1 Tuesday, 11 June 2013
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 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 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 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

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

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

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.

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

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

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.

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.

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?

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?

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

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

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.

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

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

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'Donohoe was to make very
25 careful notes and be prepared, I presume, to answer

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

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

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

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

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

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?

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

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.

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

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

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

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

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,

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?

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?

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

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

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.

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

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."

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

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

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

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

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

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

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

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

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

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

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?

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

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

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.

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.

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

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.

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.

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

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.

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?

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.

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

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?

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?

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

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.

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.

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

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

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 ..."

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

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

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

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

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

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

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.

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

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

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,

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

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

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

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.

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

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.

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.

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:

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

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

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"?

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

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

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

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?

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.

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?

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.

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.

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

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

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.

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

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

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

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

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

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

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

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

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

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

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":

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?

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

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

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.

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

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

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

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

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.

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

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?

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

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

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

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

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.

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".

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

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

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

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

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

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

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

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?

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,

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

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.

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.

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

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

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

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

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

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

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 --

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

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 --

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 --

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

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

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.

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

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)

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

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

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

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:

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

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

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?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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,

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

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

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 plummetted.
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

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?

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

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

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

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

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

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

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?

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

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.

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

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

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

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 --

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

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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