Wednesday, 19 June 2013

(10.00 am)

(Delay in proceedings)

(10.14 am)

THE CHAIRMAN: Good morning. Mr Wolfe?

MR WOLFE: Good morning, sir. Dr William McConnell, please.

DR WILLIAM McCONNELL (called)

Questions from MR WOLFE

MR WOLFE: Doctor, good morning.

A. Good morning.

Q. You have already provided to the inquiry a number of statements. The first statement which you provided to the inquiry concerned directly the case of Raychel Ferguson and that was witness statement 047/1, dated 25 October 2011.

A. Yes.

Q. Then you provided two further witness statements, one dated 5 December 2012, and the next dated 31 January 2013 --

A. Yes.

Q. -- arising out of what we call "Lucy Crawford aftermath". And they're numbered 286/1 and 286/2; is that correct?

A. That's correct.

Q. We ask all our witnesses this, we ask them: do you wish

to adopt those written witness statements which will be used to supplement your oral evidence today?

A. Yes.

Q. I'm obliged. We find within your witness statement, at 286/1, page 2 -- if we could have that up on screen, please -- an outline of your qualifications and your career history.

A. Yes.

Q. Thank you. We can see that you qualified with a medical degree from Queen's University Belfast in June 1970.

A. That's correct.

Q. And the rest of your academic qualifications are set out. Moving to (b) on that page, we can see your occupational or career history, dating back to 1972. More recently, you were appointed as director of public health, as it was to become known, in 1985 in the Western Health and Social Services Board.

A. Yes.

Q. And you worked in that capacity through to 2009, when you retired from the position?

A. Yes.

Q. Could we perhaps go back to page 1 of your witness statement? You set out in the middle of that page, doctor, a number of your memberships of advisory panels and committees.

A. Yes.

Q. We can see that you were a member of the chief medical officer/directors of public health group from 1985 until your retirement. Was that the group, doctor, that was to discuss, on 2 July 2001, the death of Raychel Ferguson and the Solution No. 18 issue, if I can put it in those terms?

A. That's the same group, yes.

Q. And we'll look at that later. You were an ex officio member of all the department's specialty advisory groups, including paediatrics, anaesthetics, et cetera?

A. Yes.

Q. Tell us something about that. The department had obviously a number of advisory groups relating to various specialties.

A. That's right, and those would -- many of them would meet once a year, some might meet twice a year. The membership of those would have been determined by each group. The paediatric group across Northern Ireland would determine who would represent each hospital or trust or whatever on that, and the four directors of public health were also ex officio members of that and had the opportunity to sit in on those meetings if they felt that was considered appropriate at that time.

Q. And what would be on the menu for those annual meetings?

Let's take paediatrics. Would that be the big structural or strategic issues or what would be it?

A. Primarily it would be those. Perhaps if major changes were being proposed to hospitals within Northern Ireland or paediatric settings, then those would come up for discussion. Issues of concern about staffing or other issues could also be raised by the individual members and put on to that agenda.

Q. And it would be a way of feeding in from the local hospitals or the local providers directly into the Department of Health?

A. Yes. It tended to be predominantly around specialty issues rather than raising -- paediatricians or anaesthetists may not have raised more general issues about the hospitals; it would have been about their specialties, how they were performing, how they were being structured across Northern Ireland, but it was definitely both an inward and an outward constructed agenda.

Q. Yes. And you have said that you were a member of the Western Health and Social Services Board and a member of its healthcare committee.

A. Yes.

Q. Could you help us with the healthcare committee in particular? You've referred to it in your witness

statement as being a subcommittee or a subgroup of the Western Board.

A. It was a formal subcommittee of the Western Health and Social Services Board. My position on that would have changed over time because when the construct of the boards and trusts in particular changed, prior to that directors had been full members of those committees, but as the structure changed, then we would have been in attendance rather than full voting members of those committees.

Q. So your influence on it in terms of --

A. Changed slightly.

Q. -- voting capacity was reduced upon the formation of the trusts?

A. Yes. I think the department, in determining those sorts of changes, were keen that it would be seen publicly that the appointed board members, appointed by the minister, had a greater influence.

Q. Yes. The change that we're most interested in was in or about 1996 when the Sperrin Lakeland Trust was formed. Does that imply that prior to that change that officers from the various hospitals which were to become the Trust were members of that committee?

A. No.

Q. No?

A. No, they were not, no.

Q. So who staffed that?

A. It would have been the directors at the Western Board, the general manager, director of public health, director of finance, those sorts of roles.

Q. And then post-1996, the same people formed the committee?

A. I'm not sure that it was exactly 1996, but at that stage the board was reconstituted and there would have been five members of the public appointed by the minister as full board members, plus a chair, plus three directors of the board, and that was the chief executive -- sorry, it would have been, I think, four: the chief executive, the director of finance, the director of social services and the director of healthcare. So if you like, the formal officers of the board were always outnumbered, I suppose is the way one might put it, by the appointed members from the minister.

Q. And you were a non-voting member of the board --

A. Yes.

Q. -- wearing your director of public health hat?

A. That's right.

Q. In that more recent era, let's pinpoint the year 2000, what would have been on the agenda typically of that Western Board healthcare committee?

A. That might have been things like the future structure of hospital services or perhaps strategic changes to individual specialties like orthopaedics, those kinds of issues, issues of health education, health promotion. I'm trying to remember back now to ... But it would definitely be more strategic issues like that. The board was looking to change over a period of time.

Q. Albeit, I think if I've got the name of the committee right, I think in your witness statement you do indicate that in terms of operational issues, you would have understood yourself as having responsibility to report into that committee any, for example, adverse incidents that had come to your attention that --

A. Yes.

Q. -- might be regarded as serious and as possibly having consequences?

A. Yes. Not only within our own board areas, but things right across Northern Ireland which might have a strategic importance, where people from within the population that we were commissioning services for were being treated. For example, if there were issues in relation to cardiac surgery services in the Royal, and that was where some of our population were receiving care, then I would have advised the members of the health committee of that.

Q. We have your job description, I don't think we need to go to it, but could I ask you this: in terms of your role and where it fitted into the Western Board as an organisation, can I ask you to help us with this? We have a general manager who was Mr Frawley --

A. Mm-hm.

Q. -- and the other person whose name features prominently is a witness we heard from yesterday, Mr Bradley --

A. Mm-hm.

Q. -- who at the time of Lucy's death in April 2000 was the chief nursing officer for the board --

A. Yes.

Q. -- although was later to assume, along with that responsibility, the director of healthcare role --

A. Yes.

Q. -- but that didn't come --

A. That come --

Q. -- to him until August or September.

A. August or September, yes.

Q. Could you help with us this: in terms of your work, how did you interrelate with those two gentlemen?

A. Martin and I would have worked very closely. Obviously a number of issues of importance in health will involve both nursing care and medical care, and it was therefore important that we would work together closely on those,

although we obviously had our own individual responsibilities. So that would have been a close working relationship and obviously with the general manager, that was a line management relationship, but it was still a close working relationship, yes.

Q. So just picking up on something you said in your witness statement:

"Within the Western Board, my line of accountability was through the director of healthcare, Martin Bradley, to the chief executive, Tom Frawley, and thence to the board and to the chairman."

A. There is a point which I perhaps need to clarify on this. I had held the director of healthcare role through until, I think, probably about June of that year.

Q. Right.

A. But I was also fulfilling the director of public health role and I genuinely felt that doing both with the level of staffing that I had was becoming difficult and, at that stage, I indicated to Mr Frawley and the chairman of the board that I wished to resign from that role as director of healthcare and continue and focus on the director of public health role.

Q. The point of clarification which I think we need is this: it would appear that Mr Bradley then stepped into

your director of healthcare shoes; is that right?

A. That's right.

Q. And so at the point in time of Lucy's death being reported to the board, you weren't reporting to Mr Bradley?

A. No, it was the other way round.

Q. And indeed, by the time Mr Bradley took over the director of healthcare function, essentially from yourself, Mr Frawley was waving goodbye to you because he was off to pastures new; isn't that correct?

A. That's right.

Q. Because I think he moved to a new job in or about September of that year.

A. Yes.

Q. Very well. Can I tease this out with you? Mr Bradley, who gave evidence yesterday, talked about a closeness of the working relationships between yourself and himself and, in turn, to Mr Frawley.

A. Yes.

Q. And in terms of the typical reports that you would be making up the line to Mr Frawley, you were responsible to him for what's described as "professional matters"; is that right?

A. Professional matters within my own directorate, within the board staffing.

Q. Yes. What does that mean in real terms?

A. For reviewing the performance of the consultants who were within my department, senior registrars, issues that were ongoing within, but not more widely, not since 1996, outside the board's own organisation.

Q. Yes, you're talking about board employees?

A. Board employees.

Q. I'm obliged. But more generally than that then, applying your director of public health hat, had you obligations in terms of reporting to Mr Bradley in respect of issues that came under that side of your job? Am I not making myself clear?

A. Sorry, I don't follow.

Q. Your role as director of public health, we see from your job description --

A. Yes.

Q. -- caused you to be involved with those from whom you commission services in dealing with issues that were, if you like, in the public health sphere.

A. Yes.

Q. To what extent did you have to report on issues coming in to you from those from whom you commissioned services?

A. I'm still not absolutely clear what the point is you're getting at. Let me put it this way --

Q. Let me put a specific -- if a particular issue arose say in the Erne Hospital that concerned you as the director of public health, what was your responsibility in terms of reporting that issue internally and, in particular, to Mr Frawley?

A. Advising of any particular implications that it might have for us in terms of commissioning services from that trust. No responsibilities in terms of medical discipline, competence, et cetera, in relation to staff in the Erne. Our responsibilities were in relation to the commissioning of services: would it be appropriate for us to continue to commission services on behalf of our population from that organisation? The only additional responsibilities that I would have had in reporting issues from within trusts would have related to the very specific responsibility that I had for the control of communicable disease. If there were outbreaks of infectious disease, those then became my responsibility to look after in terms of seeing how that outbreak had been identified, the measures that were being taken, and the institution of appropriate measures to make sure that that control -- that that outbreak was brought under control.

Q. Yes.

A. That's quite separate.

Q. I'd like to explore the first part of that answer, leaving the communicable diseases issue to one side.
A. Sure.
Q. The first part of your answer touched upon the fact that issues might arise, from time to time, arising out of what is happening, say, in a trust. A trust is the body from whom you commission services, and issues might arise there that are of general importance to the health of the population for whom you're responsible. That points up the nature of the relationships between the trust and the board at that time. This was very much a relationship of purchaser/provider; isn't that right?
A. It is, yes. From 1996 onwards our functions changed significantly.
Q. Help us, if you can, by illustrating that. The board, of which you were a member, an employee, purchased services from the Sperrin Lakeland Trust.
A. Yes.
Q. There was a service level agreement that regulated that and Mr Frawley's provided us with a copy of that. But in terms of accountability, how did that change? What was the position pre-1996 and how did it differ post-1996?
A. The position pre-1996 is, had there been an issue of medical discipline or medical mismanagement or something

such as that, that would have been my responsibility. I was also responsible for the employment and management of medical staff from consultant level down.
Post-1996 --
THE CHAIRMAN: Stop there. If there was an issue of medical discipline or medical mismanagement up to 1996, when the Trust was established, that came to you?
A. It did.
THE CHAIRMAN: To what extent did you keep the chief executive, or whatever Mr Frawley was called in those days, informed about those issues?
A. I would regularly have informed him about issues in monthly meetings between -- well, it was monthly or six-weekly, depending on how things fell out, but I would regularly have kept him informed of any issues which had emerged and what action was being taken.
THE CHAIRMAN: Okay. The reason I'm asking is because Mr McKee from the Royal said that this was outside his ambit and these issues were not brought to him within the Royal. Of course, pre-1995, I think the Royal was a unit of management within the Eastern Board, but within that unit of management.
So you're saying that in the Western Board the practice was that the director of public health brought to the attention of the chief executive issues about

medical discipline or medical mismanagement? That's what you're saying for the Western Board, and then, on the other hand, the chief executive of what was the Royal unit of management, which became the Royal Trust, said that in the mid-1990s, even when the Trust was established, he wasn't told and didn't expect to be told about medical disciplinary or medical mismanagement issues by his senior staff.
A. That would have been very different from my understanding, chairman. The position which I've outlined I know was the position which was followed certainly in the Northern Board and in the Southern Board. I cannot put my hand on my heart and say it was what the position was in the Eastern Board, but I have no understanding as to why it would be any different.
THE CHAIRMAN: And you're rather surprised to hear that it was different?
A. I am surprised, yes.
THE CHAIRMAN: Thank you.
MR WOLFE: And so that helpfully describes the pre-1996 accountability arrangements. Post-1996, then, you've told us in your witness statement, perhaps it summarises it, that:
"[You] had no direct responsibility for the

operation, management, supervision or control of the services provided by the Sperrin Lakeland Trust."
A. That's right.
Q. You go on to say that:
"The regulatory authority and management control for trusts rested with the department."
A. Yes. Very specifically in 1996, the trusts were created to have that independence from boards, and their line management arrangement was direct with the department.
Q. Let's just look at what residue, if anything, continued to rest with the Western Board. There is no direct managerial accountability, and certainly as a matter of legislation --
A. No.
Q. -- that had gone with the creation of the trusts.
A. Yes.
Q. But it does appear from evidence that we've heard that in terms of, for example, adverse incidents, there was an understanding, indeed an expectation, that the trusts would report to the Western Board matters of that nature; is that fair?
A. Yes, but not reporting in line management terms. The Western Board, while it is big in geographical area, has one of the smallest populations or had one of the smallest populations of the boards in Northern Ireland.

It was also covered by a wide number of weekly newspapers and media, things like Radio Foyle. From that point of view, if something significant happened in one of our trust settings, I and the board would have expected to be advised of it happening, not in any expectation that we would begin to manage that issue, but so that we could inform board members and so that we could inform ourselves of any implications in relation to the commissioning of services.

For example, if in any specialty there was, say, three consultants in a firm and two left, I would expect to be advised of that because that could create fragility in the maintenance of that specialty service and we would therefore have to look and say, "If we need a certain level of service on behalf of our population, how are we going to seek that if we're not in a position to get the same level of service from that trust as we were before?"

Q. Yes. So if an incident happened, rather than having to hear about it via the bush telegraph, you would want the reassurance of hearing about it first-hand --

A. Yes.

Q. -- from the Trust? Is that primarily because yourselves as an organisation had responsibility for the health and safety, if you like, of the local populous?

A. Well, I would say it was for two reasons. First, it is because we needed to understand any implications on the services, just as you've said, that we were being -- which were being commissioned on behalf of the population. But second, I think it's very important to try to reassure a population that if the media came to us and said, "X has happened, what do you make of this?", that we were in a position to give some informed comment about it rather than saying, "I'm sorry, I don't know what you're talking about".

THE CHAIRMAN: But is that an issue, doctor, of managing public perception because public perception would be that the Trust was accountable to the Western Board? Even if that isn't factually right, the perception would be: the Trust has gone wrong, but we all live in the Western Board area and the Western Board is commissioning these services from that hospital, so if something goes wrong, rightly or not, the public expects the Western Board to be able to respond to it?

A. Yes.

THE CHAIRMAN: Okay. And if for instance, if there are two paediatricians in the Erne and they both hand in their notice because they've got better jobs somewhere else or more attractive jobs somewhere else, you need to know about that because that has a direct impact on the

services which you're paying the Sperrin Lakeland for.

A. Yes, chairman.

THE CHAIRMAN: That's one very easy example. If, on the other hand, there's a serious adverse incident which reflects on the competence of the Trust to provide the service which you're paying for, you want to know about that as well?

A. Yes.

THE CHAIRMAN: And you do that both from a publicity point of view but from a commissioning point of view. In other words: why are we paying Sperrin Lakeland however many hundreds of thousands or millions of pounds to provide a service if the staff they employ are not capable of providing that service?

A. Yes.

THE CHAIRMAN: Okay.

MR WOLFE: Could I just tease out with you two points that have been made by representatives of the Sperrin Lakeland Trust? First of all, Mr Mills at the time was chief executive of the Trust. He talked in his witness statement, his first witness statement 293/1 page 11, in terms of it being a requirement of the Western Board that significant issues occurring within the Trust would be reported and discussed. This language of requirement or obligation, does that sit well with you?

A. No.

Q. Well --

A. Prior to 1996, I would have viewed it as a requirement. Post-1996, with the creation of the Trust, I would have expected that it was something highly desirable. But it was not a requirement to report it to us as we were not directly, in many cases, taking action on whatever they would have advised us about.

Q. In real terms, would it not have become a requirement in the sense that if you were to hear about something second-hand through the media rather than directly from the Trust itself, as you've described -- I'm not suggesting you could have applied or would have applied sanctions, but you would have necessarily made your feelings known that --

A. Yes.

Q. -- so in that sense, would it be fair to say that the Trust might have felt obligated to --

A. I would be happy -- sorry, when you mentioned a requirement, I thought you meant that somewhere written down there was an instruction "you must".

Q. No.

A. And there certainly wasn't that. But certainly I would have expected it, yes.

Q. Then can I ask you something about your role? In his

witness statement to the inquiry, Dr Kelly, who at the time in 2000 had just commenced a role as medical director of the Trust -- he was in post about a year -- he said that it was his understanding that, having been told of an adverse incident, you had a responsibility to be satisfied that the incident was being properly reviewed and then, if appropriate -- and all cases of course are different -- you had a responsibility for disseminating any lessons learned to appropriate audiences within the Western Board area.

A. No, I had no such responsibility. I would still have expected to do that. If I was made aware by one trust that there was an issue which had wider implications I would have done two things as I think, in June and July of 2001, I demonstrated. I would have disseminated it both within our own geography, but I also would have disseminated it to the directors of public health of the other boards and the chief medical officer if I felt it had potential wider implications within Northern Ireland.

THE CHAIRMAN: Does that not add up to something very close to the same thing? The primary responsibility for investigating any serious adverse incident lay with the Trust --

A. Yes.

THE CHAIRMAN: -- but the Trust was to keep you informed of a serious adverse incident?

A. Yes.

THE CHAIRMAN: You would want to be reassured that the Trust had got to the bottom of it?

A. Yes.

THE CHAIRMAN: And when it had got to the bottom of it and you saw the outcome of the review, you would then decide whether there was anything which needed to be disseminated beyond that particular trust and that could be disseminated to the other trusts in your area, to the other boards and/or to the department?

A. No. You see, the difference is that I also expected that to be going to the department.

THE CHAIRMAN: Directly from the trust?

A. Yes.

THE CHAIRMAN: Right. But in a sense then there's a bit of an overlap here. You would want to know from the trust, and -- let's say it's Sperrin Lakeland -- you would then decide whether to disseminate that to Altnagelvin and the Foyle Trust?

A. Yes.

THE CHAIRMAN: Going outside the Western Board area, you might have a view that the other boards need to know about this as well, and you yourself might tell the

other boards and you might tell the CMO.

A. Yes.

THE CHAIRMAN: But you would, in any event, have expected the trust to have told the CMO?

A. Yes.

THE CHAIRMAN: So there's two routes to the CMO in an appropriate case?

A. Yes.

THE CHAIRMAN: Thank you.

MR WOLFE: In fact, doctor, if I may say so, it's perhaps illustrated by the approach that was adopted in the Raychel Ferguson case. Your link at the Altnagelvin Hospital was Dr Fulton. He had, before coming to you, as I understand it, made a report in on behalf of the trust, the Altnagelvin Trust, into the CMO's office, but at the same time, if you like, took you to one side and said, "Listen, there's an issue here". You then put it on the agenda at departmental level; isn't that right?

A. That's right, yes.

Q. So what we've just dealt with there, if I can summarise, is define, if you like, a role for you, and perhaps other Western Board colleagues, in satisfying yourself that the trust, having made an adverse incident report to you, you then or you and your colleagues then have been to be satisfied that the trust are moving in the

right direction in terms of reviewing that incident and taking the necessary action.

A. Yes.

Q. Is that fair?

A. Yes.

Q. Could I put to you, if you like, stage 2 of the process? Assuming that a trust is carrying out a review or an investigation, Mr Frawley takes up:

"At the next stage what would the Western Board be expected to do when the trust reported back at the conclusion of its review?"

And what he said is -- this is his witness statement, 308, page 8:

"Where the investigation and its conclusions resulted in the preparation of a formal report [as here], I would have had an expectation that the report would be shared with the board ..."

That would be your view as well?

A. Yes.

Q. "... in order to enable the board to consider whether the board needed to initiate any action in light of the report."

So to take a far-fetched example, the report might come back with holes in it and he seems to be suggesting that if it did come back with holes in it, the

Western Board would see for itself a role in making that much known to the trust.

A. To the trust, yes. I would particularly have examined, if you like, two things in relation to most reports that came to me: the process and the content.

Q. Yes. He says, just to finalise this point, with which you seem to be in broad agreement:

"In making such a judgment, I would seek the views of the relevant professional leads."

For example, yourself or Mr Bradley, perhaps if it's more of a mainstream nursing issue.

A. Yes.

Q. And:

"[He] would seek your input in terms of whether the findings, conclusions and recommendations proposed by the trust were a proportionate response to the incident which had been investigated."

A. Yes.

Q. So he's being very clear: it's not for the officers of the Western Board to take the hand of the trust and carry out the investigation or necessarily direct on the investigation; he, like you, I think, illustrates his point by saying, "We have to be satisfied that a review is being undertaken, then we await the report and then apply some judgment to it".

A. Yes. The sort of process that I would have expected to happen would have been, at a conclusion, the trust to write to the board with a report, that to be brought probably initially to the like of a healthcare committee, who would have asked the professional leads, "What is your view on this?". It would then have formulated a view, which would have been returned by the board itself, not by an individual officer, to the trust, saying, "Here are our views and comments".

Q. Yes. Thank you. Could I then put the other side of the triangle into the mix, and that is the department? In legal terms, it would appear that the managerial or accountability relationship was directly between the trust and the department post-1996.

A. Yes.

Q. Help us if you can: what was your understanding of the process that was available to each of those parties to conduct this accountability relationship?

A. Well, I knew that the -- perhaps not in tremendous detail, but I knew that the trusts, the chief executives and on occasion the chief executive and the chair of the trust, would meet regularly with officials from the department. I think that was headed by the Permanent Secretary's department, I'm not sure whether it was the Permanent Secretary or one of his assistants

or deputies who would have held those accountability meetings with the trusts.

Q. Was it your understanding that those accountability meetings were a mirror image of the accountability arrangements that pre-dated 1996 in the sense that you, in the Western Board, had been supplanted by the department, is that fair analogy, so that those working in the hospitals had an accountability to you pre-1996 for the broad range of issues, including operational matters and professional matters?

A. Yes. My expectation would have been that the department fulfilled the same role. If they had changed the line management away from us to themselves, my expectation was that they were fulfilling the same expectation.

Q. Have you any sense of whether that actually happened as, if you like, as soon as the new regime came in, as soon as the new arrangements came in?

A. I could not be categorical.

Q. I ask that question because, in fairness to Mr Mills -- and we'll get into whether Lucy Crawford's case was or should have been reported to the department in just a few moments -- but keeping this general at the moment, he seemed to reflect in his evidence the absence of a process or a mechanism for that kind of operational type accountability, certainly in or about 2000.

A. I could not really say, but my expectation would have been that there was both an operational and strategic reporting of issues.

Q. Certainly he was very clear that there were regular meetings at chief executive level with the department. I think he shared your view that that would be at Permanent Secretary level, a point you've reflected in your witness statement. But he was making the point insistently that this was to discuss strategic, structural issues, and not the minutiae of operational and certainly not adverse incidents.

A. Well, I suppose I have some difficulty in understanding a system that didn't take account of both.

THE CHAIRMAN: Previously, pre-1996, when the board was accountable directly to the department, and you would meet from time to time the Permanent Secretary and so on, you might go to some of those meetings, might you?

A. Yes.

THE CHAIRMAN: I'm sure I'll be corrected about this at a later stage in the inquiry, but there may be some distinction between the role and functions of, say, the Permanent Secretary on the one hand and the chief medical officer on the other. Would you have had meetings at which the chief medical officer was present?

A. Our accountability reviews would have involved their

senior team, including professionals headed by the Permanent Secretary with our senior team headed by the general manager and the professional and finance and other leads there as well, so it was a team to team accountability.

THE CHAIRMAN: And the CMO would be part of the departmental team?

A. Yes.

THE CHAIRMAN: Thank you.

A. Sorry, perhaps I should say "could be". Not always were all of those people at the meetings, but certainly they had the opportunity to be.

THE CHAIRMAN: Right. And since not every meeting can cover every issue, there might be some meetings at which the input of the CMO and the professional leads at the board end would be more relevant than others?

A. Yes.

THE CHAIRMAN: So as not to waste people's time, those meetings would be arranged to have the relevant people present for whatever was on the agenda?

A. Yes, chairman.

THE CHAIRMAN: Thank you.

MR WOLFE: Can we move then, doctor, on to the specific events around you being informed of Lucy Crawford's death? The inquiry is aware that there is a note on

Mr Mills' file, which states that he provided information to you about the incident and you stated that you would advise Mr Bradley.

A. Yes.

Q. I think you tell us that you can't recall the detail of the conversation with Mr Mills other than that the information was about Lucy having been admitted unwell, her collapse had occurred following treatment in the Erne and she had been transferred to Belfast and subsequently died.

A. I have one other recollection, but I cannot be categorical about this. I did advise -- my memory is that I did advise Hugh Mills of the need to advise the department. The reason why I remember something about that is I can remember some comment about, "But I'm not sure who to inform or how to inform them", and me saying something about, "There is a duty press officer and you can channel information through them". Why I was thinking in those terms at that time was I was conscious -- just as I did not want to have something happen within our board area and not be aware of it, I was conscious that both the Permanent Secretary and the minister would not have had [sic] something as significant to have happened in Northern Ireland and them not to be aware of it, unless approached. I was

not at that time thinking in terms of any wider repercussions.

Q. I want to maybe further examine that point now. You have said in your witness statement that you had a belief or you hold a belief that the death was reported to the department; is that fair?

A. Well, having said that, my expectation would have been that something would have been carried through. I would not have seen it as my role as the DPH to go back to a trust chief executive and say, "Did you or did you not do that?", but my understanding would have been that, having said that, that would have been carried through.

Q. Could I just have up on the screen, please, your witness statement on this point? It's WS286/2 at page 4. You are asked at (e):

"Did you take any steps to ascertain whether the Trust had reported the death to the department?"

And you say:

"In the information provided by the director of acute services, Mr Fee, and the chief executive Mr Mills, I believed that Lucy's death had been notified to the department and did not, therefore, need to take any further steps to ascertain this. This is based on my recollection and I have no record, either paper or electronic, to confirm this."

And so if we just go down the page, you're asked:

"Please identify who it was that made you aware that the Sperrin Lakeland Trust were already in discussion with the department."

This refers back to an answer that you had given in your first witness statement and just moving down the various items at item (c):

"In what forum did these discussions take place? My understanding is that this would have been in telephone communication between the chief executive of Sperrin Lakeland Trust and senior department staff."

I just want to see if we can bottom out what you're saying there, doctor. You appear to be alluding to information provided to you, and I want to establish whether that was provided to you directly in the sense of "I have made a report" or were you inferring from what was being discussed at the time that a report was bound to have been made?

A. Well, perhaps clumsily, as I look at it now, what I think I'm trying to say here is that I had advised them to report it. At no stage did anyone come back to me and say, "We didn't report that", or, "We had difficulty reporting it".

THE CHAIRMAN: So your belief that it was reported is based on your assumption that the advice you gave would be

followed?
A. Would be carried through. And had it not been, I might have expected someone to have come back to me and say in a future discussion, "We weren't able to do this".
THE CHAIRMAN: And should I also infer from the evidence you've already given about the structures that you might have thought at the time that this is something that they perhaps didn't need all that much advice on anyway, that the trust should have realised that this was something that was so significant that it should be reported to the department?
A. Yes.
THE CHAIRMAN: Right.
MR WOLFE: In an answer a moment or two ago -- and I realise that you're doing your best to dredge up a memory of something that happened 13 years ago or so now, but you say, thinking about that first telephone call with Mr Mills, that you may well have talked in terms of this being something quite significant, this death. What did you mean by that? Is it the human factor, the death of a young baby in such unexpected circumstances?
A. Yes. The sudden and unexpected death of any child is a significant event. When it occurs within a hospital setting like that and has not been expected, I would regard that as significant.

Q. So again, help us if you can -- and I may be pushing too far -- do you think you might have said that about its significance as a reason why a call should be put in to the department?
A. I could not in any way say what specifically I said or didn't.
THE CHAIRMAN: Can I take it, doctor, that Mr Mills didn't have to ring you very often to tell you that there was a sudden and unexpected death in the hospital?
A. That's absolutely so, yes.
THE CHAIRMAN: So the fact that this information has reached Mr Mills and the fact that he's passing it on to you emphasises the significance of this event?
A. Yes, chairman.
THE CHAIRMAN: So if it's another tragedy like an infant being killed in a car accident, Mr Mills doesn't get on the phone to you?
A. No.
THE CHAIRMAN: Okay. Or a child who dies of leukaemia, Mr Mills doesn't get on the phone to you?
A. No, chairman.
THE CHAIRMAN: But there was something particularly significant in the way in which Lucy had died that led to Mr Mills contacting you?
A. Yes.

THE CHAIRMAN: And you then are saying to me, in effect, it should have been obvious to Mr Mills that he doesn't stop with me, he goes on to the department?
A. I would consider so.
THE CHAIRMAN: And it is more than a question of press control; it's a question of: this is a significant event in terms of the provision of health services?
A. Yes. I'm not sure that I could go on that further step at that moment in time because no one was clear about what the reasons for it happening were.
THE CHAIRMAN: That was exactly the concern, of course, that nobody was clear, wasn't it?
A. Yes.
THE CHAIRMAN: But as events did move on and we had Dr Asghar's involvement and so on, then at that point did it become clear to you at least that this looked like a significant event in terms of the provision of health services?
A. It looked like a significant events in terms of the provision of health services, but it still looked like it was relating to one specific unit, to one specific group of doctors. At that point nothing that had been brought to my attention, or that I could have interpreted from what had been brought to my attention, would have indicated any wider relevance in terms of

needing to tell any other units.
THE CHAIRMAN: In that context, you're saying that there was no reference here to Solution No. 18?
A. That's right.
THE CHAIRMAN: Okay.
MR WOLFE: Can I ask you, doctor, whether you took any steps to assure yourself that a report had actually been made? Because we have the evidence of Mr Mills that in fact no report was made.
A. I didn't. I didn't take any steps. Having said what I'd said, I expected that to be followed through. I did not consider making any steps. I mean, genuinely -- and this is not just with the benefit of hindsight -- I would not have been of the habit of checking out advice that I had given to a senior colleague, especially a chief executive, to go back later and say, "Well, did you do that?"
Q. I just put on the record to you Mr Mills' position being that he is quite clear that he didn't report and nobody advised him to report.
A. I cannot offer any other view on that other than what I've already indicated to you this morning.
Q. Yes. And while you have said that you weren't in the habit of, if you like, checking back on whether advice that you had given had been followed, you will have

observed Professor Scally's opinion, expressed in the report for the inquiry, that he is concerned that no one in the Trust took steps to determine that the death had been reported to the department.

THE CHAIRMAN: No one in the trust or board?

MR WOLFE: No one in the board, I should have said.

No one in the board took steps to check out the position; is that a valid criticism?

A. I don't consider it so, no.

Q. The role that you had at that time, when this report comes in to you from Mr Mills, internally what was expected of you in terms of communications?

A. In the report of the event?

Q. Yes.

A. My own expectation, and presumably Hugh Mills' as well, was that I would convey that to Martin Bradley and to the general manager of the board.

Q. Mr Bradley's evidence is that you have done so. At that point, in terms of your interaction with the Trust itself, had you any actions to take at that comparatively early stage?

A. I don't believe so. I'm trying to think what you might be expecting.

Q. The report has come in of the death. You disseminate that information internally. What steps did you take

externally with the Trust?

A. I would have expected to have followed that up in the next week to understand what they were going to do in terms of investigating the events at around that time. That then was relayed back to me. I think Martin Bradley had an initial discussion with Eugene Fee, with Hugh Mills. I also had communication then that Dr Quinn was going to be asked for an initial rapid review of the notes.

Q. Just before we move to Dr Quinn, you have said something in your witness statement about your internal communications. You said it in your second witness statement at page 2, that you would have reported to the chief executive and the director of healthcare. At that time, of course, you --

A. I was, yes.

Q. That's just an error in your report?

A. It is, yes.

Q. What you meant, I suspect, was that you reported it to Mr Bradley?

A. Yes.

Q. You say then that:

"[You] would then have contributed to further reports made by the chief executive and Mr Bradley to the healthcare committee of the Western Board."

A. Yes.

Q. And you described earlier the function of the healthcare committee. Is it your memory that at one time or another you communicated Lucy's death to the healthcare committee?

A. I would be amazed if I had not and that there had not been discussion within our healthcare committee at the board of an event such as that. Even had officers not been raising it, I would have expected board members, perhaps those who were resident in the southern part of the board or who had been closely following the proposed changes in service provision to have been raising this and saying -- so either through them or directly through us, I would have anticipated that being discussed at the healthcare committee.

Q. How often did that committee meet?

A. It met five or six times a year.

THE CHAIRMAN: Doctor, I just want to get this clear. I don't understand that there was any local publicity about the event in Enniskillen at the time; am I wrong? We're going to go through this in stages, but in the days immediately after Lucy's death, was there publicity locally about her death?

A. I'm sorry, chairman, I cannot recollect.

THE CHAIRMAN: Because if there wasn't, then the members of

the public who were on the healthcare committee would not have known anything to take to the committee. A month or two later might be different, but at that stage, in the initial week or two, there wouldn't be anything to take to the committee at that point, would there?

A. I apologise, chairman, I thought in the questioning we were covering the six months, the 12 months following.

THE CHAIRMAN: Are we going through this in stages, Mr Wolfe?

MR WOLFE: We are. We're still at a comparatively early stage.

A. I'm sorry.

Q. I introduced the healthcare committee. Maybe if we put your answer up on the screen so that we can get it in context. It's WS286/2, page 2. You're asked about your responsibility to advise the board and its healthcare committee of Lucy's death. You outline the various steps that you took.

A. Mm-hm.

Q. And you explain what action, if any, was taken and the composition of the healthcare committee. Your memory seems to be, regardless of whether there was any press interest in this, this issue, your memory seems to be

that you'd be surprised if you didn't bring the case, the incident, to the attention of the healthcare committee?
A. Yes, but I think I would have to say that in that -- is it 1(a)? -- I was not specifically looking at the two or three weeks after Lucy's death, I was considering the time from then through -- potentially right through until 2004, who I would have made reports to, what I would have reported, et cetera.
Q. Yes.
A. That was not specifically aimed at that initial period of a couple of weeks.
Q. Yes. But having said that, I wonder does this analogy hold good? If you're telling the Trust chief executive that this is a very significant event which the department ought to know about, then those, if you like, appointed by the department to form part of your healthcare committee would likewise want to be told by you, who has first-hand knowledge or second-hand knowledge of what is happening?
A. Yes, I would have expected to have reported that to the healthcare committee within one or two meetings of it happening -- as soon as I was in a position to adequately describe to them what had occurred and what we understood to be going on.

Q. Those meetings are minuted, of course, and you've told us in your witness statement fairly that you have personally checked the records of the healthcare committee from early 2000 until the end of 2004 and you have found no detail of any report specifically given by you or the chief executive or the director of healthcare.
A. Yes, and I cannot understand that.
Q. That either suggests that the issue wasn't raised at the committee or someone wasn't doing their job right in maintaining minutes?
A. No, or that board members were briefed outside the committee. On occasions, there were issues which were dealt with after a meeting had finished, and a board member might then raise something with board officers, and there would be brief discussion on that. That may not be minuted.
THE CHAIRMAN: Yes, but your basic position, as you said a moment ago, is that you can't understand why there is no reference in the minutes of the healthcare committee for four years to Lucy?
A. No.
THE CHAIRMAN: So while I fully understand that every committee meets on the basis that there are discussions around the fringes before, during or after the meeting,

there should still be some reference in the healthcare committee minutes to what's going on in the Erne. The detail of it may not be very specific, but there should be some reference in the committee minutes?
A. Yes, chairman, and that's why I went back on a number of occasions to go through minutes over and over and over again and to try to ensure that there was nothing which might have been found since the last time I had reviewed them.
THE CHAIRMAN: Can I just interrupt Mr Wolfe for a moment and query something with you just so that I understand the structure better? Apart from the healthcare committee, was there a Western Health Council?
A. Yes.
THE CHAIRMAN: I'm thinking about the body that Stanley Millar was involved in.
A. Yes, that's the Western Health and Social Services Council.
THE CHAIRMAN: What's the comparative functions of the healthcare committee on the one hand and the council on the other?
A. The council is supposed to be a body representing the public as a -- I'm trying to think of the word that I'm looking for -- sort of guardianship body.
THE CHAIRMAN: Like overseeing --

A. Complaints.
THE CHAIRMAN: Complaints, right. How much different is that from the role of the healthcare committee?
A. Oh, very different.
THE CHAIRMAN: Would you have been asked to attend meetings of the health council from time to time or not?
A. Intermittently, but that perhaps might have been some years, once a year, some years twice a year, but usually to discuss a specific issue.
THE CHAIRMAN: And similarly, Mr Bradley and Mr Frawley, or not?
A. Yes.
THE CHAIRMAN: Okay, thank you.
MR WOLFE: Could I ask you just a question, while we are on the subject matter of the records of the healthcare committee? The records exist, you're telling us, it's just that they don't contain any reference to what we're talking about?
A. Well, certainly when I went into the board, copies, paper copies of different minutes of healthcare committees and of the board, were produced for me.
Q. More generally on the issue of records, you may be aware that, in or around 2004/2005, the inquiry made a call for records to be produced by all of the, if you like, major actors in relation to any of these deaths.

A. Yes.
Q. And what was produced on behalf of the Western Board were records pertaining to the period after and including 2004, which was the year of Lucy Crawford's inquest. But no material at all was produced, save an e-mail, which I'll turn to in a moment, from Mr Frawley to yourself.
A. Mm-hm.
Q. You were still employed by the board at that time; is that right?
A. That's correct, yes.
Q. Can you help us in terms of whether any particular request was made to you at that time to gather your records and place them in the hands of an administrator for delivery to the inquiry?
A. Yes. Very specifically, Stephen Lindsay, who was chief executive at that time, set up a project and specified an administrator who would head up that project to collect all of those records. I was asked to review everything relevant in my department. I reviewed all the paper files, any written files, and any of the electronic documentation which would have been either on my laptop or the desk computer. Those were all identified, the administrator then came over and double-checked all of that. Now, in some senses for me

it was a bonus because she had previously been my PA, so she knew the workings of my department. She was able to identify the files, look at them, check the electronic record, garner everything that was relevant, and then that was taken to Mr Lindsay's office and sequestered to be forwarded to the inquiry.
THE CHAIRMAN: Sorry, you're saying there was documentation which was gathered and provided to Mr Lindsay's office?
A. Yes. I can't comment on the extent of what that was, but I certainly would feel that there was paper and some electronic records.
MR WOLFE: Specifically in respect of the period 2000 to 2004? Because that's where the gap appears to be.
A. From my office, yes.
Q. Sorry? Say that again.
A. I wondered whether you were asking me in relation to the healthcare committee or to my department.
Q. I'm thinking more generally. In respect of the Western Board, within that period 2000 to 2004 --
A. I don't know.
Q. -- if you just let me finish the question so you hear it -- to include documents emanating from your particular office, to include the Western healthcare committee. Anything at all for that period. Can you help us whether in terms of whether there were

documents?
A. I cannot help you more widely than my department because the project was being run from the chief executive's office. But in relation to my own department, I believe there were electronic and paper records that had some reference.
Q. We know, for example, that the Trust had written to you in May 2000, Dr Kelly had written to you in May 2000. You would expect to see that letter on your file --
A. Yes.
Q. -- if we can see it on the Trust's file?
A. Yes.
Q. We would expect to see any notes that you might have made arising out of telephone conversations, recording advice that you might have given, all that kind of thing --
A. Yes.
Q. -- but the inquiry has seen nothing of that; can you assist us any further?
A. No, I can't assist you any further with that.
THE CHAIRMAN: Mr Lockhart, we're going to have to come back to that.
MR LOCKHART: Yes.
THE CHAIRMAN: Since Mr Frawley is due to be the last witness from what was the Western Board tomorrow, we're

going to have to come back to it tomorrow. I'm tired, in the context of this inquiry, of documents being called for and then we get a witness who says a document exists.
MR QUINN: Mr Chairman, I feel I should get up and make the point on behalf of the parents on this point. This is worse than hearing that a document exists and hasn't been forwarded. This looks as though the documents have been gathered and haven't been forwarded, which is a much worse offence than the documents simply being negligently cast aside. So on behalf of the parents that I represent, I would ask you, Mr Chairman, to make a full investigation into what now seems to be a cover-up.
THE CHAIRMAN: We'll follow up on what's gone wrong.
MR GREEN: The Dr Kelly letter does actually exist among the inquiry documents.
THE CHAIRMAN: It comes to us from the Trust?
MR GREEN: Yes, absolutely.
THE CHAIRMAN: But the point which emerges, Mr Green, which may end up assisting or not assisting your client, is that it always seemed odd that there were no documents from within the Western Board apart from a single e-mail, which Mr Frawley provided, but he provided that, I think, as an attachment to his witness

statement.
MR GREEN: Yes, I agree.
THE CHAIRMAN: So we haven't a single document from the Western Board for the period 2000 to 2004.
MR GREEN: Quite.
MR WOLFE: We were at the stage of the first contact from the Trust to yourself, telling you about the death and the steps that you think that you took. At that early stage, arising out of that first contact, were you told that there was to be a review of the death or an investigation within the Trust?
A. I was told that initially Dr Murray Quinn would be asked to do a rapid initial review of the notes. That was not unusual, in my terms, that someone would quickly scan things -- someone experienced and knowledgable would quickly scan things and then say, "Okay, a further review needs to take account of this, this, this and this", but my expectation was not ever that Dr Quinn's initial review was to be it.
Q. I don't want to be unfair to you, so I'll help you with this. I'm being quite deliberate in talking about the first contact between yourself and Mr Mills. Certainly on his account, the information in terms of communicating Dr Quinn's involvement to you came a number of days later.

A. Yes.
Q. But I suppose the question, before I get to Dr Quinn's involvement and your knowledge of Dr Quinn's input, was to ask you: how did you become aware that a review was to be conducted?
A. From contact with Mr Mills. I think that was the 21st June, perhaps. It was information -- there was a message left for me from Hugh Mills to say that he had approached Murray Quinn or that -- I'm not sure whether he said he or that Murray Quinn was being approached to do a rapid initial review of the notes.
Q. Just before we get to Dr Quinn and your view of that and the implications of that, could I put to you something that Mr Bradley has told us? He says that upon being told of an unexpected or unexplained death, he saw a function for either himself or, more generally for a board officer such as yourself, to take a number of steps. He said that it would be incumbent upon a board officer to ask the trust who's reporting the death what action is being taken to investigate the circumstances. Is that something that you would agree with and, if so, did you seek to establish that with Mr Mills?
A. It's not something that I would have raised immediately in the initial conversation when I was being informed of the event. It's something that would occur, would be

reasonable in a number of days afterwards, yes.
Q. You allude to further information coming to you from Mr Mills or from the Trust, perhaps, that a review is to be conducted.
A. Yes.
Q. I know that it was on the 21st that you were told or a message was left for you telling you about Dr Quinn's involvement, to what extent do you think you sought to establish at that point how deep or how, if you like, thorough this review was going to be?
A. At that stage I was relatively clear that this was a rapid initial scan, which would then be used -- if someone says to you, "I'm getting someone to come in and do a rapid, initial scan of the notes", then my assumption from the use of the word "initial" is that this then defines something which is going to follow up later. It begins to identify the area and the issues which need to be covered.
Q. Who do you think was describing the Trust's initiative in those terms?
A. Hugh Mills.
Q. Had you any views on that and did you express them?
A. I considered that that was a reasonable start to a process.
Q. Well, could you help us with this? Did you say to

yourself, "Right, that is a reasonable initial step, I will await and see the outcome of that", or perhaps, alternatively, did you say, "Well, that's a good start now, but I think there will be a need for further action down the line"?
A. I didn't say there will be a need for further action. The very use of the phrase "initial" to define the areas which needed to be examined later, I considered conveyed that impression.
Q. The next matter that Mr Bradley suggested should have been in the toolbox of a board officer such as yourself, or indeed himself, would be to ask the trust reporting the death if the coroner had been informed. Again, does that seem reasonable that a board officer would seek to ascertain that from the reporting trust?
A. I think it's -- I'll answer that in two ways. I think now in retrospect that might seem reasonable. At the time, I had no reason to consider -- I had never, as I think I may have conveyed elsewhere -- in 29 years in public health medicine I have never had to directly approach a coroner to check whether they have been involved. It's part of the training of every doctor, the issues are clearly set out by the Coroner's Service, to understand that if there is no explanation for a death, a sudden and unexpected death in a hospital,

that needs to be conveyed to the coroner and discussed and the relevant issues identified. Because one needs to get to the point where either a death certificate can be signed off or there's an alternative conclusion to arrive at a death being identified.

Q. Notwithstanding what you say was a reasonable assumption on your part that because people are trained, the profession is trained to report, that a report was bound to have been made --

A. I did not ever consider the need for me to directly approach the coroner or to ask whether the coroner had been involved. It seemed so automatically obvious to me that that did not need to be done.

Q. And just for the avoidance of doubt, was there any discussion in terms of Mr Mills, for example, volunteering that the coroner had been notified?

A. No. Not that I can recollect.

Q. Again, I wonder can you help me with this? The child died in the Royal Belfast Hospital, arising out of or at least it could well have been reasonably suspected of arising out of events that had occurred in the Erne Hospital from where she was delivered moribund to the Royal Hospital. Was there, in your expectation, good reason for the Erne to report that death to the coroner?

A. Well, a death in circumstances such as that can be reported by any party involved in the treatment of the child. It can either be reported in the setting where the death has occurred or it could be reported in the circumstances which we have here by those who were significantly involved in the early treatment.

Q. The third thing that Mr Bradley talked about was the need to advise or to suggest to the Trust that they make the department aware, and you've dealt with that already in your evidence.

The fourth thing he says is that:

"An officer of the board should be requesting of the Trust that any learning that might be achieved arising out of their investigation or their review should be reported back to the board."

Again, arising out of your initial contacts with Mr Mills, was there an expectation made clear that they would report back to the board and keep you informed of developments?

A. I expected to be advised. I'm not sure that I ever would have stated that. I mean, if they're going to provide a report, it surely is going to include those issues.

Q. On 21 April, as you have noted, Dr Quinn's name was mentioned in a message left for you by Mr Mills. Could

I ask you some questions about that? The report that was left for you, or the message which was left for you, was that the first time that you realised that the review was going to use an external person to assist it?

A. Yes, I believe so.

Q. You've said in your --

THE CHAIRMAN: Sorry, just one moment. In your witness statement, could we bring it up, at 286/1, page 5? Do you see at question 6, doctor, you've gone through being telephoned on 14 April, the next paragraph, "On 19 April, it's recorded ...", on the next paragraph, "On 21 April, Mr Mills left a message ..." When you were providing that response, did you do that by reference to the documents which you had from your time in the board?

A. I don't know. I don't know whether that was on the basis of the information that the Directorate of Legal Services had provided to me. I don't think I would have had that detail. I couldn't have been able to provide that detail without reference to documents.

THE CHAIRMAN: Yes, and if you couldn't provide that detail without reference to documents and if you knew that you had documents from this period about your involvement, can I assume that you would have wanted to refer to your own documents and records from that time in order to assist the inquiry?

A. Yes, but I wouldn't have retained any documents.

THE CHAIRMAN: I understand that. Because I understand from what you've said that when the call went out -- I think actually the initial call went out from the Permanent Secretary when the inquiry was established. So whether the action that you described a few moments ago came on foot of a call from the Permanent Secretary or whether it came on foot of a call from the inquiry, when you were being asked for a witness statement -- and you were clearly being asked for quite a lot of detail in that statement -- you would have wanted to have had access to the documents from that period, which would have reminded you who you spoke to, who wrote to you, who you e-mailed back and so on.

A. Yes, chairman.

THE CHAIRMAN: And just taking this answer to question 6 in isolation, it rather appears that you did have access to quite a lot of information.

A. Yes. I don't know whether that information came via the Trust or where, but I must have had access to some information to be able to provide that detail.

THE CHAIRMAN: Thank you.

MR WOLFE: Could we just go back to page 5 of that statement we have on the screen? In answer to question 6, doctor, this is just a helpful place to go to to remind you of

the circumstances in which you were advised of Dr Quinn's imminent input. You say:

"On 21 April, Mr Mills left a telephone message for me advising that he had asked Dr Murray Quinn to review the clinical notes relating to Lucy Crawford and provide advice to the Trust. I do not recall any discussions with Mr Mills in advance of him asking Dr Quinn to conduct this review, although he may have discussed this with Mr Frawley or Mr Bradley."

Could I just ask you then, having noted there that you don't recall any discussions with Mr Mills in advance of Dr Quinn's appointment, could you take a look at the following document for me, please? 318-002-001. This is a document which relates to a conversation between yourself and Margaret Kelly --

A. Mm-hm.

Q. -- who was the Western Board's link person into the root-cause analysis that was being conducted by the Sperrin Lakeland Trust after Lucy's inquest. I wish to draw your attention to a number of points that have been attributed to you.

This is your recollection of how you learnt about the incident and you recalled a telephone call from Mr Mills, and you put it in terms of advising that he was thinking about approaching Dr Quinn with a view

to asking him to review the case notes and provide the Trust with his opinion.

The note goes on to say that you advised that Dr Quinn could certainly review the notes, and indeed this may be helpful, given that he had provided paediatric clinics to the Tyrone county and Erne hospitals. However, you are said to have cautioned Mr Mills that such a review would not be seen as independent as Dr Quinn would be seen as being too close to the situation, and therefore a wider external review through the Royal College would be required:

"A copy of Dr Quinn's review of the case was not shared with Dr McConnell."

I want to pick up on just the first of those points. What you seem to have described there is, if you like, a telephone conversation prior to Mr Mills' appointment of Dr Quinn, at which you had an opportunity, you seem to be saying, prior to the appointment, of expressing your perhaps reservations about Dr Quinn's involvement, albeit that you did see some advantage in having him look at the notes. Can you help us with that, doctor, because it contrasts, can I suggest, with what you've said to the inquiry in your witness statement, whereby the first you know about Dr Quinn, by reference to your recollection, was the message that had been left for

you?

A. Yes, I'm sorry, I cannot help you with that. I don't know on what basis I was saying that at that time. I do recollect a conversation with Dr Kelly regarding the independence, but that was much later. I don't recall why I have thought that there was a telephone call from Hugh Mills.

THE CHAIRMAN: Sorry, when you say "Dr Kelly", that's as distinct from Margaret Kelly?

A. Dr Jim Kelly.

THE CHAIRMAN: Do you recall seeking to Margaret Kelly at all in 2004?

A. No.

THE CHAIRMAN: Because her note is really quite specific, isn't it?

A. I don't recollect that at all, chairman, I'm sorry.

MR WOLFE: If I could put Mr Mills' perspective into the mix, doctor. He would say that he didn't, in essence, consult with you prior to the appointment of Dr Quinn and at no stage can he recall you expressing any reservations to him about the independence or perceived lack of independence of Dr Quinn.

A. No, and I would have been most unlikely at that stage to have made any reference to that because I was seeing this just as a rapid and -- as I have said before,

a rapid initial review by someone who knew the unit, knew the context, knew the setting and would be able to define the areas which should be covered by a later, wider review.

Q. You have suggested in an answer or two back that you had a conversation with Dr Kelly. Could you help us with that? Are you saying that you had a conversation with Dr Kelly, in which you raised concerns about whether the review by Dr Quinn could be considered adequate?

A. Not prior to that review being done. When it later was beginning to emerge that the Royal College were being involved, that was, I think, at the stage where I had said to Jim, "I'm glad to hear that," because in line with the medical negligence stance that we took, we did not engage independent experts from within our own geography. So if a medical negligence issue had occurred in Enniskillen hospital, I certainly wouldn't even have regarded someone from Altnagelvin as sufficiently independent and from outside, and would have sought to go elsewhere in Northern Ireland or to England or Scotland for an independent review of the medical negligence case and I was applying the same standards and principles to this.

Q. Could we just look at an answer you've given to the inquiry in respect of your interaction with Dr Kelly

in relation to all of that? WS286/2, page 5. You can see the preface to the question, number 4:

"Arising out of [an earlier answer that you had given] where you comment that you believe you would have advised Dr Kelly of the need for the Trust to consider conducting a wider review. Please address the following matters. Why did you reach the view that a wider review involving experts from outside the span of your area was necessary?"

And you go on then to say that:

"Any review of a medical event needs to have credibility in the eyes of the family involved, the wider public and the health professionals."

And you point up the risk that Dr Quinn's view could be seen as being biased --

A. No, sorry, I think very specifically and importantly in that sentence is the word "alone" --

Q. Okay.

A. -- which you missed out in reading it there. I would stress that word because I was not saying that his view shouldn't be considered; I was saying his view alone would be unfair.

Q. Yes. Let me read it verbatim in all fairness:

"Any review of a medical event needs to have credibility in the eyes of the family involved, the

wider public and health professionals. Until the mid to late 1990s, paediatric services had been provided by visiting paediatricians from Altnagelvin Hospital and Dr Quinn would have been one of those visiting consultants. There could, therefore, be a risk that Dr Quinn's view alone could be viewed as, in some way, biased towards a service which he had once been a part of."

If I can just stop there because I don't know that there's any particular need to read the rest of it. The question that emerges is this: are you saying that a concern for a perceived bias in those terms, was that expressed to Dr Kelly?

A. If that were going to be the only review, not if the review were going to move on and consider independent experts from outside.

Q. Yes.

A. I have no quibble at all with the quality and experience of Dr Quinn's capacity to give a rapid initial review --

Q. Yes.

A. -- but not as a sole input.

Q. But my point is a more specific one. In any conversation that you had with Dr Kelly, did you express a concern in the terms that are set out here?

A. Possibly not in as detailed a way.

Q. Because one view of it might be that it having been made known to you that the Trust wasn't just stopping with the Quinn review, if you like, and was quickly moving on to the Royal College's review, there would not be any particular need to express the reservations that are contained here in front of us?

A. No, there was an evolving -- if I could just say, the picture was constantly evolving over the weeks following. There was initially Dr Quinn's report, then it was made clear that there was going to be an internal review within the hospital, and as that was coming to a conclusion, then it became clear that there also was going to be input from the Royal College of Paediatrics and Child Health. So the position was constantly moving on and I was comfortable with the way that was going.

Q. Yes. But in the context where we are talking, your concern was of a need to properly investigate and get to the bottom of this child's death?

A. Yes.

Q. What the Trust was moving on to do, following the initial review, which was assisted by Dr Quinn, was to engage with the Royal College to address a much wider issue than simply this child's death, it was, as I suspect you would understand, moving on to look at the performance and competence of a particular consultant,

Dr O'Donohoe, arising out of a complaint made about him from a Dr Asghar.

A. It was also investigating a specific number of deaths, it was also investigating whether there was any dysfunctionality within the paediatric department; it was not solely around one individual.

Q. Yes. Well, there was only one death that was to form --

A. Sorry -- I meant other cases, sorry. Other patients. My apologies.

Q. The point of distinction which Dr Stewart -- who was the Royal College's regional adviser and the author of the Royal College's review -- was at pains to make -- and it's clear from her terms of reference she wasn't being retained to carry out a medical report or a medical review of this child's death -- was her examination of the child's death was incidental to her analysis of the performance and competence of Dr O'Donohoe. The question to you, I suppose, is whether you appreciated that what the Royal College was doing was not per se an investigation of that death.

A. No, I don't think it was either made clear or that I sufficiently clarified that that was the nature of the Royal College of Paediatrics' input.

MR WOLFE: It's 12 o'clock, maybe it's a suitable time.

THE CHAIRMAN: Doctor, we have to break for a while to allow

the stenographers some respite. We'll start again at 12.15. Thank you.

(12.00 pm)

(A short break)

(12.30 pm)

MR LOCKHART: I wonder if I could just deal with a number of matters which came up when you were discussing the documentation request?

THE CHAIRMAN: Have you turned up the letter of 14 May as well?

MR LOCKHART: Yes. I'm concerned just to clarify matters, because obviously Mr Frawley --

THE CHAIRMAN: Just for everybody else, could you please bring up two pages together, 319-043e-001 and 002? I think this contains most of what we want to refer to.

MR LOCKHART: Yes. You will see that this issue in particular has been the subject of extensive correspondence and this letter represents perhaps the most detailed response to the detailed enquiries which were made by the board in response to a number of letters from the inquiry. What I'm concerned about is that in fact Mr Frawley, chairman, who you mentioned will be giving evidence tomorrow, as you know he retired from the board at the end of August of 2000, and his knowledge, I suspect, of this is limited.

THE CHAIRMAN: If I didn't make it clear earlier, what I was anxious to do was to make sure if there is any more documentation around that we have at least before Mr Frawley starts giving evidence. Because Mr Frawley left when he did in the summer of 2000, I understand how his personal direct involvement in this will be negligible, but the other point which people can see when they look at these letters is, if we look at the second page, Mr Lockhart, the top paragraph explains in the last sentence that:

"Copies of these files were sent by the chief executive's office on to the inquiry as requested by Mr Gowdy."

And those documents would, on this letter, include the sort of information that Dr McConnell has been referring to before the break, right?

MR LOCKHART: Yes.

THE CHAIRMAN: There's then halfway down the page, a paragraph which starts:

"In relation to the third paragraph of your letter, the board has made contact with Karen Meehan."

We do have a record of Ms Meehan forwarding the files which are referred to on page 3 of the letter.

MR LOCKHART: Yes.

THE CHAIRMAN: We do have those files. What I have now

organised to be done during the break is that we will have one further final check as to whether the inquiry has any record of receiving the files which are referred to at the top of page 2 in that last sentence.

MR LOCKHART: Yes. What we've also done, which is not contained in this letter, is we've also instructed the board to carry out -- and they've already done so -- a reactivation of all the relevant e-mail accounts of the relevant personnel and a full search has been made, which has not, we understand, thrown up any further documentation. So the board take this extraordinarily seriously, chairman, and this letter is not the end of it either in terms of the efforts that have been made.

THE CHAIRMAN: Yes. I understand that in light of what's written in this letter -- and Dr McConnell's evidence has confirmed -- that this is not one of the unfortunate examples of nothing being done. This is an example of something having been done, but somewhere along the line, either at the board's end or at our end, the documents have been mislaid.

MR LOCKHART: Yes.

THE CHAIRMAN: I think it's fair to suggest, Mr Quinn, in the context of what Dr McConnell has said that this isn't likely to be a cover-up area, but unfortunately there are missing documents. They may or may not help

the board, but if they help the board, they may not help the trust. If they don't help the board, they may help the Trust.

I'm pretty confident that I'll hear later on today from the inquiry office in Belfast whether the documents which are missing have been tracked and, if it is, I will be the one who comes in with the red face later on today or tomorrow morning. If it isn't, since this letter indicates that what was forwarded to us were copies of the files --

MR LOCKHART: Yes.

THE CHAIRMAN: -- then that would suggest that somewhere the originals of the files are lying around. It's complicated, I presume, by the fact that the board -- that have been changes in the --

MR LOCKHART: There have been changes in personnel, but I understand -- and I take it from enquiries I have been able to make since this issue arose this morning -- when Mr Gowdy gave his edict to the various boards, that was been actioned and the documents that were obtained were kept in a safe and that those documents have been sent on two occasions to the inquiry -- the same documents, I must say, not different documents -- in response to requests from the inquiry.

THE CHAIRMAN: If it's our fault, I will tell you tomorrow

or later on today.

MR LOCKHART: Equally, can I say that we will continue to update the inquiry with any other efforts we've made in the interim, but we do take this very seriously and I am concerned about the intervention and the reference to cover-ups.

THE CHAIRMAN: Thank you. Back to Dr McConnell.

MR WOLFE: Doctor, just before the break, we were looking at the view which you held that the initial review which was conducted by the Trust was, if you like, not going to satisfy you in terms of its depth or thoroughness, and that you saw a need after this initial look to run a broader investigation or review; is that fair?

A. That's fair.

Q. And we'll come back to that in another way just in a moment or two. But the next step in the chronology, if I can introduce it in this way -- put up on the screen, please, WS308/1, page 94. This is an e-mail from, as I understand it, Mr Frawley's secretary or PA -- is that right? -- Carol Mooney. It's dated 8 May 2000. This is disclosed to us by Mr Frawley as part and parcel of his witness statement. He's writing to you, clearly three or four weeks after the child's death. He has been informed by Hugh Mills and he's saying to you and to Mr Bradley:

"I think it is important that we get some definitive advice and I would be grateful if you could keep me apprised. Many thanks."

Doing your best, doctor, you obviously received this e-mail. What was it asking you to do?

A. From this, I would take it that I was being asked to get some definitive advice from the Trust on what process they were going to follow for further examination of the issue and that both Martin and I then would bring that back for discussion, probably with the general manager initially and then, I would have expected, more widely within the board. I don't think in any way I would have taken that to say we should be seeking external independent advice on this. That would not be my understanding.

MR LOCKHART: Could I, just for the sake of clarification, indicate that the document that is on the screen came up through the trawl that was carried out by the Trust, not through Mr Frawley bringing it with his own statements?

MR WOLFE: My friend is absolutely right. I should have said it came in two ways. First of all, it was as an attachment to Mr Frawley's statement, but I think it probably chronologically came before that as part of a file that came in this year from DLS. I'm obliged.

Just to define your interpretation of that, this

isn't a call by Mr Frawley for the board to go and seek its own, if you like, expert advice on what's happening or what had happened to the child, but a call from him to get clarification from the trust as to what has been happening in terms of their review four weeks or so after the death?

A. Yes. That's my understanding.

Q. And on 15 May 2000, you received perhaps just that kind of clarification. If we could have up on the screen, please, 036a-046-099. I beg your pardon, if we maybe just go to the first page as well, 098.

As you can see, or you will see if we had the last page up on the screen, this is a letter to you, doctor, from Dr Kelly --

A. Yes.

Q. -- the medical director of the Trust. As we can see from the opening sentence -- and it was clarified by him in his evidence last week -- he says that you made a telephone call to him, enquiring as to what was happening, and this was his response to you.

A. Yes. If I take it from Tom Frawley's e-mail, the chronology looks as though it would have been Tom contacting Martin and myself, me then contacting Dr Kelly's office and saying, "Look, we need to be apprised further of what steps are being taken within

the Trust and where things are. Can you bring me up to speed?"

Q. Yes, so that all marries and tallies?

A. Yes.

Q. We don't need to concern ourselves with too much of the substance of this, but you're now, can I say, formally getting a more detailed account of what was the clinical background to the child, and that is set out on the left-hand page and into the top of the right-hand page, indicating that the case went to post-mortem and at that stage:

"Informal reports on the post-mortem indicated gastroenteritis and brain oedema."

And that further detailed reports were awaited. And then a number of specific concerns are identified:

"1, the absence of a clear diagnosis and pathophysiological mechanism for the death. 2, there are concerns in relation to the rate of fluid replacement. Essentially the regime for the shocked infant was continued longer than the anticipated two hours."

And there is an issue to do with delayed venous access.

On down that page, you are told -- or perhaps reminded because you know this already -- that

Dr Murray Quinn has been retained for the purposes of providing advice, and you are being told the next stage is a full analysis of the investigation report from Dr Anderson and Eugene Fee with a planned review on the case with Murray Quinn.

This letter, doctor, is it giving you more information than you'd had previously?

A. I think it may be in terms of just who was involved in the internal Trust review, that it was Eugene Fee as director of acute services and Dr Anderson as the clinical director of the maternal and child health directorate.

Q. You gave me an answer earlier when I was asking about your knowledge of Dr Quinn's input that it was expressed to you as an initial review carried out by him. That seemed to be the sense of your answer.

A. Yes.

Q. Whereas in fact what was happening was that the coordinators of the review were Messrs Fee and Anderson, and Dr Quinn was assisting that review or feeding into that review as part of a wider evidence-gathering mission on the part of the coordinators; is that something you didn't know until you received that letter?

A. I'm not sure, even on receipt of that letter, that I'd

have appreciated any significant difference between what I had originally anticipated and what was now being told to me.

Q. If we could go over the page, please.

THE CHAIRMAN: Sorry, one moment. The paragraph on the bottom right, the last paragraph on the second page:

"Initial interview has taken place with the family."

MR WOLFE: If you read on, that alludes to Dr O'Donohoe's meeting with them. As we can see there, it records that Dr O'Donohoe had outlined the planned review of the case to the family. This witness, of course, wouldn't appreciate that there is controversy around that in that we know, as the inquiry, that the Crawford family do not share the view that they were notified that a review was to be established.

But you reading this letter would have assumed that you were being given an accurate account that the family were aware of the review?

A. Yes, and I think even the use of the words "initial interview" would have conveyed to me that this was not a one-off, that the intention was to engage with the family on a more continuous basis.

Q. If we could then go over the page, please.

THE CHAIRMAN: Mr Wolfe, remind me: Dr O'Donohoe didn't meet them as part of the review, did he?

MR WOLFE: He didn't. The evidence before the inquiry --

THE CHAIRMAN: This is the meeting where he arrived and he didn't have the notes and the meeting was to be re-arranged but wasn't?

MR WOLFE: The evidence that the inquiry has before it derives from Mr and Mrs Crawford's interviews with the police and they say that they asked for the meeting with Dr O'Donohoe and provided him with one week's notice, and at that meeting he arrived without the notes. There's some suggestion that he told them that the notes were with Dr Kelly for further investigation, but they have said in correspondence to the Trust, as you know, that the idea that there was to be a formal review wasn't made known to them until the autumn of 2000.

THE CHAIRMAN: Thank you.

MR WOLFE: The last page of this letter, doctor, says on the part of Dr Kelly:

"I will, of course, have more details as the full investigation reports come online and will be happy to share all details with you in due course ... happy to receive any suggestions or additional comments you wish to make."

It's Dr Kelly's evidence that he received no response to you in respect of this letter and you have no recollection, as I understand it, of making any

response.

A. No.

Q. At this stage in the process, were you satisfied with what you were being told?

A. I was satisfied with the process that was ongoing and obviously I would have considered probably at that time that the sensible thing to do was to wait for the conclusion of that work and the reports to be sent in to us, and then go back with comments. I also would have expected that it wouldn't necessarily just have come to individuals, but even that interim report would have come more formally to the board.

Q. Yes. Of course, you were tasked by Mr Frawley of seeking information.

A. Yes.

Q. That was what the e-mail was asking you to do on your interpretation and presumably you fed that back into the Western Board's system.

A. Yes, I would have.

Q. So the next stage chronologically was, as I understand it, that you had a meeting in June with Dr Kelly. Let me bring up on the screen, please, 030-008-015. This is a note dated 15 June in the hand of Mr Mills. You can see under the heading 3 and then towards the end of that section 3:

"Discussing with Bill McConnell tomorrow."

Can you make that out?

A. I can, yes.

Q. That is in the context, Mr Mills recalled, of -- you can just see the words "regional advisor" one line up.

A. One line up, yes.

Q. And then it says "Dr H", which is a reference to Dr Halahakoon, who was the lead paediatrician in the trust. So the context for all of that, doctor, according to Mr Mills, was that Dr Kelly was coming to see you to discuss their plans to move forward with a regional adviser, perhaps through the Royal College, because, ten days earlier, on or about 5 June, the Trust had received a letter from Dr Asghar, who was a staff-grade paediatrician in the Trust, raising some concerns about Dr O'Donohoe. Does that fit with your memory?

A. It fits with the pattern. I'm not sure about that I remember specifically that it was 15 June that I met with Dr Kelly. I know that meeting -- well, I think that meeting related to a meeting of the scrutiny committee, looking at medical negligence issues. I know it was another meeting at which we knew we would both be present and then discuss the issue in conjunction with that.

Q. I suppose the point that emerges from this is: if the Royal College was being discussed with you at this point, is it not clear that it was being raised with you in the context of wider concerns about Dr O'Donohoe as opposed to specifically the death of Lucy Crawford?

A. No.

Q. That's not your memory?

A. That's not my memory. My memory was of a progression, as I think I've referred to before, of Dr Quinn's report, an internal review and then an expectation that external advice would be sought in relation to the issues which were emerging. I cannot recollect it ever being made specifically clear to me that the engagement of the Royal College was around wider issues rather than this. Or certainly, if it was, I knew that it included a detailed examination of Lucy Crawford' case.

Q. We'll look at the Royal College just in a moment. Just something you said there. At this stage in the chronology are you still separating out in your mind a Dr Quinn review and then separately an internal review? Because that's how you said it.

A. Yes. That was my understanding of the progression that one would be done first, that that would contribute to their internal review, and then on the basis of those two, a wider review would be undertaken. And that to

me, at that time, I would have considered quite a normal pattern.

Q. Yes. Let's just come then to the review report, which was produced by the Sperrin Lakeland Trust under the auspices of Mr Fee and Dr Anderson.

A. Yes.

Q. Do you have a recollection of receiving the review report?

A. I don't have any record of a letter coming in to me with those attachments. I have a copy of that report entitled "The Review of Lucy Crawford's Case". I think it's 033-102-260. And appended to that, I think there's a copy of Murray Quinn's report. But I don't have -- I have not been able to find anywhere a record of a letter coming in or any information coming in of that being sent specifically to me.

Q. Yes. Let me come back at that. The report that you have apparently in front of you on a file, how long have you had that in your possession?

A. Probably since last -- since November 2012.

Q. So that's a document that has come to you via the inquiry process, whether from the inquiry itself or via your solicitors?

A. Yes.

Q. Very well. The next point is this: when you point to

that document, which we have up on the screen, it's dated 5 July 2000. I just want to be clear. If you go to a document 033-102-264, this, as we understand it, is the cover page to the final review report. Because what happened, doctor, if I can explain it in these terms, is that Mr Fee carried out an initial draft report, which he forwarded to Dr Anderson, and then Dr Anderson suggested some recommendations that should be included in the report, and they were included in a final report, the first page of which is in front of you, and that is dated 31 July 2000. Whereas you're pointing to a cover sheet which is dated 5 July 2000.

A. Yes.

Q. This may be a case of mere semantics or it may not. You clearly can't remember when you received the report. You didn't receive it under formal letter?

A. No.

Q. Well, let me ask the question in this way: do you recall receiving a review report complete with appendices?

A. The appendices that I have are statements and fluid charts.

Q. Exactly. If you go to it, if we can have up on the screen, please, 033-102-269. The way we understand that the report was, if you like, published or produced, it came with an initial five or six pages of analysis by

the authors of the report and then, added to the report, was this document called "appendices", and then the various items or appendix items are listed. They are the contributions to the review, and you can see, for example, at number 1, it's titled "Medical report". That's the report of Dr Murray Quinn.

So I'm not asking you what you got in 2011 or 2012; I'm asking you to cast your mind back to the summer of 2000, if you can. Do you carry with you a memory of having received a rather bulky document that included an initial several pages of analysis plus these reports or appendices?

A. I don't.

Q. Is that that you didn't receive them or you don't remember?

A. I don't recollect whether I received them or not.

Q. Well, you knew, doctor, that Dr Murray Quinn was a gentleman who was going to be assisting the Trust with its review.

A. Yes.

Q. In fact, your thoughts were that he was actually carrying out an initial review and then there would be an internal review.

A. Mm-hm.

Q. You presumably were on the lookout for a report from

Dr Quinn.

A. I would have expected both a report from Dr Quinn and a report from their internal review.

Q. Yes.

A. It is quite possible that I got that. All I am saying is that I cannot definitively remember a report coming to me and whether it included appendices or not.

Q. Yes.

A. I would suggest that it is likely that something would have come to me because that's the basis (a) that I would have been expecting and (b) that I would have reported on internally within the board. Had nothing been coming to me, I would have been surprised and concerned.

Q. Well, can we proceed then on the assumption that you received, in paper form, a report? Leaving aside the details of the dates, et cetera, you received a report. The shortcoming in your memory is that you cannot say definitively that you received all of the appendices --

A. Yes.

Q. -- or indeed any of them?

A. Yes.

Q. Going back then to what we agreed this morning in terms of what Mr Frawley was saying would be the expected conduct of the board and its officers upon receipt of

a review report, you'll recall that he said that he would have sought advice or information from his professional leads in terms of whether the report, its conclusions and recommendations represented a proportionate response to the problem.

A. Yes.

Q. And can you help us, first of all, in terms of process? Did that kind of question or that call for advice or discussion emerge from the general manager?

A. I'm quite sure that -- I cannot definitively say, but I'm quite sure that it would have. We had regular review meetings, there would have been issues that would have been put on the agenda for those and I'm sure that, on foot of the e-mail that he had sent to both Martin and I, he would have sought an update from one or both of us, or perhaps the two of us together, in a meeting with him.

Q. And of course, the inquiry is without any written indication or documentary indication that any such meeting or discussion occurred. Can you tell me whether the healthcare committee that we spoke about at length earlier, whether it was furnished with the report and whether it was discussed within that forum?

A. I cannot tell you in the absence of that documentation. I would fully have expected that on foot of the

discussion with the general manager that it's likely it would have considered the need to further apprise the healthcare committee of anything relevant from that report. The only thing that I am conscious of is the fact that there still was the ongoing involvement of the Royal College of Paediatrics and it's around the timing of that and what the timing would have been to feed back into the board that I cannot be sure.

Q. In terms of your recollection, do I interpret your answers correctly when I say that you believe that you would have discussed the report, at the very least, with the general manager?

A. Yes.

Q. In terms of the analysis of the report that would have been undertaken, presumably by yourself, you have said earlier that you would tend to read such reports from two perspectives. First of all, procedural: had they carried out a procedurally-effective investigation; is that fair?

A. Yes.

Q. That would be the question you'd wish to address. And secondly, from a substantive perspective: had they addressed all the right issues and produced answers or explanations that are satisfactory in the round?

A. Well, either have they addressed them, or have they

addressed some and are they intending to address others.
Q. Yes. On the procedural front, were you satisfied?
A. Well, I was satisfied at that time. In retrospect, I now know about constraints that were applied to Dr Quinn's involvement and I now am conscious of the fact that some staff provided statements and some staff were interviewed and didn't provide statements. I was not at all conscious of any of those at the time. It also -- any information I had received referred to engagement of the family. I was not conscious of the fact and had not been informed of the fact that that had not occurred. Therefore on the basis of what I was being presented with, yes, I was content at that time.
Q. On the substance front, whether satisfactory explanations or conclusions had been reached, were you content?
A. I was content that there was clear indication of miscommunication between staff and that that needed to be tightened up, that there was a need for better protocols in terms of the prescribing of fluids and the recording of fluids and the range of other issues that I would need to refer to -- the range of other issues that were addressed in here. Also that a mechanism was being put in place to ensure that that -- that those things which needed to be corrected would be addressed.

I was not conscious of the fact at that time, as I am now, that the process for putting that in place was insufficient.
Q. What do you mean by that, that the recommendations, at least in some respects, weren't implemented?
A. They were not being followed through and no recording appears to have been happening of which were being put in place, which elements of training were being put in place and the sorts of things one might expect.
Q. One of the issues that the review explored was the aetiology of this child's death. If we can go back to the substance of the report itself. If I could ask you to consider this. It's at 033-102-265. One of the critical parts of the report, doctor, are the findings. Within that section it says in the last five lines:
"Neither the post-mortem result or the independent medical report on Lucy Crawford, provided by Dr Quinn, can give an absolute explanation as to why Lucy's condition deteriorated rapidly, why she had an event described as a seizure at around 2.55 am, or why cerebral oedema was present on examination at post-mortem."
So in terms of extracting from this review process an understanding of what had happened to the child, the Trust was no further forward. Did you see that as

an issue that required further work?
A. Yes, and that further work, as I understood it, was going to occur through the engagement of the experts or expert from the Royal College of Paediatrics and Child Health. I also, at this stage -- and I think for some time afterwards -- was of the view that an inquest was going to be held, the coroner had been involved and that either an explanation would be found or that an inquest would hear this.
Q. Just going back to a matter of process perhaps. It should have been obvious to you from the report that the clinicians at the Royal Belfast Hospital for Sick Children had not been engaged in this process. Was that clear to you?
A. Yes, it would have been clear to me in that the review that had been sent to me did not describe any engagement.
Q. That's right. And in terms then of how the board responded to this report, that is the Western Board, did any formal response emit from yourselves?
A. I don't recollect any formal response coming out. In relation to the engagement with the clinicians from the Royal Belfast Hospital for Sick Children, the input from the Royal College of Paediatrics and Child Health was going to come from consultants engaged in

paediatrics in Belfast.
Q. Yes. I'm not at this point asking you about the specifics of any response, but rather: should the Western Board have been formally responding to this review report into what you earlier described as a particularly significant event?
A. Had that been sent formally to us, yes, we would have been considering it and going back to the Trust.
Q. So you're telling us that you don't believe it was sent to you formally?
A. I don't believe so, no. I have no record that I can find of that report being sent in, what the content was, any covering letter, or how it was considered. If that had been, I find it difficult to understand then why Tom Frawley would have been coming on the basis of a conversation to Martin Bradley and I to say, "Keep him apprised", because he would have been being apprised by a report coming in through a different channel.
Q. Yes, but he's in the kinds of conversations that you're having with other people: he's speaking with Mr Mills, you're having conversations with Dr Kelly, Mr Bradley is speaking to Mr Fee. That's all leading up to the production of this report. The report, as we understand it, is coming to your organisation pursuant to a requirement, an unwritten requirement, that the Trust

is obliged to keep its commissioning body informed of the outcome of its review. So whether or not it ends up in your hands formally or informally, does it not call for the Western Board to sit down as a body and to critique the report in order to satisfy itself procedurally and substantively and then to make a formal response?

A. Certainly the former. I'm not sure about the formal response if we had not been asked for one, but certainly I think we should have been sitting down, critiquing it and going back to the Trust with views and comments.

Q. And in terms of that then, apart from your recollection of perhaps speaking to Mr Frawley about it, you can't help us any further in terms of how it was discussed within the board?

A. I can't, I'm sorry.

Q. And in terms of what then emerged from any discussion and sending that back to the Trust, you can't help us in terms of whether anything at all was done in that respect?

A. I'm sorry, I can't, no. I would very much like to be able to, but if I don't have the information in front of me, I cannot recollect it at this stage.

THE CHAIRMAN: I'm sorry, you drew the distinction a few moments ago in your answer between what you would do if

you received a report formally and you received a report informally. You said if you received a report formally then you would sit down, critique it and respond. It does seem clear that you had a report. However it got to you, you received a report. We don't have confirmation that you received it on a formal basis, but you had it.

A. Mm-hm.

THE CHAIRMAN: So if you had it on an informal basis and you would only reply formally if you received it on a formal basis, why not ask for it on a formal basis? Throughout this inquiry, there seems to be a hang-up about formalities when children die. You have a report which comes to you about some of the circumstances of a child's death and in the answer that you've just given -- and it mirrors evidence heard previously in the inquiry -- your response depends on how formal the receipt of the information is.

A. That's not necessarily what I was trying to convey. If the board was going to respond, it would need to respond formally. On many occasions I have gone back individually, but not to a trust board, but to an officer, an individual within a trust, and said, "I've received this, I've had a look at it, this is my view, my view".

THE CHAIRMAN: Okay. But this is an event of such seriousness that it should come to you formally and there should be a formal response; right?

A. Yes.

THE CHAIRMAN: Okay. There may be a query about board documents having been mislaid between the board and the inquiry, but whatever about that, we don't have any formal response in the Trust files, which do seem to be complete. Okay? That would suggest that there is no formal response from the board to the Trust. Again, there is no copy of a letter formally sending the report from the Trust, but is this not getting hung up on the wrong issue? If you know there's a report there and you've received it somehow informally, do you not say, "Look, send it to us on a formal basis and we will respond"?

A. In retrospect, probably, yes. That is what should have happened.

THE CHAIRMAN: You know the report is complete. You know the report is complete because you have the conclusions of the report and you have the recommendations.

A. Well, chairman, if I could go back to the progression of events that I've described before? As I saw it, there was the Murray Quinn report, this report. I was also conscious of the Royal College of Paediatricians being

involved. Now, they did two reports. I only received one of those, another one didn't come to me. And it was around the time when this progression was all happening that I then became aware of the events at Altnagelvin, all of this time there had been no indication that this was anything other than an individual issue of the handling of one child with no greater external significance, and that there were not issues that I needed to convey on elsewhere.

It then, in the spring of 2001, did become evident, and immediately on detecting that there was a wider issue, I acted on that. So it was an evolution of events. Yes, at a point in time I'm quite sure now, looking back on it, that we and I should have commented further on this report that we had received from Sperrin Lakeland Trust, but I was then further expecting input from external experts and it may be that what I was waiting for was that external input before responding to the totality.

THE CHAIRMAN: Thank you.

MR WOLFE: You are familiar with the observations of Professor Scally in the report that he provided to the inquiry?

A. Yes.

Q. Doctor, within his report he observes what he says was

a failure on the part of the Western Board to scrutinise the review report produced by the Trust in order to determine whether it constituted a proper and thorough investigation of Lucy's death. You're not in a position to help us today in terms of whether in fact there was that level of scrutiny, are you?

A. I don't believe so, no. I believe that we received that report, I'm confident that it would have been examined, but I have no papers or records that convey that I went back or that we went back to the Trust to say, "Here are some problems that we have with this review". There also, I think, were parts of what was contained in the information that I was being provided that did not convey some of the deficiencies in terms -- I had no consciousness of the constraints on Dr Quinn's report. I had certainly not picked up on the issue of some people having only provided statements, others having provided interviews and not provided statements, and I had no sense of the deficiencies in relation to the interrelationship with the family.

Q. He goes on to say in his report that what the board, and perhaps you in particular as the director of public health, should have been doing is:

"To identify for the Trust the need to carry out a proper and thorough investigation, perhaps by

reference to written terms of reference and by engaging with, if you like, a joint process the clinicians at the Royal Belfast Hospital for Sick Children, where she was treated before her death."

Is that a fair criticism? Should the Western Board have been more proactive in critiquing the report and coming up with that kind of recommendation if it was serious in its role as an advocate for the local populous, bearing in mind its responsibilities for the health and well-being of that populous?

A. I think it is a reasonable conclusion arrived at on a retrospective basis. It is easy to be wise after the event and, looking back on it, yes, I could agree with what was being said. In the year 2000, I don't think we were anything like as advanced as we are now in terms of conducting reviews and external examinations. I think clearly we could have done more in terms of assessing that review and going back to them at that point in time.

Q. When you read the report, doctor, did you identify any issue in it that was of broader significance than just -- I don't mean this in any sense harshly -- a medical accident in one case or child?

A. No. It was not until a point much later, I think at the end of June in 2001, when the issue of Solution No. 18

was identified to me, arising out of the further tragedy at Altnagelvin, that any wider significance began to emerge. But I have to say that even at that point, on the basis of what had been fed back to me by independent external experts, there was still the issue of other confounding factors in Lucy's death in relation to bilateral bronchopneumonia, in relation to the level of her illness before she arrived in hospital. So it was still not clear what the absolute cause of death was. The reason why I fully expected that then to be further examined was because I think, like Dr Kelly, I had an expectation that this would be further considered by the coroner's office and be the result of an inquest.

Q. I wonder is that correct, doctor? Because if you read the report produced by the Trust, you will observe that the nurses were telling the investigators that it was common practice to treat a child who had dehydration with a fluid regime of 100 ml per hour of a fluid that was low in sodium. Clearly, that fluid regime, or at least the fluids described to Dr Quinn were given, if you like, a clean bill of health by him in his report. I'm conscious that you say you don't necessarily remember receiving his report, but assuming that you received the analysis conducted by the reviewers, you might have seen that issue.

A. No, I'm sorry, I am not a paediatrician. I am not an anaesthetist, I am not an expert in fluid replacement in children. The relevance and significance of that issue would not have been clear to me. And in fact, Dr Quinn, as an expert paediatrician, was not raising it and, later, Dr Stewart, as an expert paediatrician, was not raising it.

THE CHAIRMAN: I think that's fair because Dr Auterson within Sperrin Lakeland, rather like the others, if he raised it at all, he raised it very obliquely, so we had a series of people who say they had a clearer view than they expressed in writing.

A. And certainly would have more expertise in the field of treating children and fluid replacement than I would have as a director of public health.

MR WOLFE: We'll come to Dr Stewart's position in a minute because how you have characterised it is not how she would have characterised it. But leaving that point to one side, did you read the report then, doctor, as indicating to you that while the fluid regime was not something that was attracting criticism, there was nevertheless an issue to be explored in terms of the precise circumstances of the child's death?

A. The issue in relation to fluids was conveyed to me and certainly the impression that I took was in relation to

fluid volumes and speed, not in relation to the nature of the particular fluids which had been used.

Q. Could I ask you then this: if it had been made clear to you from the report that here was a fluid regime that was inappropriate -- and I'm not saying for one minute that the report did say that, it plainly didn't, it's a hypothetical question. But if the report was describing the regime in terms of its inappropriateness, can you help me with this? Would the Western Board have been an appropriate forum or vehicle to disseminate the message about that inappropriate regime beyond simply the Sperrin Lakeland Trust?

A. It would have been a possible forum. I wouldn't have considered it necessarily the appropriate forum because that's an issue which would need to be conveyed to all units across Northern Ireland, and I would have thought that the right mechanism for that would be both through perhaps the paediatric and the anaesthetic channels, for that to be raised centrally so that it can be conveyed -- considered first to see whether it was appropriate that something needed to be changed and then, if something did need to be changed, to get an expert group to consider what it needed to say and to disseminate that across Northern Ireland, and I believe that that is essentially, if you like, what happened in

2002.

Q. So just to be clear: if it had been made clear in the report that, across this Trust, Solution No. 18 was being used for replacement purposes, and if that had been identified as a problem, the board would then have taken steps to ensure that that was reported further afield, whether by doing it itself or by asking the Trust to report it in to the department?

A. Yes, probably the steps that I would have taken then would have been to communicate that to my director of public health colleagues, also indicating that I was going to raise it centrally and with the central paediatric expertise.

MR WOLFE: I see it's 1.30.

THE CHAIRMAN: I thought at one point today, doctor, that we might be able to finish your evidence by lunchtime, but it's 1.30. There's not terribly long to go, perhaps up to an hour at most. Rather than keep you here non-stop and to give everyone a break, can we break until 2.15? We'll certainly be finished by 3.30, perhaps a little before. Thank you.

(1.33 pm)

(The Short Adjournment)

(2.15 pm)

(Delay in proceedings)

(2.23 pm)

THE CHAIRMAN: Mr Wolfe, just before we start, let me go back to the documents issue.

I think you've all just received copies of some correspondence, which is relevant, and if you look, there are four letters. I'll go through them quite briefly.

The first letter you'll see is written on 20 October 2004 by Mr Gowdy, who was the Permanent Secretary at that time in the Department of Health. It's a letter to various board members, asking them to ensure that all relevant records and documents are secured so that, if necessary, they can be made available for future examination. That was sent in the immediate aftermath of the Ulster Television documentary, the previous week. And the various trusts were asked to confirm, by 5 November, that this action had been taken. At that stage, I ask you to note that the inquiry had not been established.

The second letter is the response which was sent by Ms Meehan, the chairwoman of the Western Board, who effectively confirms that she has taken steps to secure and keep safe all documentation held by the Western Board pertaining to the deaths of Lucy and Raychel. And she is holding it for independent

examination.

The next letter, dated 1 December, comes from me, after the inquiry has been established and I have been appointed. In the final paragraph of the first page, I ask Ms Meehan to arrange for all notes, documents, et cetera, to be delivered to the then inquiry office by 10 December 2004. On 8 December, ahead of schedule, Ms Meehan provided the response which I'd asked for in two files, file (i) is now file 17, file (ii) is now file 18. That's the extent of the Western Board documentation which we received until this year, when what became known as file 318 was provided on foot of a request from Mr McLoughlin, the assistant solicitor to the inquiry.

We have checked the Belfast offices in the last two hours and can find no other files from the Western Board. The letter which we referred to earlier, which is at 319-043e-002 and 003. On 002 at the end of the first paragraph, it is stated:

"Then, in turn, copies of these files were sent by the chief executive's office on to the inquiry as requested by Mr Clive Gowdy."

Unless Mr Gowdy made a separate request from the one which I've just shown to you, he simply asked that the documents would be held. I asked on foot of that that

the documents would be forwarded, and I received the response which is referred to on the right-hand side of the screen in the middle of the page, the paragraph which starts with the word "finally".

There's a small error in the dates. The dates in that paragraph should be 1 December and 8 December, not November, but the two files there are correctly identified, file (i) as the letter notes, became inquiry file 17, file (ii) became inquiry file 18. I'm afraid we can't take it any further at our end. I'd be very grateful if some last check could be done before we finish this phase of the evidence. Thank you.

Mr Wolfe?

MR WOLFE: Just in that context, about documentation, when you received the letter that we looked at some time earlier this morning from Dr Kelly, I think it was dated --

A. 15 May?

Q. Yes. Would it have been the practice at that time for you to open a file within your office or for your administrative assistant to open a file?

A. Normally, yes.

Q. And would it be given a code or a record number?

A. No, just a name probably.

Q. Can I also ask you, doctor, to look at a document that

we looked at briefly this morning? It is 318-002-001. Remind yourself of the date again. You are in conversation, it would appear, with Margaret Kelly on 2 November 2004, which was just a couple of weeks after the UTV programme had broadcast and a couple of weeks before the inquiry was announced. Just at the bottom of the page you're asked:

"Was there a formal reporting mechanism in place in 2000?"

And it says:

"Dr McConnell advised that, in 2000, no formal reporting mechanism was in place for reporting untoward incidents. However, he had an agreement with the medical director in each trust that he would be informed if such an incident occurred. No report was provided to him at the time of Lucy Crawford's death."

Do you see that?

A. Yes, I do.

Q. Self-evidently, from what we've heard this morning and from other witnesses, a report was made to you in respect of Lucy Crawford's death.

A. Yes.

Q. Can you recall this conversation at all with Ms Kelly?

A. No, I can't. My apologies.

Q. What she's recorded here is incorrect, whether or not

you said it?

A. Yes. Can you advise me what the context was that the discussion was taking place in?

Q. This is a document that we, as an inquiry, have received from the Directorate of Legal Services. That's as much as I can tell you.

A. Okay.

Q. Very well.

THE CHAIRMAN: It was described, doctor, on the index, I think, as it came to us, as:

"Conversations between Dr Bill McConnell and Margaret Kelly regarding Lucy Crawford."

A. Right. I don't remember that.

THE CHAIRMAN: And it does seem to be immediately after the Ulster Television documentary. Okay.

MR WOLFE: Just to finish with what we had started before lunchtime, which was the input that you gave in relation to the review report, which the Trust had produced and, if you like, the absence, at least in a formal sense, of any output from the board back to the Trust. Can I pick up on one point you have made in your witness statement, just so that you can help me to understand it? It's witness statement 286/1, page 9. Could we have page 8 up alongside it, please?

At the bottom of the left-hand page, please, doctor,

if you could pick up on that. The question asks whether:

"... you made any formal or informal response to the Trust having been provided with a copy of the report?"

And it says:

"See above response to (a)."

And you bemoan the absence of records in your answer to (a), and you outline the best of your recollection regarding the conclusions that you had reached; do you see that?

A. Yes.

Q. You then set them out:

"That the range of issues covered by or explored by the report seemed appropriate; the range of staff involved/contributing to the review seemed appropriate; issues of concern had been identified ... and the lack of a specific cause had arisen and that further work or review was required or was desirable."

A. Yes.

Q. It's then the second part of answer 15 that I wanted to deal with. You say:

"Any formal response would have been made by the board or the healthcare committee."

I think we've covered that to some extent this morning. You have no knowledge or recollection of any

formal response:

"I am not sure whether I made any written personal response to the review report given my lack of availability of records from that time, but I am sure I would have discussed the issues arising with Dr Kelly and/or Mr Fee."

And I want to move on to that in a moment, but this next point is where I require clarification. You say:

"The opinion regarding appropriate fluids referred to comparing the type of fluid used with that which would have been used in RVH/RBHSC wards, but, at that time, my understanding is that APLS guidelines would still have referred to the use of Solution No. 18, as had been previously mentioned by Dr Quinn."

A. Yes.

Q. Can you help us with that? The APLS guidelines in a case of a dehydrated child, as we explored yesterday with Dr Stewart -- and I can take you through it if necessary -- quite clearly do not refer to Solution No. 18 as being appropriate in a situation of dehydration.

A. I would not have been familiar with the detail of APLS guidelines. I would have been aware of their existence and I would not necessarily have been in a position to pick up on the difference between maintenance and

replacement.

THE CHAIRMAN: Sorry, but do I understand that from this response that, in your discussion in 2000 with Dr Kelly and/or Mr Fee, there was some discussion about the APLS guidelines?

A. I think that the only timing at which that arose was in 2001, at which point, I think, Jim Kelly had become aware that changes had occurred in the way that solutions were used in the Royal. That was on foot of the, I think, alert and discussion from Dr Fulton.

THE CHAIRMAN: Yes, but you see, these questions, question 15 and the sub-questions, relate to your response to the Trust review. And you seem to be introducing, in answer to question (b), a reference to the APLS guidelines and what was going on in the Royal in relation to Solution No. 18.

A. I suppose that confusion may arise from what I've said in this sentence because certainly what I intended was:

"... but my understanding is that APLS guidelines at that time would still have referred to the use of Solution No. 18, as had been previously mentioned by Dr Quinn."

I suppose I'm going back to apply to then knowledge of which I became aware of later.

THE CHAIRMAN: Except Mr Wolfe started this line of

questioning by indicating the APLS guidelines did not still refer to the use of Solution No. 18.

A. Well, as I tried to explain, chairman, my technical knowledge would not have covered picking up on the nuance or difference between maintenance and replacement therapy.

MR WOLFE: I think how I read your answer, sir, was that you were seeking to suggest Dr Quinn had made reference to APLS guidelines in comparison with the Royal's approach, whereas in fact in his report, which you may or may not have seen, as you told us earlier, doesn't, in the context of his discussion of fluids, refer to either.

A. I think from recollection -- I'd have to go back and look -- one of the conclusions from it is that the fluids were appropriate.

Q. That is right, that's what he said, and he expressed surprise if that volume of fluids would have prompted the cerebral oedema. But your answer seems to be, if I may say so, certainly confusing for the reader -- this reader in particular -- and I'm wondering if you can help us any further in terms of what you meant by it?

A. All I'm trying to convey there is that Dr Quinn had referred to the use of the fluids, the types of fluids, as being appropriate. I then became aware, significantly later, that things had changed within the

Royal Belfast Hospital for Sick Children, but that there'd been no wider communication or change and that solutions which weren't being used there were still being used in other units.

Q. Yes. So if I can attempt to summarise, you recognise that Dr Quinn was indicating that the fluids were appropriate?

A. Yes.

Q. And you saw, based on your knowledge of APLS, a basis for that?

A. No, what I'm indicating is I did not have any detailed knowledge. I had merely knowledge of the fact that such guidelines existed. I would have not needed, as part of my role or expertise, to be familiar with the detail of APLS guidelines.

Q. Let me move on. Dr Kelly told us that he can remember, in or about September of that year -- and we're still in the year 2000 -- discussing the review report with you, but in the context, or at least at the time, of discussing other things with you. He was discussing the structural changes or the planned structural changes to the delivery of health in that region and he was also discussing with you the other lines of work that were being undertaken in the context of Dr O'Donohoe and, in particular, the Royal College project or Royal College

intervention, which was now being sought.
A. Yes.
Q. That would have been an opportunity for you to deliver any observations in relation to the review report that had been completed. Can you help us at all on whether you made any observations?
A. I cannot recollect whether I did or did not.
Q. The Royal College report of which Dr Stewart was the author was completed in or about April of 2001 --
A. Yes.
Q. -- and you were sent a copy of it by Dr Kelly; is that correct?
A. I was, yes.
Q. If we could just have up on the screen, please, 036a-028-069. This is Dr Kelly's short letter to you, he's obviously had earlier discussions with you. He's now enclosing a report from the College in respect of concerns raised on the competency of Dr O'Donohoe:
"Cases have been reviewed in detail and enclosed in the copy are the comments of Dr Moira Stewart who was the lead clinician."
He is also including with this, doctor, as you'll see in the second paragraph, notes of a follow-up meeting and questions that he felt arose out of the reports to assist in clarifying the position for himself

as medical director, so he's asking for your comments on the reports. Could I just put on the screen then, please, the notes of that meeting, which he alludes to? It is 036a-027-067. Is that familiar to you, doctor?
A. Familiar to me now.
Q. You would have received them at the time, obviously.
A. As I say, I don't have that, so I can't confirm to you whether I did or not, but if Jim says he sent the report plus these to me, then I'm happy to accept that that was done.
Q. Just to orientate you, this is a note which Dr Kelly made arising out of his discussion with Dr Stewart. He puts in a composite form, just before the big black box, in A1 to 5, the various answers that he received to the questions above. So he's saying:
"Capillary refill time, raised urea and CO2 level point to circulatory failure. IV fluids were indicated earlier. Overall amount of fluids once started not a major problem, but rate of change of electrolytes may have been responsible for the cerebral oedema. RVH ward guidelines would recommend normal saline, not one-fifth normal, as the replacement fluid."
And I can show you the report as well and maybe we'll turn to that in a moment, but what I want to get from you, doctor, if you can help us at all, is your

recollection of what was being discussed between yourself and Dr Kelly, if anything, with regard to the case of Lucy Crawford as distinct from the wider competence that Dr Stewart had been tasked with reviewing in her report?
A. I don't think there was a distinction being made between those. The timing of this coincided almost exactly with the issues being raised with me from Altnagelvin that I then took to the department and, I think, also Altnagelvin's reporting to their department about the concern about Solution No. 18. I was not -- there still seemed to me to be some issue of what was the cause of death, what was the contributory part of bilateral bronchopneumonia, how ill the child had been previously before coming into hospital and the extent to which the fluid replacement regime, in terms of volumes, was handled properly and appropriately. And I think it was probably on foot of this that then I began to explore, both with Dr Fulton and probably -- although I can't confirm when -- with Jim Kelly, about the fact that there seemed to be a difference between what was happening in one specialist unit for paediatrics and that which was happening in other units across Northern Ireland.
Q. And the one specialist unit --

A. RBHSC.
Q. Maybe we'll move to that in a moment, but I just want to have your answer in relation to what was being discussed. Yourself and Dr Kelly, at the meeting, as I understand you, you had to discuss Dr Stewart's report.
A. It would have been the entire circumstances surrounding Lucy's death and probably the issues -- I think I went back in a letter and talked about --
Q. Yes, let me just help you with the sequence. You wrote on 5 July 2001, and yourself and Dr Kelly met on 8 October 2001. Can I highlight to you some aspects of the note that you have in front of you on the screen? It's saying that:
"Overall amount of fluids once started not a major problem, but the rate of change of electrolytes may have been responsible for the cerebral oedema."
And then it's pointing out the fluids issue.
A. Yes.
Q. The Royal is saying, according to this note, normal saline is the proper replacement fluid, whereas one-fifth normal had been used in Lucy's case, and you would have been aware of that from the review report which you had had the previous year. I'm anxious to learn from you whether you drew a connection, whether

in the report that you received from Dr Stewart or Dr Stewart's report and this note, between the use of fluids in Lucy's case and her death.

A. That would not have been flagged up to me as such a significant issue as I am now conscious of.

Q. Did Dr Kelly discuss his understanding of the death and the cause of the death?

A. Only, I think, to the extent that he was saying, "I'm now conscious that there appears to be a difference in the types of fluids used in one unit than from the rest".

Q. Just moving to that point, where, as you understand it, did he gain that knowledge of a difference of approach between the Royal and other hospitals?

A. I can only give you my understanding of how that may have been, and I think it was on foot of his discussion, perhaps with Dr Fulton, because Dr Geoff Nesbitt, the consultant anaesthetist in Altnagelvin, had identified, I think on foot of their review of Raychel's death, that there appeared to be this difference. I don't know whether that emerged in that way or directly in discussions with Dr Stewart.

Q. He would say that it was as a result of his discussions with Dr Stewart that he first became aware of the difference of approach between different hospitals,

later to be confirmed then in a discussion with Dr Fulton on the fringes of a medical directors' meeting some time in June. But you can't help us any further?

A. I can't. I think that I was only made aware of the fact that there was a difference, not necessarily how Jim Kelly had become aware of that difference.

Q. The report that you received -- and I'll just put it up on the screen so that you can see the form of it. It's 036a-025-052. This is the section of Dr Stewart's report that related to her work on Lucy Crawford. I'm happy to allow you to read through it, it runs to four or five pages, but the point that she made quite firmly to the inquiry yesterday was that this, in design and in function, was not a medical report. She was conscious that she had a remit which she tried to stick within, which was to address the case of Lucy Crawford by reference to the competency issue that had been posed for her surrounding the conduct of Dr O'Donohoe. Therefore, she didn't see herself as being retained to bottom out the medical issues surrounding Lucy Crawford's deterioration and death.

I think you're telling us plainly that you don't draw that distinction.

A. I don't. I mean, if it's a detailed examination of the case, it is a detailed examination of the case and the

competencies around it.

Q. Can I ask you this: you have told us that, arising out of your analysis of how the Trust had conducted its internal review, you were always of the opinion that they would need to go broader in terms of their follow-up.

A. Yes.

Q. Did this report of Dr Stewart meet that objective?

A. I considered that it did. In discussion with Jim I felt that he considered it did.

Q. Notwithstanding that it was, as has been described, a report into the competency and performance of a clinician as opposed to a medical report?

A. But in relation to a specific case --

Q. Well, it didn't reach --

A. -- and I would expect the same issues to be covered.

Q. As I say, I'm happy for you to read it, but I don't think it's necessary. If you can recall, this report didn't reach any firm conclusions with respect to the child's death; it set out a number of possibilities.

A. Yes.

Q. Is that what you envisaged would be done?

A. Yes, because, again, at that time, I think -- whether through Jim Kelly or not, but I think it was also his understanding -- I expected, if firm conclusions were

not reached, there would be a coroner's inquest.

Q. Just on that, in terms of whether there was to be a coroner's inquest, had you received any information at that point indicating that there was to be such an inquest?

A. No.

Q. Was it something --

A. But we had a sudden and unexpected death in a hospital.

Q. Yes.

A. All such deaths are to be reported to the coroner and should be followed up if the coroner's not satisfied that a cause of death can be signed off.

Q. So at that point in time, and here we are talking the summer of 2001, you still fully anticipated that an inquest would occur?

A. I did.

Q. Had you received any indication or notification to suggest that that was what was happening?

A. No, I would not have expected such. I had not been directly involved clinically in this case. It's normally -- in fact, almost without exception it would be the consultants involved in the care of anyone who died in a sudden and unexpected way to discuss that with the coroner. If anyone were following up, I would have thought that would have been within the Trust,

particularly perhaps by the medical director and the chief executive. I have never, as I think I did say earlier, in 29 years had the need to check independently with the coroners whether such events were going on.

MR QUINN: Mr Chairman, if I can come in for a moment? I have a clear note -- and I very much apologise for not being able to reference it on the transcript -- but my note and my recollection on this point was that when Dr Stewart was asked about this point specifically, she said she asked Dr Kelly specifically about the inquest and he told her that the coroner was informed, but that it was not thought necessary to have an inquest.

THE CHAIRMAN: Yes.

MR QUINN: If I could maybe just explore that through my learned friend asking questions and putting it in the context of a time frame, perhaps we'll get somewhere with that.

THE CHAIRMAN: My note is the same as that. In effect:

"I asked Dr Kelly about a coroner's inquest. He said the coroner had been informed, but didn't want to hold an inquest. I was surprised".

MR QUINN: That's correct.

MR WOLFE: Put this in a time frame, doctor. That exchange between the chairman and my learned friend Mr Quinn relates to something that Dr Stewart said yesterday.

She said that when she met with Dr Kelly at the tail end of May 2001, it became clear to her through that discussion that, while the case had been reported to the coroner, he didn't plan to hold an inquest.

You're keeping in touch with the Trust periodically and your colleagues are keeping in touch with the Trust periodically in relation to Lucy's case --

A. Mm-hm.

Q. -- and I wonder, doctor, did you get any clarification at all through your dealings with the Trust in relation to the holding of an inquest?

A. No, and my understanding would be different than that which has just been expressed because my understanding is that, much later in 2001, Dr Kelly still was under the impression that there was going to be an inquest.

Q. Is that because you were speaking to Dr Kelly about these issues?

A. No. No, but having looked at his comments and his evidence, it's clear to me that he was still of the view in late 2001. Had that changed, I would have expected to have been told. Not being told, I considered that nothing had changed.

Q. Sorry, all you're saying to the inquiry with that intervention is to say, "I have read Dr Kelly's account and I know what he's saying"?

A. Yes.

Q. No more than that?

A. No more than that.

Q. That in essence is the controversy that is in play here, doctor. But you can't help us any further with that?

A. I cannot add anything to that.

THE CHAIRMAN: You know, doctor, if an inquest is going to take place, the coroner asks the body involved, whether it's the Royal Trust or Daisy Hill or whoever, to provide the names of the people who were involved in the treatment of the patient --

A. Yes.

THE CHAIRMAN: -- so that they can provide statements for the coroner.

A. Yes.

THE CHAIRMAN: Isn't it then a little curious that although everybody says, "We all thought there was going to be an inquest for a girl who died in April 2000", that at no point in 2000 or 2001 had anybody received a request from the coroner's office for a statement?

A. I suppose, chairman, my response to that would be I'm conscious of the fact that sometimes the holding of an inquest can take place a significant time after the event.

THE CHAIRMAN: Yes, but that doesn't mean that the evidence

isn't gathered. There may be a delay in the holding of an inquest, but it doesn't mean that two years later the coroner hasn't even asked anybody for a statement or 18 months later the coroner isn't asking people for statements.

A. Yes, I understand that.

MR WOLFE: Could I have up on the screen, doctor, your response to Dr Kelly's sending to you of the Dr Stewart report. 036a-029-070. Here you're thanking Dr Kelly for the feedback received from the Royal College. You've had a good look through this and you're more than happy to discuss it. You say:

"Overall, initially, this seems to capture a range of the issues of which you and I have now become all too familiar. There are issues of systems failures, communication failures and individual performance failures, but I suppose the most [sic] pertinent comment that I am not sure that all of these are sufficiently clear and serious to form the basis of very definitive action in relation to Dr O'Donohoe."

And so the letter goes on. So you're responding, doctor, if I may say so, in respect of the competency issues that had been addressed in the Royal College report. You're saying nothing in that letter about any progress that might have been made in the further

investigation of Lucy Crawford's death.
A. No, I think I'm commenting slightly more widely than that on their system review as well, because I'm identifying systems failures, communication failures and individual performance failures --
Q. Yes.
A. -- not just individual competency issues.
Q. All of which we knew about 12 months earlier arising out of the Erne's internal review. What we didn't know with any degree of certainty arising out of that report is why Lucy had died, hence, as you've explained to us, the need to broaden out this review and to attempt to achieve greater certainty. I think you've been at pains to stress to me in your evidence that you were looking at the report of Dr Stewart as serving this goal of trying to achieve greater clarity, but when we look at your response to it, you don't touch upon that issue at all.
A. No, but I suppose this is happening at almost exactly the same time, within two/three days, from when I had identified to the department concerns that had been brought to my attention about the use of Solution No. 18.
Q. I'm not sure how that answers that question.
A. I'm not exactly sure of the question.

THE CHAIRMAN: Let me ask it this way: you've now heard of the terrible events in Altnagelvin which have led to Raychel's death --
A. Yes.
THE CHAIRMAN: -- and an issue has been raised with you, through various methods, that part of the problem may be Solution No. 18 and the use of Solution No. 18.
A. Yes.
THE CHAIRMAN: You know that the Sperrin Lakeland Trust has been looking, during the previous year, at how Lucy died; right? You know that her death is unexplained and unexpected. You know that she received Solution No. 18. You know that there is an issue or there may be an issue about whether fluids played any part in her death. And you know that no cause of her death has been identified.
A. Yes.
THE CHAIRMAN: The question really is: why does the penny not drop, at least to suggest, "Let's look a bit closer at Lucy's death to see if her death had something to do with Solution No. 18, mixed with the rate at which she received it, or whether she should have received it at all"?
A. Because there were still issues being identified, other potential issues, as part of the cause of death in Lucy's case. I also indicated, I think at the bottom of

this, obviously that Jim Kelly and I needed to follow up with a more detailed conversation. I accept in retrospect exactly what you've said that perhaps I should have been more specific, but I'm not expert enough in the use of solutions to arrive at that conclusion.
THE CHAIRMAN: I also accept, doctor, that what seems blindingly obvious today sitting here may not necessarily be blindingly obvious at the time. But if you have the unexplained death of one child who received Solution No. 18 and the later death of Raychel with immediately red flags being raised about Solution No. 18, on the information I'm being given, nobody in the Western Board area -- and by that I include Sperrin Lakeland Trust -- then drew any possible connection between the two deaths.
A. That is probably so.
THE CHAIRMAN: I have to accept that in order to understand why nothing at all happened in Lucy's case in terms of any serious exploration of why she died until after Raychel's inquest was picked up by Stanley Millar. I have to accept that everybody in the west missed the connection.
A. I think -- I accept that too. I think that is possibly because there were other confounding factors.

THE CHAIRMAN: Thank you.
MR WOLFE: So if I've got your evidence right, doctor, you remained interested in trying to identify, through the Trust, why Lucy died --
A. Yes.
Q. -- notwithstanding the absence of any formal output from the board in respect or in response to the Trust's report in the year 2000? And then when a second opportunity comes along in 2001 and you're asked to respond to the report, you say nothing about the death at all. Is that fair, doctor, or is there some other --
A. I think the absence of me saying anything about it at all does not convey that I was not interested. Clearly, from this letter, I did wish to continue to follow up with Jim Kelly to find out what had been going on, what was the cause.
Q. Well, in the October meeting then, of which we appear to have no record, was the issue of Lucy's death discussed?
A. I cannot be definitive because I have no record of that either.
Q. Did you not make --
A. I cannot imagine that it would not have been.
Q. Were you in the habit of making records of attending these meetings?
A. My usual habit at that time, either in telephone

conversations or in discussions that I was going to have with people, would have been to make notes at the time and later then to have those typed up and added to any relevant file, or perhaps, if there was no particularly relevant file, to have them put on to my laptop or desktop computer.

Q. Can I bring you back then to your knowledge of Raychel's death? And that was brought to your attention by Dr Fulton; isn't that correct?

A. Yes.

Q. The inquiry will, in due course, deal with Raychel governance as a discrete set of hearings and no doubt your evidence will be relevant to that. But just dealing with one discrete point arising out of your involvement at that time or your knowledge at that time of Raychel's death, you were made aware by Dr Fulton, is that correct, of the change or difference, I should say, in fluid practice between the Royal and elsewhere, and in particular the Royal and Altnagelvin?

A. My recollection of that is that it was Dr Nesbitt who, in his initial examination of this, had identified this issue, that he had discussed it with Dr Raymond Fulton and that Dr Fulton, in advising me of the issue, made me aware also of that fact.

Q. Yes. You then become aware of this difference of

approach through that source. Was that something you were able to, if you like, investigate and bottom out, whether with the Royal or with other peers or colleagues within the Health Service?

A. No, that would not have been something that I would have considered it appropriate to personally examine. I considered my role was to alert other directors of public health so that equally they could inform their units of a potential concern, but also to identify it to the department so that, if necessary, they could bring together expert paediatric representatives to look at that issue.

Q. What I'm particularly interested in establishing from you, if you can help us at all, is whether you were able to establish whether in fact there had been some change of approach in the Royal with regard to the use of replacement fluids and, if so, were you able to achieve an explanation for that change?

A. No, I did not further investigate that. I considered it my role to appropriately identify this to others and ask that they would look at it. It would have been extremely difficult for me necessarily to involve clinicians from the Royal and other parts of Northern Ireland, whereas the department had a clear mechanism, perhaps through the Specialty Advisory

Committee, for getting such a group together to advise.

Q. And just to be clear and to clarify any uncertainty about this, the story that you were getting from Dr Fulton, who had got the story from Dr Nesbitt, as I understand it, about the change in the Royal, were you getting the same story from Dr Kelly? You've already alluded to Dr Kelly's learning, and you were unsure whether he was learning it from Dr Stewart or from Dr Fulton. But was he giving you the same story as Dr Fulton about his knowledge of a change of fluids in the Royal?

A. I was hearing the same message from the two.

Q. That's just what I want to clarify, whether it was the same story, if you like, or could they have been talking about different things?

A. No, the message, that I was hearing certainly, was that there had been a change centrally, but that had not necessarily been communicated to satellite units.

Q. And then finally, doctor -- just before finally -- the first Royal College report that you received, was that something --

A. Sorry, there was only one Royal College report that I received. I did not receive two Royal College reports.

Q. Okay. Royal College report 1, you received it, you

received the notes of the meeting between Messrs Stewart and Kelly. Did you bring that report, if you like, in-house and discuss it internally?

A. It would have been most unusual if I had not.

Q. Again -- Mr Frawley away by this point in time -- do you have any recollection at all about the forum in which it was discussed?

A. No, at that point it would have been quite likely that I would have discussed that with Martin Bradley and that then, either individually or jointly, that would have been discussed with the chief executive.

Q. There was then a second Royal College report. Were you aware that one was, if you like, being formulated, being conducted?

A. I don't think I was aware of a second Royal College report until much later.

Q. Well, it was published in or about August 2002. Dr Kelly had rather assumed, he said in his evidence, that Mr Mills would pass that to you. When Mr Mills was asked about it I think he rather resignedly accepted that it hadn't gone.

A. No.

Q. Are you saying he didn't even know it was being undertaken, this second review?

A. Yes, I'm pretty sure that that is the case, and then

became aware of it later.
Q. And when you say "later", in preparation for these hearings?
A. Yes.
Q. As late as that?
A. I think it may have been as late as that.
Q. And in the spirit of the relationship that pertained between the board and the Trust at that time, can I suggest to you that you ought to have been provided with a copy of a report, particularly where it was touching upon the death of Lucy Crawford?
A. Yes, but I think there is another event in between, which may have potentially changed things, I don't know, in the mind of the Trust and that was the development of this into a medical negligence issue. Because it was the practice of each of the trusts not to involve the board in any cases after 1996 of medical negligence. They had their own independent scrutiny committees. I became aware recently of a medico-legal report done, I think by John Jenkins for the Trust, and I think that may have been in between the two. It may have been that, and that wouldn't have been shared with us. It may have been something relevant to that that the Trust did not then share any further reports with us.
Q. I'm not sure that that necessarily provides

a justification and I'm not suggesting that you're putting it forward as a legitimate justification.
A. No.
Q. Because it was certainly Dr Kelly's expectation that it would be shared and of course, as a report, it was outwith the medico-legal process in that it was an assessment of the performance and competence of a particular clinician --
A. Yes.
Q. -- which, from a patient safety perspective and in your capacity as the commissioner of services for the local populous, it rather ought to have been placed in your possession or the board's possession for scrutiny?
A. Yes, certainly in the board's possession, yes.
Q. And by contrast with the report which Dr Stewart had earlier furnished in 2001, this report was unequivocal in its conclusions that hyponatraemia was the cause of cerebral oedema in this child's case. You're aware of that now?
A. I'm conscious of that now, yes.
Q. Presumably, conscious of that now it's something that you would have liked to have had clarity of at the relevant time?
A. Yes, because it would have further enhanced then the issue that I'd already raised with the department.

THE CHAIRMAN: But that being so, if you had been aware of it, if you had been made aware of the second Royal College report which had said, "We now know what killed Lucy; it was hyponatraemia", that would have inevitably prompted some more questioning from you about "When on earth is this inquest happening?"
A. Yes.
MR WOLFE: I'm obliged. I have no further questions.
THE CHAIRMAN: The other point about the second report is that you were advised about the first report because it was regarded in the Trust as being relevant for you to be made aware of it, and that first report looked at the care which had been given to four different patients by Dr O'Donohoe; okay?
The second report, as Dr Stewart described it yesterday, was to look at the competence, but also about allegations of harassment and there was something of the third element she said.
MR QUINN: Harassment and bullying.
THE CHAIRMAN: Harassment and bullying and also about communications, because there was a concern, which we needn't go into in any detail, about a lack of communication between the different members of the paediatric team. Can I take it, doctor, that that combination of issues is every bit as relevant or would

have been every bit as relevant to the Western Board as the development of this line of concerns coming out of the Erne?
A. Yes, in the same way as, as I think I referred to earlier, if two out of three paediatricians had left at a time, it might create a vulnerability in the service, but if you had a service that is dysfunctional, you also want to be conscious of that to consider whether you continue to commission services from that unit.
THE CHAIRMAN: And you would certainly want to know what the Trust is going to do about making a dysfunctional service functional again?
A. Yes.
THE CHAIRMAN: But that report didn't reach you?
A. No.
THE CHAIRMAN: At any relevant time?
A. No.
THE CHAIRMAN: Okay. Are there any questions from the floor? Mr Lockhart?
Okay. Doctor, that brings an end to your evidence today. Thank you very much for coming. You don't have to say anything -- some people do, some people don't -- but if you do want to say anything that you haven't covered already, you are welcome to do so now.
A. Chairman, I'm not sure whether it's appropriate or not,

but I'm very conscious of the report of Professor Scally. As I went through, I thought it was perhaps relevant to make some comment because, as I went through it, I noted that there were 14 different references within the report as follows, that made the role and responsibility of both the board and myself relevant to this inquiry and an understanding of those.

There are one or two points about where he is saying things like:

"However, it is apparent and difficult to avoid the conclusion that it retains some elements of the directly-managed situation."

I think there's perhaps a misunderstanding within Professor Scally's report about the nature of a reasonably close working relationship as distinct from any confusion about management responsibilities. I certainly was very happy to have an ongoing and helpful relationship with relevant colleagues within the Trust, but at no stage did I confuse that with change in management responsibilities. I was very conscious of what the chief executive, the Trust, the medical director and the Trust, et cetera, should do and I just was concerned to ensure that there was no confusion, despite those comments within Professor Scally's report. So that was, I thought, an important point to make.

If I can make one final very short statement. I deeply regret that the parents of Lucy and Raychel have had to go through so much suffering. I've tried to go through these events and my recollections of them as accurately and as completely as I can. With the benefit of hindsight, if there were things which might have been done better, either within or outside my role, I would have wanted to see those happen. But certainly, I would like to try to reassure you and the families that I tried to act appropriately, sympathetically and professionally at the time. Thank you, chairman.

THE CHAIRMAN: Thank you very much indeed, doctor.

Okay, ladies and gentlemen, that finishes this afternoon. Sorry, Mr Lockhart?

MR LOCKHART: I wonder if we could clarify if Mr Frawley is tomorrow morning or tomorrow afternoon?

THE CHAIRMAN: He's the only witness tomorrow. Dr Curtis has been put back to next Tuesday, I think, so it's just Mr Frawley. Is 10 o'clock okay?

MR LOCKHART: 10 o'clock is fine.

THE CHAIRMAN: Thank you very much. 10 o'clock tomorrow morning.

(3.25 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X