 that you've suggested. I think the important issue is  
22 here if something has a regional significance, then  
23 there was a channel, be that through SACs or even  
24 through the regional approach to clinical audit, the  
25 development of guidelines. There was this organisation

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1 give me an example of what they did which is effectively  
2 spreading a lesson learned in the Royal or something  
3 picked up in the Royal outside?

4 A. Well, I can't recall specifically if something had  
5 emerged in the Royal. I certainly know guidance on  
6 meningococcal disease for example progressed from the  
7 Children's Hospital right through to regional  
8 guidelines.

9 THE CHAIRMAN: Dr Taylor's told us something about that.

10 A. CREST have had a large volume of regionally developed  
11 guidelines. One of the other -- on the whole subject of  
12 clinical audit, when I was deputy CMO I was concerned  
13 that there was -- the focus of clinical audit was a bit  
14 diverse and not very focused. We had audit happening  
15 within trusts. Regionally, we had audits at area board  
16 level and then there was regional audit and  
17 multi-professional audit at departmental level, and also  
18 the Postgraduate Medical Council had a remit for  
19 clinical audit.

20 I actually, when I was deputy CMO, commissioned  
21 a review of clinical audit arrangements across the  
22 region. Out of that has emerged the development of an  
23 organisation which has replaced CREST and it's known as  
24 GAIN, guidelines and audit something else, I can't  
25 remember, network. So that came into being just before

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1 I retired or after I retired.  
2 MS ANYADIKE-DANES: Can we go back to the CREST point where  
3 you say that was an opportunity to get guidelines out  
4 regionally, and presumably also a way of disseminating  
5 learning in the way that I had said that maybe the  
6 hospital could do it, you said this is already a vehicle  
7 which could be used. Is that correct?  
8 A. That's correct, yes.  
9 Q. Then if that's the case, if we pull up Mr Leckey's first  
10 witness statement, witness statement 091/1, page 2, if  
11 you see the answer to 2, his answer, which is a question  
12 we gave him. We wanted to know what the mechanisms were  
13 in 1995/1996 for the dissemination of expert opinions  
14 obtained by him for his assistance at inquests to the  
15 medical profession. So what we were dealing with is  
16 a situation where, as a result of the inquest, a medical  
17 report or opinions had been obtained, there is  
18 a discussion on certain issues, as you know there was  
19 with Adam, and we were seeing what could have been done  
20 to get that learning out. As far as the coroner was  
21 concerned, there was no mechanism for doing that, he  
22 said:  
23 "There was discussion at the inquest as to how the  
24 views of Dr Sumner could be disseminated amongst the  
25 medical profession in Northern Ireland. The consensus

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1 stage that there was the vehicle that you've just  
2 discussed that could potentially or possibly achieve  
3 that end. And what I'm asking you is, can you think of  
4 any reason why he wouldn't be being told that?  
5 A. I can't think of any reason why he wouldn't have been  
6 told it, and I also feel that if he felt that the  
7 opinions of expert witnesses needed to be promulgated,  
8 he had the opportunity to do that, either directly  
9 through the Department of Health or through the four  
10 area boards, through the directors of public health, or  
11 writing directly to Trust medical directors, and I'm not  
12 sure that that ever happened.  
13 Q. Okay. Then if we go to another matter which you might  
14 be able to help us on, how it could have happened.  
15 There has been an issue as to the extent to which the  
16 Children's Hospital itself reduced its use of  
17 Solution No. 18. Are you aware of that issue,  
18 Dr Carson?  
19 A. I'm not sure that I was aware of it at the time.  
20 Q. I don't mean at the time. Have you become aware of the  
21 issue?  
22 A. I have become aware that there was change in practice  
23 in the use of Solution No. 18, yes.  
24 Q. I have taken the clinicians more directly involved  
25 through the details of it. I don't particularly want to

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1 [and there would have been representatives of the  
2 Royal Trust there] was that there was no effective means  
3 of doing so other than through the medical literature."  
4 And result of that, there was an editorial published  
5 in 1998. So if that system existed, why wasn't  
6 the coroner being told that and why wasn't it being  
7 used?  
8 A. I can't answer for the coroner.  
9 Q. Sorry, yes.  
10 A. The coroner, within his rules, has the ability to  
11 communicate directly with those who he considers to be  
12 in a position to take responsible action.  
13 Q. Yes, that's slightly different. That's if he wanted to  
14 signal to the Trust, the Royal, that there were matters  
15 that he felt that they ought to take up arising out of  
16 the care that Adam received. This is slightly  
17 different. This is looking for a mechanism whereby you  
18 can disseminate the learning, the reports he's received  
19 from expert witnesses, and he is saying, and he's saying  
20 it on the basis of what others also address him on, that  
21 there wasn't a way of doing that and the only way you  
22 could do it was to publish. We know that Dr Armour  
23 published and Dr Arieff agreed to and did provide an  
24 editorial.  
25 So the coroner was certainly not being told at that

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1 take you through the PSNI statements and so forth.  
2 Dr Nesbitt, who was the prime mover of the point from  
3 Altnagelvin -- suffice to say that in trying to see the  
4 extent to which Altnagelvin Hospital's post-operative  
5 fluid regime either was similar to or, if it wasn't  
6 similar to, how it was different to the practices in  
7 other hospitals, he rang around hospitals and one of the  
8 hospitals he rang was the Children's Hospital.  
9 His evidence is that he was told, and ultimately  
10 he was told it by Dr Chisakuta, that the  
11 Children's Hospital had reduced their use of  
12 Solution No. 18 for post-operative surgical children,  
13 and he was given two reasons for it. One was to do with  
14 deaths, although it wasn't clear when those deaths had  
15 occurred, and the other was because, six months prior,  
16 the Children's Hospital had concerns about the  
17 possibility of low sodium levels associated with its  
18 use, presumably.  
19 So that's what he was being told. We actually have  
20 not yet been able to find or identify a clinician at the  
21 Children's Hospital who can say that that happened and,  
22 if it happened, when it happened. But what we have got  
23 is some statistical material from the pharmacy, charting  
24 the orders and use of Solution No. 18. Ultimately, it  
25 comes down to a graph which we've been provided it,

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1 which is 319-087d-003. If we can pull up alongside,  
2 just so that you see what we had originally,  
3 319-087c-003.

4 This one here was January 2000 to July 2001. Those  
5 dates were to try and capture the six months prior to  
6 Raychel's death point. You can see how it's formed on  
7 the graph from January 2000 to July 2001, and you can  
8 see that having bubbled around a little bit, it does  
9 seem at the beginning of 2001 to have been on a downward  
10 trend, even though there are blips upward.

11 If you then go to a much larger data set that the  
12 DLS were good enough to give us, and this is now  
13 covering 2000 to 2004, January 2000 seems to be missing  
14 from that, but leaving that aside, if you look at the  
15 graph, you can see a similar thing is happening, that  
16 from January 2001, leaving aside a spike in February, on  
17 the whole the use is on a downward trend. You would  
18 accept that?

19 A. Yes.

20 Q. And it really flattens out into almost nothing at all.

21 A. Yes.

22 Q. And what we were seeing in that shorter snapshot of  
23 events is mirrored really by this. I should say in  
24 fairness that I had made an error when I introduced this  
25 before. I had indicated when I was putting it to

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1 that. But if they made that decision because of deaths  
2 or near misses, would you not need to know about that?

3 A. If they made the link between that and, for example, the  
4 statement made to the coroner, then potentially, yes.

5 THE CHAIRMAN: The statement to the coroner was in 1996 and  
6 we see here that the decision in effect was taken or  
7 seems to have been implemented in around about spring  
8 2001, so it doesn't seem to me to relate at all to what  
9 Mr Leckey was told in Adam's inquest in 1996.

10 A. I accept that.

11 THE CHAIRMAN: What worries me is that the use of it, the  
12 extent to which Solution No. 18 was used continued at  
13 a significant level until early 2001.

14 A. Yes.

15 THE CHAIRMAN: And then for some reason, it plummeted.

16 A. I do not know what clinical decisions or changes, what  
17 changes of staff, what prompted or what triggered the  
18 change in the use of No. 18 Solution. I have no idea  
19 what -- it would be interesting to know how much of this  
20 happened at ward level, how much of it happened in the  
21 operating room. I don't know. I can't explain it.

22 THE CHAIRMAN: Okay.

23 MS ANYADIKE-DANES: I'm just going to pull up a letter,  
24 I hope, any minute now, but the point that I want to put  
25 to you is really to press you a little on the point that

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1 Dr Hicks that there was now some difference between the  
2 chart that you see on the left and the chart on the  
3 right and the data set had changed in some way. I was  
4 in error there, the data set hasn't changed and the two  
5 are consistent with each other, albeit that the one on  
6 the left is a much longer series, if I can put it that  
7 way, but the trend is still there.

8 What I want to ask you is: some of this change would  
9 coincide with when you were medical director.

10 A. I was medical director during that period of time, yes.

11 Q. Exactly. If there was going to be a decision not to use  
12 something that we are told is as basic for  
13 paediatricians as Solution No. 18 was in those days,  
14 is that a decision that you would know about?

15 A. No, not necessarily.

16 Q. If that decision were prompted by its association with  
17 deaths, near misses or other risks in the care of  
18 paediatric patients, is that something you would expect  
19 to know about?

20 A. Not necessarily.

21 THE CHAIRMAN: Sorry, doctor, I think I can understand how  
22 it is that if paediatricians or anaesthetists decide,  
23 "We will use far less of Solution No. 18 now, we'll use  
24 some other solution", you might think that that is  
25 a paediatric decision, you don't need to worry about

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1 the chairman was asking you, which is: if the use of  
2 Solution No. 18 were associated with deaths in the  
3 Children's Hospital, would you not expect to know that?

4 A. If any drug, any treatment regime, was associated with  
5 an abnormal, out of variance in terms of mortality --  
6 I would have expected to be informed of that in some way  
7 or other.

8 THE CHAIRMAN: In fact, that would be quite basic, wouldn't  
9 it?

10 A. Well, I would have expected it to happen, yes.

11 THE CHAIRMAN: Thank you.

12 MS ANYADIKE-DANES: I wonder if I can pull -- sorry.

13 A. The use of drugs and the use of antibiotics, there have  
14 been lots of changes. Drugs have come into fashion,  
15 gone out of fashion. Some drugs have been associated  
16 with side effects and complications, and they gradually  
17 disappear. The Trust medical director doesn't always  
18 know what triggers a change in practice.

19 THE CHAIRMAN: You won't know if a drug becomes less  
20 fashionable or perhaps a better version comes along.

21 A. Sure.

22 THE CHAIRMAN: And if a better version comes along, then the  
23 trend will be to use the better version and to cut back  
24 on the use of the older version. I presume that's a  
25 fairly standard development, is it?

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1 A. That would be a fairly standard development. Quite  
2 often it's associated with a higher cost and therefore  
3 you get into a discussion with the commissioners, the  
4 boards, the whole contract. "We want to stop using drug  
5 X, this drug is far better, but it's twice the price".  
6 So, yes, it would have.

7 MS ANYADIKE-DANES: Can I please pull up 036a-055-141? This  
8 is a letter being written by Dr Kelly, medical director,  
9 to the consultant paediatricians at the Erne Hospital.  
10 We can see what he says. It's dated 21 June 2001, so  
11 shortly after Raychel's death:

12 "At a medical directors' meeting in the last few  
13 days, I was made aware of a recent death in paediatrics  
14 [that's Raychel]. The case appeared to involve the  
15 development of severe hyponatraemia leading to seizure  
16 activity and coning. The medical directors present were  
17 able to report a number of near misses round the  
18 province and we were been made aware of an article  
19 in the BMJ [that's the 'Lesson for the Week' article  
20 2001, Halberthal, but in any event it is an article that  
21 relates to hyponatraemia]. It also appears that the  
22 Children's Hospital has changed its guidelines and no  
23 longer uses No. 18 Solution post-surgery or for  
24 rehydration in paediatric medicine and so I would  
25 therefore ask that consideration is given to review our

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1 the Children's Hospital has changed its practice. The  
2 graph seems to indicate that something was happening  
3 in relation to the use of Solution No. 18, quite what we  
4 don't know yet. But I think it was the chairman who  
5 asked Dr Hicks, if a decision was made on changing the  
6 use of Solution No. 18, which is as I've put it,  
7 a fairly basic fluid for IV fluid management for  
8 children, then that decision would need to have gone up  
9 the hierarchy, and she accepted that. We don't need to  
10 pull it up, but the reference is 7 June, page 35. What  
11 do you think she meant when she was agreeing with the  
12 chairman that that decision would have had to have gone  
13 up the hierarchy?

14 A. Sorry, the decision to?

15 Q. To change, so either reduce the use of Solution No. 18  
16 or to substitute it for something else. We don't  
17 actually know what those figures mean. All we see is  
18 those figures. And part of the reason we don't know  
19 what they mean is nobody has yet acknowledged that there  
20 was any change in the use of Solution No. 18 at the  
21 Children's Hospital. But assuming those figures are  
22 correct and they do in fact represent a change, the  
23 question that was being put to Dr Hicks was: how would  
24 you have such a change, what would be the mechanism for  
25 it? And she accepted the chairman's suggestion that for

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1 practice to using normal saline in these circumstances."

2 One of the questions I wanted to ask you is: were  
3 you aware that Solution No. 18 had been associated with  
4 a number of near misses around the province?

5 A. No.

6 Q. Were you aware that Solution No. 18 had been associated  
7 with anything of concern in paediatric treatment?

8 A. No.

9 Q. If that were the case, would you have expected somebody  
10 to have informed you of it?

11 A. In the Trust, you mean?

12 Q. Yes.

13 A. Yes.

14 Q. And how would that -- what would be the mechanism for  
15 doing that, somebody comes and knocks on your door, is  
16 there a meeting where these sort of things get routinely  
17 aired?

18 A. It would be more appropriate for it to have emerged  
19 through the meeting of the clinical directors with me in  
20 the chair as Trust medical director. That would be the  
21 most appropriate way of doing it.

22 Q. That is being said there by Dr Kelly, his explanation --  
23 he may just simply be repeating something that  
24 Dr Nesbitt has said. But in any event, there's  
25 Dr Nesbitt and Dr Kelly, both seeming to indicate that

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1 that to have happened, that would have had to have gone  
2 up the hierarchy.

3 THE CHAIRMAN: Let me add to that. I think I was putting to  
4 her a suggestion which had been made by an earlier  
5 witness, who had said that that change would not be made  
6 without it having gone up the hierarchy. It may have  
7 been Dr Crean, but I can't swear to that.

8 MS ANYADIKE-DANES: I think that's right, Mr Chairman.

9 THE CHAIRMAN: In effect, two of the experienced paediatric  
10 team in the Royal have said to us, in terms they're  
11 saying, doctor, "We didn't change from Solution No. 18  
12 because something better came along", in essence they're  
13 saying, "We changed from Solution No. 18 because there  
14 were concerns about its safety".

15 A. Right.

16 THE CHAIRMAN: I am not going to be definitive that it's  
17 because there were several deaths. There is a reference  
18 here to near misses, adverse incidents or however  
19 they're described. Even if it's short of deaths, if  
20 there are near misses which lead to a change in the use  
21 of Solution No. 18, such a dramatic change in the use of  
22 a standard fluid, that is something that you would  
23 expect to come to you through the paediatric  
24 directorate?

25 A. Yes, I agree with that. But at the same time, changes

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1 like that could have occurred without a directive from  
2 the medical director.  
3 THE CHAIRMAN: Absolutely. I think really what  
4 Ms Anyadike-Danes is getting to is this, that it might  
5 be even more important not for you to know but for  
6 hospitals like the Erne or Daisy Hill or Altnagelvin to  
7 know.  
8 A. Well, I understand the linkage there. I have to say  
9 that it would have been unusual and certainly not in my  
10 experience common for a Trust or a department within  
11 a Trust disseminating guidance to the rest of the  
12 region. For example, the renal unit in the Belfast City  
13 Hospital, I would not have been aware of receiving any  
14 definitive guidance or good practice or best practice  
15 from any other -- I don't think there was the same  
16 emphasis on sharing of good practice in that way. In  
17 other words, through --  
18 MS ANYADIKE-DANES: Can I ask you why not? And if I may  
19 preface it in this way: the Children's Hospital, within  
20 the Royal Trust, is not just any children's hospital and  
21 it's not just any Trust because it is the regional  
22 centre for paediatric care. And when you were  
23 describing before the relationship that the Trust had  
24 with the boards, you recognised that because it was  
25 a regional centre, in fact it had these relationships

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1 culture. Why shouldn't it be the culture?  
2 A. Well, because the culture was different at that time.  
3 We all know that. Shared learning after a death or  
4 a serious adverse incident was relatively uncommon. It  
5 was rare. You tended to -- you didn't advertise your  
6 failures. That culture was prevalent throughout the  
7 NHS, not just in Northern Ireland, but elsewhere. You  
8 advertised your successes and then you made links  
9 between: this is the best way to treat and we've  
10 developed guidelines or a protocol or a care pathway  
11 that results in a better outcome. So you promoted your  
12 successes. I think the culture at that time was that  
13 you didn't advertise your failures.  
14 Q. I'm going to come to that just in a moment, but in this  
15 instance what might have happened, and certainly  
16 Dr Crean thinks he's identified it, is that those in the  
17 Children's Hospital who knew about fluid management did  
18 appreciate the risks of the use of low sodium fluids.  
19 In fact, they were seeing the product of that by some  
20 children being transferred to them who had suffered from  
21 an inappropriate fluid regime. So it's not a matter of  
22 not trumpeting your failures, as a responsible regional  
23 centre why could you not envisage the  
24 Children's Hospital performing that service or carrying  
25 out that function?

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1 with all four boards. So it provides a service for the  
2 entire region. And one would expect that within its  
3 paediatric intensive care it has perhaps some of the  
4 most specialist of certain disciplines, maybe paediatric  
5 anaesthetists, certainly neurologists because it's also  
6 a regional centre for neurological care. So if you've  
7 got within that hospital these specialist people and  
8 they have formed the view, made a link, between the use  
9 of a fluid that is in common use up and down the region,  
10 and potential risks for children, why would you not  
11 expect that message to be got out to those who are less  
12 likely to be able to perhaps make that link for  
13 themselves?  
14 A. Clinicians in the Royal in all of our specialties would  
15 take part in regional teaching meetings, so I'm -- and  
16 there is every evidence that consultant specialists  
17 would participate in educational and training  
18 opportunities in non-teaching hospitals round the  
19 region. So what I'm saying is that the dissemination of  
20 that sort of information was usually conducted along  
21 professional educational lines, rather than through  
22 a management administrative line. Do you understand  
23 what I'm ...  
24 Q. Well, yes, but I was picking you up when you talked  
25 about the culture. You seemed to think it wasn't the

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1 A. There's nothing to stop them doing that, but it would  
2 have been conducted at a professional, individual level.  
3 I mean, I'm struggling to see ...  
4 THE CHAIRMAN: What changed the culture, do you say? Sorry,  
5 please tell me that isn't still the culture.  
6 A. Well, 2003 and the duty of quality and the whole  
7 development of clinical governance and the openness and  
8 sharing of knowledge. That has changed since 2003.  
9 THE CHAIRMAN: Okay. Well, prior to 2003 if the Trust was  
10 not responsible for the quality of care, which I think  
11 is the point Mr McKee has made and in effect you're  
12 endorsing it, was the responsibility for the quality of  
13 care with the department? Sorry, apart from each  
14 individual clinician having a personal responsibility --  
15 A. I was just going to say that the onus and the primary  
16 responsibility is that with the individual clinician, to  
17 be quite honest.  
18 THE CHAIRMAN: I understand that. Beyond the individual  
19 clinician, prior to 2003 within the Health Service who  
20 was responsible for the quality of care provided by the  
21 Health Service, or can you not put it beyond the  
22 individual?  
23 A. I think it would be quite difficult to identify any  
24 person or persons who are totally responsible for that.  
25 One could argue that directors of public health in the

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1 four health boards had a responsibility to oversee the  
2 health and well-being of their population and therefore  
3 liaised with individual trusts that are delivering care  
4 to say, "Here is a standard that should be in place".  
5 Don't get me wrong, I mean I think the hospital -- our  
6 fracture surgeons, our cardiologists, our dentists, our  
7 obstetricians, our ophthalmologists did a lot of this  
8 inter-hospital education and briefing and awareness, and  
9 there were many regional meetings held in the Royal.  
10 There was -- if not weekly, certainly monthly,  
11 ophthalmologists would have come into the Royal Victoria  
12 and had an educational training meeting at which new  
13 trends, new developments, lessons learned could be  
14 communicated. So this happens all the time.  
15 MS ANYADIKE-DANES: But apparently not in relation to this  
16 aspect of fluids even though, according to some of the  
17 paediatric anaesthetists there, they recognised that the  
18 particular practice that they were concerned about, if I  
19 can put it that way, in relation to Solution No. 18 was  
20 happening by paediatricians in the district hospitals.  
21 A. I understand the point you're making there, but I can't  
22 correlate that awareness of the paediatric anaesthetists  
23 with their lack of agreement around the statement that  
24 was made to the coroner.  
25 Q. Yes.

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1 of care."  
2 And then if one goes up and pulls up alongside it  
3 315-021-003, you see there:  
4 "Culture, leadership and teams."  
5 It says:  
6 "The future that distinguishes the best health  
7 organisations is their culture."  
8 It goes on to talk about the directorship at  
9 a particular hospital, saying that:  
10 "We need to create a working environment which is  
11 open and participative, where ideas and good practice  
12 are shared, where education and research are valued and  
13 where blame is used exceptionally. It is likely to be  
14 one where clinical governance thrives and the challenge  
15 for the NHS is the active creation of such cultures in  
16 most hospitals and primary care groups of the future."  
17 That was an article that was published in July of  
18 1998 and when I heard you raise culture there, what is  
19 the culture that you were -- because you were charged  
20 really with trying to bring in clinical governance and  
21 operate it. What were you trying to do to redress or to  
22 change the culture as you've just described it to the  
23 chairman?  
24 A. I knew Liam Donaldson and I have worked with Liam  
25 Donaldson. I also knew Gabriel Scally when he worked

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1 A. That doesn't ring as far --  
2 Q. Can I ask you finally on this point about culture  
3 because it is an important point and it has been made  
4 in the context about governance generally and the need  
5 to change culture. When you provided your first witness  
6 statement in relation to Lucy, you referred to a paper  
7 by Sir Liam Donaldson. As you know, he was instrumental  
8 in the whole issue of governance. There is another  
9 paper which he co-authored with Gabriel Scally. It's  
10 called "Clinical Governance and the Drive for Quality  
11 Improvement in the NHS in England", admittedly. I just  
12 want to pull up a part, the first page to orientate you,  
13 315-021-001. The paper starts down at the bottom.  
14 In the first paragraph they refer to something that  
15 you've mentioned also, which is:  
16 "In the past, many health professionals have watched  
17 as board agendas and management meetings have been  
18 dominated by financial issues and activity targets. The  
19 government's White Paper outlines a new style of NHS  
20 that will redress this balance."  
21 Then if you see the summary points in that box  
22 there:  
23 "New approaches are needed to enable the recognition  
24 and replication of good clinical practice to ensure that  
25 lessons are reliably learnt from failures in standards

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1 here. He spoke at a training conference that  
2 I organised as well on the very same subject. This  
3 article that you've referred to was probably the  
4 first -- this is a seminal document. In fact, if I'm  
5 not incorrect, it's the first time this real term of  
6 "clinical governance" really came into general parlance  
7 in the medical literature.  
8 As I said, I had a huge amount of respect for Liam  
9 Donaldson, and he worked very closely with the British  
10 Association of Medical Managers, and I made reference to  
11 that at my last attendance at the inquiry. It was  
12 largely -- and I suspect this document and possibly  
13 another document might have been the documents that were  
14 referred to by the chief medical officer at a paediatric  
15 SAC meeting. This might well have been what triggered  
16 Dr Campbell making reference to clinical governance at  
17 that stage at the SAC.  
18 But it was on the back of that sort of work that  
19 in April 1999 we introduced and approved at Trust board  
20 our own procedures for introducing the concept of  
21 clinical governance in the Royal Hospitals. I was  
22 leading on that in the Trust, and that was my  
23 responsibility as Trust medical director, to see that as  
24 being my leadership responsibility and to drive that  
25 culture change within the Trust. You'll have to

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1 recognise that this was a period of significant turmoil  
2 within the medical profession. Doctors did not  
3 appreciate, enjoy, working within a managed environment.  
4 I suspect lawyers are maybe the same. But you  
5 understand the point I'm making. There was huge  
6 reluctance to allow management to dictate or to direct  
7 to them changes in practice because the clinician knows  
8 best. That was the culture that existed for a  
9 generation and longer.

10 My initiative in taking that forward was very much  
11 a personal drive on my own part. I was encouraging  
12 other Trust medical directors through the clinical  
13 medical directors' forum to do likewise. But this was  
14 happening at Trust level before there was any guidance,  
15 formal guidance from the department, and before  
16 a statutory duty to put anything that approached  
17 clinical governance in place.

18 So what we were doing -- and I was very conscious  
19 that things were moving ahead very rapidly in England,  
20 and in Northern Ireland we were lagging behind. But  
21 I believe that in the Royal Hospitals the systems that  
22 we were trying to develop in a very large, complex  
23 organisation were appropriate for that time and ahead of  
24 their time.

25 Q. Then if we take that you're trying to develop --

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1 could contact us tomorrow to see about that. Thank you  
2 very much indeed.

3 I'm sorry about that, ladies and gentlemen. It's  
4 our first overrun of this segment and I intend to make  
5 sure that we adhere to the timetable for the rest of the  
6 witnesses.

7 MR QUINN: Sir, there are some minor housekeeping issues  
8 in relation to Mr and Mrs Roberts. We may not be able  
9 to deal with those tomorrow, I'm not sure, but there is  
10 a document that I have found in relation to forensic  
11 analysis of handwriting. Myself and my learned friend  
12 have talked about this matter and perhaps if I submit  
13 this document to you, we could maybe deal with this on  
14 Thursday or Friday.

15 THE CHAIRMAN: Thank you very much.

16 (5.06 pm)

17 (The hearing adjourned until 10.00 am the following day)

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1 THE CHAIRMAN: I'm sorry, it's after 5 o'clock. Doctor, I'm  
2 afraid I'm going to have to finish for today. I'm very,  
3 very sorry we haven't quite got through all of your  
4 evidence. I'm not going to ask you to come back  
5 tomorrow, but could I ask you if at some point over the  
6 next week or two if you could give us some little more  
7 time? We'll try to liaise with you over some 24 or  
8 48 hours when that might be mutually convenient.

9 A. I could come back tomorrow if that was of any help.

10 I don't have my diary. I do have commitments next week.

11 MS ANYADIKE-DANES: Perhaps, Mr Chairman, if I could get  
12 some soundings about that?

13 THE CHAIRMAN: I think Mr Wolfe is taking Dr Kelly tomorrow.  
14 I know that already looks like a long day. I don't want  
15 two witnesses running over, Dr Carson running into  
16 tomorrow and Dr Kelly running into Thursday.

17 Doctor, could you consider the week of 24 June?

18 A. I don't have my diary with me. I could get back to you.

19 THE CHAIRMAN: I'm very grateful to you for offering  
20 tomorrow, but I think tomorrow looks like a heavy enough  
21 day as it is and for a number of reasons, next week  
22 isn't going to suit.

23 A. What was the date, Mr Chairman?

24 THE CHAIRMAN: Monday the 24th. If I could leave you with  
25 that and maybe ask you if we could contact you or you

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1 I N D E X

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3 DR TREVOR ANDERSON (called) .....1

4 Questions from MR WOLFE .....1

5 DR IAN CARSON (called) .....120

6 Questions from MS ANYADIKE-DANES .....120

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