

Tuesday, 4 June 2013

1  
2 (10.00 am)  
3 (Delay in proceedings)  
4 (10.08 am)  
5 THE CHAIRMAN: Good morning. Just before we start with  
6 Dr Crean's evidence, a few points.  
7 Mr Uberoi, I'm going to deal with the issue which  
8 has been raised on Friday on behalf of Dr Taylor about  
9 the extent to which Professor Kirkham might be involved  
10 in any other cases. That gives everyone -- Mr Quinn and  
11 the trusts -- until then to consider what their position  
12 is.  
13 MR UBEROI: Thank you.  
14 THE CHAIRMAN: We will deal with it at some point on Friday.  
15 And I think, just while you're on your feet, Dr Taylor  
16 is to give evidence later on today. As I understand it,  
17 an issue has arisen about his involvement in the  
18 treatment of Lucy, which was an involvement which was  
19 attributed to him in a trust summary; isn't that right?  
20 MR UBEROI: Yes, sir. It just arose, if you remember  
21 perhaps, in the middle of Friday where my learned friend  
22 Ms Anyadike-Danes mentioned that his name potentially  
23 appeared on a prescription sheet. That was news to me  
24 and I have taken some instructions on it and I have also  
25 had further discussions with my learned friend and I

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1 So it looks as if he's not able to assist if it is not  
2 Dr Taylor.  
3 THE CHAIRMAN: Thank you very much.  
4 MR UBEROI: I'm sure Dr Crean is endeavouring to help, but  
5 Dr Taylor was never asked, so the confusion didn't  
6 emanate from him.  
7 THE CHAIRMAN: Thank you very much. Okay, there are other  
8 issues to deal with as the day goes on, but I'm anxious  
9 to hear Dr Crean's evidence, so if Dr Crean would come  
10 forward.  
11 MS ANYADIKE-DANES: I think my learned friend Mr McAlinden  
12 said Dr Crean had been able to inspect the originals of  
13 Lucy's notes. Those are the originals at the Royal; is  
14 that right? There seems to be an issue as to whether  
15 the originals from the Erne are still available.  
16 We were trying to see the originals just to clarify  
17 certain points like this and I wonder if the DLS could  
18 help us at some convenient point in a break as to  
19 whether there is indeed some issue as to whether her  
20 notes are missing in some way.  
21 THE CHAIRMAN: Okay. The notes from the Erne or the notes  
22 from the Royal?  
23 MS ANYADIKE-DANES: I'm not entirely sure. We had sought  
24 the complete set of her notes to make sure that if there  
25 were issues like this we could resolve them fairly

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1 could foreshadow the evidence that he's going to give  
2 and bring you up-to-date with the discussions we have  
3 had or I could leave it until the evidence --  
4 THE CHAIRMAN: I'd like to know a bit more before then, if  
5 at all possible, through the Trust. At 061-039-125, if  
6 that could be brought up, there is an entry just over  
7 halfway down the page on the right-hand column. There  
8 is an entry which carries four names from 13 April 2000,  
9 Dr McLoughlin and Dr Taylor is the second name. That  
10 apparently was extracted by the Trust, which prepared  
11 this chronology from an earlier page, which is  
12 061-002-004. If I understand the point correctly, if  
13 you look down the left-hand side, entry number 7 is  
14 what -- the signature at the end is what the Trust  
15 attributed to Dr Taylor. You have consulted with  
16 Dr Taylor and he says that's not in fact his signature.  
17 MR UBEROI: That's exactly right, sir.  
18 THE CHAIRMAN: In that event, it's important to know that  
19 before Dr Taylor gives evidence, but I'd also like to  
20 know whose signature it is, if anybody can help us with  
21 that. I don't know if Dr Crean will recognise any of  
22 these signatures, Mr McAlinden, or if the Trust knows.  
23 Were you alerted to this point?  
24 MR McALINDEN: I was. Dr Crean inspected this document, the  
25 original, and actually identified Dr Taylor's signature.

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1 quickly and I think the secretariat has got an e-mail to  
2 suggest that some part of her notes may no longer be  
3 available or may be missing temporarily or something of  
4 that sort.  
5 MR McALINDEN: Certainly in relation to the Belfast records,  
6 the Belfast records are preserved in their entirety and  
7 in the possession of the Belfast Trust.  
8 THE CHAIRMAN: Yes. My understanding from what I was told  
9 earlier, Ms Simpson, is that the original Erne notes  
10 aren't available; is that right?  
11 MS SIMPSON: I understood that was the case, but I'll  
12 certainly check that.  
13 THE CHAIRMAN: Thank you.  
14 DR PETER CREAN (called)  
15 Questions from MS ANYADIKE-DANES  
16 MS ANYADIKE-DANES: Good morning, Dr Crean. Do you have  
17 your CV there?  
18 A. Yes, I do.  
19 Q. You have already given evidence. I think you gave  
20 evidence in relation to the governance section of Adam's  
21 case; is that correct?  
22 A. That's correct, yes.  
23 Q. So you'll probably know the form. What I'm going to do  
24 is I'm going to ask you whether you adopt the evidence  
25 in statements that you have already made in relation to

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1 this part of the inquiry's work, Lucy's case, subject to  
2 anything that you say in your oral testimony.  
3 A. Okay, thank you. Yes, I do adopt them.  
4 Q. Let me for the record say what they are. The first is  
5 the statement that you made -- I think it was actually  
6 made for the Trust -- which is undated. It's  
7 013-001-001. It's signed, but undated. We don't need  
8 to pull these up, this is just for referencing. Then  
9 you have a deposition because you gave evidence to  
10 the coroner. That deposition, the reference for that is  
11 013-021-071. It's dated 17 February 2004.  
12 Then you made a PSNI statement, the reference for  
13 that is 115-029-001, and it's dated 14 March 2005. Then  
14 you've made two statements for the inquiry in this  
15 section, the series is 292, the first of which is dated  
16 7 November 2012, and the second of which is dated  
17 23 January 2013. And you adopt all those?  
18 A. Yes, I do.  
19 Q. Thank you very much indeed. Could I ask, before you  
20 made your statements to the inquiry or even before you  
21 came today, have you discussed Lucy's case with any of  
22 your colleagues or with anyone else apart from your  
23 legal advisers?  
24 A. No, I haven't, no.  
25 Q. Thank you. So then if we go to your CV and if we pull

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1 to some of the questions I'm going to ask you. Leave  
2 aside the Northern Ireland Society of Anaesthetists and  
3 go to the right-hand page there, 002. Paediatric  
4 Intensive Care Society from 1998 to 2005 and then  
5 you have your membership of the Irish Intensive Care  
6 Society and the Northern Ireland Intensive Care Group.  
7 Can I just ask you a little bit about the Paediatric  
8 Intensive Care Society? What do you understand was its  
9 purpose?  
10 A. In 1988 -- was actually the first meeting and it was  
11 just -- in many ways paediatric intensive care in the UK  
12 was quite a bit behind what was happening in the US, for  
13 example. It was really in its infancy back then and it  
14 was just, I guess, trying to get a lot of like-minded  
15 people together to discuss common problems. I remember  
16 even, I think, at that first meeting John Jenkins from  
17 Northern Ireland actually presented a case that I had  
18 been involved in with him. So it was really just  
19 sharing experiences and just trying to get some sort of  
20 a forum where people could discuss common issues because  
21 there really wasn't anything like that at the time.  
22 Q. So would I be right in saying what you were really  
23 looking for is those particular issues that are of  
24 relevance to the very ill child who will be in intensive  
25 care and to see, in perhaps a more multidisciplinary

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1 up 306-087-001 and then put 002 alongside it. You have  
2 been a doctor since 1976; is that right?  
3 A. That's correct, yes.  
4 Q. You have been a consultant in paediatric anaesthesia  
5 at the Children's Hospital since October 1984.  
6 A. Yes.  
7 Q. And in fact your expertise in paediatrics, your  
8 specialty in paediatrics, goes back to July 1982; is  
9 that correct?  
10 A. Even before that, I think. My last rotation before  
11 I went off to Toronto was actually in the  
12 Children's Hospital, so I started that about  
13 January 1982.  
14 Q. I understand. Have you then been in paediatric  
15 intensive care since 1984; would that be correct?  
16 A. Yes, I did just over a year's training when I was in  
17 Toronto, that was part of my two-year rotation there, so  
18 I started there and came back as a consultant in 1984  
19 and I was doing both paediatric anaesthesia and  
20 intensive care at that time.  
21 Q. And you were in the Toronto Hospital For Sick  
22 Children, July 1982 to June 1984; is that correct?  
23 A. That's correct, yes.  
24 Q. Then if we look at the membership of the societies, we  
25 won't go through these in detail, but some are relevant

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1 way, how some of those issues might be addressed and how  
2 you might share some of your expertise on those issues?  
3 A. Yes, because it was open not only to anaesthetists and  
4 paediatricians, but surgeons, nurses, pharmacy people,  
5 so it was trying basically just to share experiences and  
6 I guess in the early days we were feeling our way in  
7 forward to which direction we were going to go and it  
8 was mainly based around case reports, I think.  
9 Q. Thank you. And then if we go to 006 and put up 007  
10 alongside it, you were sub-director for anaesthesia in  
11 ICU in the paediatric directorate and you were there  
12 from 1995 to 1997. You also, going down through your  
13 Northern Ireland membership, Paediatric Anaesthetists  
14 Group in Northern Ireland; you were chairman of that,  
15 and something that I'm sure you're going to be asked in  
16 another section of the inquiry's work, about your  
17 membership of the working group on hyponatraemia in  
18 children.  
19 And then, just on page 007, we see you as a member  
20 of the Federation of European Associations of Paediatric  
21 Anaesthetists and also a member of the paediatric group  
22 for the National Confidential Enquiry into Perioperative  
23 Deaths from 1998 to 1999.  
24 Can I ask you, when you say that one of the purposes  
25 of establishing the Paediatric Intensive Care Society

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1 was, in a multidisciplinary way, to try and look at  
2 common issues for children who find themselves in that  
3 kind of unit, when you're meeting nationally like that  
4 and then you come back to your local hospital, how do  
5 you integrate or what is the means by which you can  
6 integrate any learning that you have in that kind of  
7 forum?

8 A. Often, in a forum like that, it's usually the things  
9 informally that you hear, maybe in the bar afterwards or  
10 something like that, a lot of learning goes on there.  
11 One thing you do is maybe reassure yourself that what  
12 you are doing is good and appropriate and you may pick  
13 up things that you can maybe learn from and try to  
14 integrate those into your own working practices as well.  
15 That sort of thing. There will be case reports that can  
16 be very interesting, but it's about networking and  
17 talking to people. And even, you know, having someone  
18 at the end of a phone line somewhere that if you do have  
19 a problem, you can phone them ask and ask their advice.  
20 You can be quite isolated in Northern Ireland when it  
21 comes to people to talk to.  
22 Q. I would imagine extending your contacts is very helpful,  
23 particularly if you know from having spoken to somebody  
24 that they were involved in something which you now feel  
25 that you're engaged in and it would be good to chat that

1 bringing all the anaesthetic groups in Europe together.  
2 And in many ways a lot of paediatric anaesthesia at the  
3 time in Europe was in its infancy. Many of them based  
4 themselves on the practice in UK at that time, so in  
5 many ways the UK was taking a lead in that.

6 THE CHAIRMAN: I think what we're getting at is  
7 this: I understand entirely, because lawyers do the  
8 same, you talk to colleagues about what you would do in  
9 this situation, what you would do in that situation, and  
10 you learn off that. But if you're the sole person  
11 at the Royal, I assume, who was an executive committee  
12 member of the European association, is that right, at  
13 any one time?

14 A. I was probably only one of two people in the UK on that,  
15 not just the Royal.

16 THE CHAIRMAN: The question is: apart from picking up stuff  
17 informally in a over a chat over dinner or something on  
18 the tangents of a conference, was there ever a time when  
19 anything was brought back formally into the Royal so  
20 that you looked at this and said, "Actually, they're  
21 doing this better in London than we are and we can  
22 improve from London, so let's put something in place in  
23 the Royal"?

24 A. If I can come back to you on that because many of these  
25 organisations -- this was like an administrative role

1 through, but I was thinking in a more formal or  
2 systematic way because that may be a bit ad hoc for the  
3 purposes of developing something for the overall benefit  
4 of the Children's Hospital. Is there a way in which, in  
5 a more systematic way, you can bring that learning back  
6 to the Children's Hospital?

7 A. The meeting was pretty loose at the start. It was a guy  
8 called Duncan Matthews from Great Ormond Street that  
9 actually started the Paediatric Intensive Care Group or  
10 Society. He was a paediatrician who worked in intensive  
11 care there and I think it was just initially to get  
12 people into the same room once a year to try and get  
13 a discussion group going and take it from there. It was  
14 pretty informal at that time and it was mainly about  
15 case discussion and networking at the time.

16 Q. Yes, that's that group. But as I was taking you through  
17 your CV you actually have the benefit of being a member  
18 of a European group and a number of other societies than  
19 just that particular one from the UK and I meant a more  
20 general question.

21 A. Sorry, okay. Well, the European group, I was at that  
22 because I was secretary of the Association of Paediatric  
23 Anaesthetists. And it was called the Federation ...  
24 FEAPA -- I can't remember what the acronym is right now,  
25 it has been disbanded. Really what they were doing was

1 that you had and it was about administering the  
2 organisation. What you would have done was that you  
3 would have picked this up maybe at one of their  
4 four-year meetings. I think what's happened with many  
5 of these organisations over the years and  
6 the Association of Paediatric Anaesthetists -- I will  
7 call them the APA to abbreviate, if I may -- they in the  
8 2000s developed a guideline committee, for example, and  
9 I think it was important that you could highlight these  
10 guidelines, they were on the website, that you could --  
11 not everyone was a member of that. So you could show  
12 people this is a guideline here, it's on the website,  
13 maybe you'll want to take on board for your own  
14 practice.

15 THE CHAIRMAN: Exactly. Because if you were one of only two  
16 people in the UK who was at these events and perhaps at  
17 other events too, for instance Dr Taylor and Dr McKaigue  
18 might want to get the benefit of whatever you'd picked  
19 up at them/ is that right?

20 A. That's correct, and I think nowadays it's part of your  
21 appraisal revalidation process because what you do  
22 is that you have to reflect on, you know, meetings and  
23 organisations that you have been to and not everyone can  
24 get to all the meetings so you try and reflect on that  
25 and bring back good practices that you have seen there.

1 THE CHAIRMAN: How does that good practice become adopted  
2 in the Children's Hospital? I mean, have you ever  
3 issued a note or a protocol or a formal practice?  
4 A. Well, okay, I'll give you an example of something that's  
5 come up recently. There have been concerns, actually,  
6 from the group in Sick Kids' in Toronto about the use of  
7 codeine in children. Over there they don't use  
8 anti-inflammatory drugs for pain relief following  
9 tonsillectomy because they're worried about bleeding, so  
10 they give these kids lots of codeine home with them and  
11 codeine is metabolised to morphine in the body, so what  
12 happens -- some children metabolise this very, very  
13 quickly and very efficiently and some don't. And what  
14 they have found is that have been a number of deaths in  
15 America, which has caused great concern. When I heard  
16 about this and I knew there was a statement on the APA  
17 website on this, I brought that to the attention of my  
18 own colleagues here, but also the ENT surgeons as well  
19 in the Royal so they were aware of this.  
20 Our practice is a bit different is that we use  
21 codeine just for rescue pain relief and we don't give  
22 the parents a lot of it at home. I'm using that as an  
23 example of how we would try to raise a concern about  
24 a safety issue to staff so that parents are protected  
25 from that.

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1 had a consultation process, received comments and so on.  
2 And listed down there is the working party, the  
3 membership of the working party, so that you can see who  
4 they're talking about. When you get to who they  
5 received their comments from, you can see the kind of  
6 not only discipline, but also the institutions that  
7 those people are coming from. But what I wanted to know  
8 is whether you were aware of this particular document?  
9 A. Yes, I would have been, and I know many of the people  
10 that were on the working group.  
11 Q. And the reason I ask that is that when we were dealing  
12 with Claire's case -- in which you didn't give evidence,  
13 but I think you were aware of it --  
14 A. Yes.  
15 Q. -- there was an issue as to whether there were criteria  
16 in relation to admission of children to intensive care  
17 and that was an issue in that particular case. What  
18 we were told was that there weren't actually any  
19 established criteria, there was a practice at the  
20 Children's Hospital, but not established criteria, and  
21 to the extent that there was a practice it centred  
22 around whether a child required ventilatory support.  
23 And this, as I understood this standard, was actually to  
24 try and bring some sort of structure to a set of  
25 criteria which one would use to assist in that, amongst

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1 MS ANYADIKE-DANES: Thank you very much. That's exactly the  
2 sort of thing I was asking. I wonder if I could pull up  
3 315-015-001. These are the Paediatric Intensive Care  
4 Society standards for paediatric intensive care produced  
5 in 1996, but I suspect they were the subject of some  
6 discussion before then. Were you aware of these?  
7 A. Yes. One of the problems about standards is that anyone  
8 can come up with a standard and sometimes -- I mean, to  
9 get a good standard document out, you would have to have  
10 a group of people that would go through the literature,  
11 the standards should be evidence-based, there should be  
12 a period of consultation so that other people can  
13 reflect on what you are saying and then you would come  
14 up with a final document.  
15 I remember one of the standard documents from the  
16 Paediatric Intensive Care Society was quite aspirational  
17 and not every standard document you see out there  
18 I would have concerns about, that's all I'm really  
19 saying to say. But I'm sure I saw that at the time.  
20 I can't remember.  
21 Q. If we pull up 003, now that you mention who might  
22 contribute to it. There we are. It seems that there  
23 was a previous version of this, which was prepared by  
24 a working party consisting of members of the Council of  
25 the Paediatric Intensive Care Society. And then they

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1 other issues, in relation to the provision of  
2 a paediatric intensive care service. And the other  
3 thing that it deals with, if we go to -- I think it's  
4 going to be 014, it might be 015, I'm slightly out of  
5 kilter. It's 015.  
6 You can see that under the management policies  
7 there is an issue in relation to clear procedures for  
8 the admission of patients and then, under "Data  
9 collection and audit", it talks about:  
10 "Assessing the performance of a PICU unit, clerking  
11 information, undertaking audit, including details of all  
12 admissions and the collection of all patient data and  
13 analysis of morbidity and mortality."  
14 And then just a little bit further on in that same  
15 paragraph it talks about there being:  
16 "... regular audit meetings so that all staff can be  
17 made aware of any adverse occurrence or alteration  
18 in the standard and quality of care."  
19 Then it talks about the kind of information  
20 technology facility you might require in order to  
21 support that.  
22 If we pause there: were you aware of this and had  
23 you tried to see what could be done to try and establish  
24 something, not necessarily mimicking that exactly, but  
25 something along those lines at PICU?

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1 A. Yes, they're all fantastic ideas. They are.  
2 Q. That's not what I asked you. Were you aware of it?  
3 A. Yes.  
4 Q. Of this?  
5 A. Yes.  
6 Q. Was there any move or attempt to see whether those sorts  
7 of standards could be established for PICU in the  
8 Children's Hospital?  
9 A. I think you're aware that in the anaesthetic department  
10 in Children's at that time we were under crisis with  
11 manpower, and I think just trying to keep ourselves  
12 afloat and not sinking was about the best we could do at  
13 that time. All these things are great ideas, but there  
14 was no way we could move forward with those sorts of  
15 things without additional manpower and resources, and  
16 that's just a fact of the way it was then.  
17 Q. Was that point being made to the Trust?  
18 A. All the time.  
19 Q. That there are things that we could do to be assisting  
20 with governance, if I can call it loosely that, and, for  
21 that matter, its role in the improvement of care, but we  
22 don't have the resources to do that?  
23 A. If I can tell you that at the time we were probably  
24 working 60, 70-hour weeks as consultants. It was  
25 a very, very unattractive job. No matter how much

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1 A. I understand what you're saying, Mr Chairman, and  
2 I honestly think that we were pretty cushioned from all  
3 the external forces that might have been going on there  
4 at the time. I was kind of surprised -- you surprised  
5 me with the questioning, if you like, last year. And  
6 I've thought about it a lot. I'm not sure I was aware  
7 of a lot of the things that were happening outside my  
8 own working environment, those sort of factors that were  
9 being alluded to last year. I think there was a lot of  
10 support going on in the background to let us try and  
11 maintain the service and things like that. It was  
12 a hard time.  
13 MS ANYADIKE-DANES: If we were to bring matters up a little  
14 closer to the date with which we are concerned, which is  
15 2000, had the position changed at all between 1995, when  
16 you were discussing it in relation to Adam and 2000?  
17 A. Yes, there were more people involved. Paul Loane, he  
18 works up in Coleraine Hospital now, but he came back as  
19 a consultant in 1997 and he worked again in the  
20 intensive care unit in the Hospital for Sick Children in  
21 Toronto, he worked with Des Bohn, who is an adviser to  
22 the inquiry, and a lot of the ideas that Des had were  
23 all brought back with him as well.  
24 Tony Chisakuta, I think, came back in about 1999 to  
25 the hospital as well. He had been working in Great

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1 money you had, people didn't want to come and work with  
2 us. They liked working with children, they liked  
3 working with us, they liked the staff, but they didn't  
4 like the lifestyle, so there was a major recruitment  
5 problem. And I think, no matter how much money you  
6 could have thrown this, it wouldn't have worked. My  
7 wife will tell you she brought our children up on her  
8 own. She never saw me and you were just in work the  
9 whole time.

10 I agree, many of these things are very positive,  
11 they're great. Many of these things were happening  
12 in the Children's Hospital in Toronto when I was there  
13 in the early 80s and it would have been great if we  
14 could have replicated them in Belfast, but at that time  
15 I don't think it would have been possible.

16 THE CHAIRMAN: I don't want to go over all of Adam's case  
17 again, but do I understand what you have just said to be  
18 a reference to the number of paediatric anaesthetists  
19 that there were in the Children's Hospital in 1995 and  
20 1996, the pressure that was on that small group of  
21 people, and the evidence which I heard last year about  
22 the extent to which that might have been relevant to  
23 what happened after Adam's death in terms of deciding  
24 what might be done or should be done about Dr Taylor's  
25 handling of Adam's case? I'm trying to --

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1 Ormond Street. So things were starting to ease at that  
2 time. People were coming in with new ideas and it was  
3 a good experience for us at that time.  
4 Q. If, with that increase in personnel, if I can put it  
5 that way, if anybody had wanted to try and introduce  
6 standards along the lines that one sees being  
7 recommended perhaps, say, by the Paediatric Intensive  
8 Care Society, who would be the person who would be able  
9 to take that forward in the structure?  
10 A. If you're looking at an organisational person, that may  
11 have come from the lead person in intensive care. But  
12 at the time, I think we were almost swimming just to  
13 stay still, from a clinical point of view. There wasn't  
14 a lot of time to do things. For example, I know this  
15 has been discussed previously, or at least I think it  
16 has. I had a research fellow back in 1989, a guy called  
17 Jarlath McAloon, who's a consultant now in  
18 Antrim Hospital, and we were doing an audit of a --  
19 a prospective audit evaluating the outcome of children  
20 in the intensive care unit, and that was published in,  
21 I think, Archives in 1991. And it was a prospective  
22 audit over an 8-month period. But when he left, we  
23 tried to maintain the database ourselves and it was  
24 fairly general stuff about how sick the kids were when  
25 they came in, what time they came in at, diagnoses and

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1 things like that, but it was done very much on an ad hoc  
2 basis. So it wasn't done in a prospective fashion, you  
3 may be going back several days later, you wouldn't be  
4 capturing all the data, but at least we were trying to  
5 do something at that time.

6 Q. I understand that, but what I was actually trying to ask  
7 you was: who within the structure of management, if I  
8 can put it that way, is the sort of person who could be  
9 trying to introduce a new standard?

10 A. Well, I've answered that, I think, in that it would  
11 probably be the lead person for the --

12 Q. Sorry?

13 A. It probably would have been the lead person for the  
14 paediatric --

15 Q. The lead person? Thank you. That's what I was trying  
16 to get at.

17 A. I was trying to say as well that, no matter what title  
18 he may have had, that lead person would have been in  
19 many ways an administrative role within the  
20 organisation. They probably wouldn't have had a lot of  
21 time to do these sorts of things because we were really  
22 busy at the time.

23 Q. I am going to ask you a question about the lead  
24 clinician/director of PICU, but before I do that, I want  
25 to pick up on something I thought I heard you say, which

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1 he had these ideas, the general paediatricians, I think,  
2 in the Hospital For Sick Children in Toronto in many  
3 ways did their own thing with fluids and they had  
4 a different philosophy.

5 Q. If we just stick with what Paul Loane might have been  
6 bringing back.

7 A. It was much the same in Belfast as well and I think Paul  
8 was trying to change their practice to maybe just use  
9 hypotonic solutions for maintenance only. I can maybe  
10 come to something later on with this as well.

11 Q. Yes. That's what I want to ask you about, actually.  
12 Is that what he was bringing back, and if he was  
13 bringing it back, what was the forum in which he would  
14 begin to suggest might be appropriate to think rather  
15 differently about the use of certain IV fluids,  
16 particularly the low sodium ones? Where would he be  
17 doing that?

18 A. It could be informal and something slightly more formal  
19 as well.

20 Q. Which was it?

21 A. It was both.

22 Q. And when it was something slightly more formal, how did  
23 that find expression?

24 A. Well, Paul was involved, from memory, at the induction  
25 course for the trainees, so whenever the trainees -- and

23

1 is that Paul Loane came back from having worked with  
2 Des Bohn and others in Toronto's Sick Children's and I  
3 think you said he came back in about 1997; is that  
4 right?

5 A. I think it was about then. I think so.

6 Q. I think you also said he brought back some of the ideas  
7 that Des Bohn had had.

8 A. Yes, Paul would --

9 Q. Is that what you said?

10 A. Yes.

11 Q. Can I just ask you the question then in relation to  
12 that?

13 A. Sorry.

14 Q. Because the work that we have done indicates that  
15 Des Bohn was one of those people who was interested in  
16 fluid management, hyponatraemia, and low-sodium fluids.  
17 In particular, he has written some papers, he wrote that  
18 2001 paper with Halberthal. As far as you're aware, is  
19 that the sort of thing Paul Loane was bringing back?

20 A. What Paul was bringing back was, if you like, something  
21 that we had discussed, I think, at Adam's last year, and  
22 a lot of it was around the use of hypotonic solutions  
23 and the use of hypotonic solutions for maintenance  
24 fluids only. I think, even for Des in the 1990s,  
25 although he was very much in the intensive care unit and

22

1 this is the paediatric trainees I'm talking about who  
2 came into the hospital. So there would be a new influx  
3 of those every six months and he would be part of the  
4 induction day for them and he would talk about fluids.  
5 I remember him telling me that he would specifically try  
6 to get them to focus on hypotonic fluids for maintenance  
7 only, and that's where he was coming from. He was also  
8 involved in the Department of Health in the 2000s.

9 Q. I don't want to go too far into that at the moment;  
10 I want to stick to where we are. When Dr Chisakuta was  
11 giving evidence he said he included in talks on fluid  
12 regime the issue of -- and somebody will correct me if I  
13 have him wrong, but I think this is at least the  
14 sentiment of what he was saying -- that low-sodium  
15 fluids should be used for maintenance, and even that  
16 carefully, maybe tailing it off at some point, but  
17 certainly not for replacement. He said before he was  
18 giving those lectures, there were already lectures like  
19 that being given by Dr Loane. Does that fit with your  
20 recollection?

21 A. Yes, but if I could maybe touch on those sentiments  
22 because I think it's important that I pick that up as  
23 well. Although we may have suggested these things to  
24 paediatricians, the paediatric view of fluid management  
25 would have been different from that. And I would have

24

1 to bring you forward a bit, and it really wasn't until  
2 the NPSA alert in -- I think it was March 2007 -- which  
3 really changed the way even paediatricians viewed fluid  
4 management. I think for a long, long time after Paul  
5 was appointed, after Tony was appointed, that the  
6 paediatricians, not just in Northern Ireland, but a lot  
7 of places around the UK, would use a single solution for  
8 replacement fluid and for maintenance fluid.

9 Q. I'm going to specifically come to that point later on.  
10 If I could confine it a little bit in this way: leaving  
11 aside the perhaps slightly different approach that the  
12 paediatricians might have taken, for the paediatric  
13 anaesthetists, was there any common ground about the use  
14 of Solution No. 18 and low-sodium fluids generally for  
15 replacement, any common ground that that was  
16 inappropriate?

17 A. The differences were quite big. They weren't small  
18 differences and there was a lot of discussion,  
19 I remember, over the years, about this. The  
20 paediatricians, their view is --

21 Q. Sorry, I'm asking you about the paediatric  
22 anaesthetists.

23 A. Well, I am trying to answer that for you in that the  
24 paediatricians had their own specific view. They would  
25 be looking after paediatric medical patients and it

25

1 A. It was.

2 THE CHAIRMAN: Because if they got it wrong, that could  
3 result in a child ending up in PICU?

4 A. I suppose the reassuring thing for them is that they  
5 usually got it right, but it was a different emphasis  
6 than we had. That is all I'm trying to reflect.

7 THE CHAIRMAN: One more point. When you talk about this  
8 difference between paediatricians and paediatric  
9 anaesthetists, is that an issue only within the Royal or  
10 only within Northern Ireland, or was it a UK issue?

11 A. I think it was a worldwide issue. I think that probably  
12 Des in Toronto had the same sort of issues going on  
13 there as well.

14 THE CHAIRMAN: Thank you.

15 MS ANYADIKE-DANES: Thank you. When you talk about the  
16 anaesthetists in a group like that -- and this was the  
17 question I was asking you -- was there common ground  
18 amongst them that one had to address maintenance  
19 separately from replacement and that low-sodium fluids  
20 were not appropriate for replacement?

21 A. Yes. That was always my view forever really.

22 Q. From your point of view in PICU, where you might see the  
23 paediatric anaesthetists treating very sick children,  
24 you would have been surprised if there were paediatric  
25 anaesthetists not recognising the inappropriateness of

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1 worked for them and they were reluctant to change that  
2 practice. Amongst the paediatric anaesthetists, we had  
3 a different view, and it was about you separated out the  
4 maintenance fluid from other types of fluid. And this  
5 was all the more important in the intensive care unit  
6 where you had children with complex fluid needs.

7 Fluid management, for us, was fundamental. It was  
8 the core of our business, if you like. You had cardiac  
9 kids in heart failure with restricted fluid, you could  
10 have renal patients in there in renal failure with  
11 complex fluid needs. You could have septic kids in  
12 needing volume loading, volume replacement, inotropic  
13 support. It was very, very complex. So in the middle  
14 of what we did, our core business was around fluids.  
15 And it was often difficult for others to appreciate that  
16 in the same way that we did about fluids, and their  
17 needs were different. The clinical patients they were  
18 looking at were different as well.

19 THE CHAIRMAN: Let me ask you this way: I get the impression  
20 from that that it was critically important for  
21 paediatric anaesthetists to be on top of fluid  
22 management.

23 A. Very much so.

24 THE CHAIRMAN: But surely it was also important for  
25 paediatricians to be on top of fluid management?

26

1 using a low-sodium solution for replacement?

2 A. It depends, because that's not quite true, because it  
3 depends what they're trying to replace. If you're  
4 losing -- you have to replace like with like.

5 Q. Yes.

6 A. So if you're losing a fluid with a sodium content of  
7 30 millimoles per litre, it would be inappropriate to  
8 use normal saline as it has a sodium content of  
9 154 millimoles per litre. It's making sure you replace  
10 the losses with the appropriate fluid.

11 Q. Sorry, I had been too sweeping. Would I be right in  
12 saying you'd be surprised that a paediatric anaesthetist  
13 wouldn't see the inappropriateness of replacing gastric  
14 losses, diarrhoeal losses, with low-sodium fluids?

15 A. As an anaesthetist you would, but the paediatricians did  
16 it all the time --

17 Q. No, as an anaesthetist.

18 A. As an anaesthetist, that's not what you would do.

19 Q. Thank you. And just before I move away from this area,  
20 you had talked, I think, about if you had to pick  
21 a person in the position who might be able to try and  
22 introduce standards, that person would possibly be the  
23 clinical lead or the director of PICU, I think you had  
24 said. When Dr McKaigue was giving his evidence, he said  
25 he was actually the first person to hold that position

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1 and that you had asked him to take that position, which  
2 he did. What did you intend that position would  
3 involve, that role would involve?  
4 A. I think it was more kind of an administrative role  
5 at the time, and to be able to speak for us at hospital  
6 committees really. I would have thought it was more  
7 a role like that.  
8 Q. Yes.  
9 A. Each of us might have had our own individual areas that  
10 we wished to develop within the unit as well, but  
11 certainly at that time it was just basically someone to  
12 speak for us.  
13 Q. And for you, as a sub-director for anaesthesia and ICU  
14 in the paediatric directorate, what was that role?  
15 A. I think we went into this in some detail last year as  
16 well with Adam.  
17 Q. Perhaps if you could just summarise it.  
18 A. It was just to reflect the needs of the service at that  
19 time for paediatric anaesthesia and intensive care.  
20 I guess it was like an operational group meeting every  
21 week. It was just about business really, day-to-day  
22 business, and staffing issues, et cetera, things like  
23 that, funding issues, maybe needing new equipment,  
24 organisation of theatre lists, that sort of thing. So  
25 it was very much operational rather than strategic

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1 A. Well, you can see there, if you look at the timescale  
2 there:  
3 "Measurements performed two-hourly or more  
4 frequently."  
5 So it was pretty major stuff: major abdominal stuff,  
6 colorectal stuff in kids, thoracotomies, neurosurgery,  
7 that sort of thing. It's not the sort of thing that  
8 would have been done anywhere else. And Mr Chairman  
9 made the point last year: well, you were just writing it  
10 up for yourselves, basically. Really, the statement  
11 itself, the way it stands there, really only would  
12 reflect surgery that was done in the Children's Hospital  
13 at the time and subsequently.  
14 Q. What I want to do is to pull up alongside it, if I can  
15 find it, the one that actually got attached to  
16 Dr Taylor's deposition. I think it's 011-014-107a.  
17 It's slightly different. Did you ever see that?  
18 A. I think the only one I saw was -- I think it was left  
19 for me in the secretary's office and basically, "Do you  
20 agree with this or not?". I think that's the only  
21 version I saw at that time. I think.  
22 Q. The reason why I'm asking you is that the -- they call  
23 it the draft statement to distinguish it. This is the  
24 one that's presented to the coroner.  
25 A. The one on the right?

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1 at the time.  
2 Q. Thank you. Then if I move on to hyponatraemia. You had  
3 been asked previously about a draft after Adam's death  
4 that you approved. I'll just turn it up for you. It's  
5 060-018-036; do you recognise that?  
6 A. Yes, I do.  
7 Q. I won't pull it up, but what the cover fax, which goes  
8 from Dr Murnaghan to the solicitors at the time,  
9 Brangam Bagnall, says:  
10 "Herewith a draft, which was composed today by  
11 doctors Gaston, Taylor, McKaigue and subsequently  
12 approved by Dr Crean. These are the consultant  
13 paediatric anaesthetists who will be involved in such  
14 clinical problems in the future."  
15 What I wanted to ask you about is, if you look at  
16 it, had you intended that this could have any benefit,  
17 if I can put it that way, for a hospital outside of the  
18 Children's Hospital?  
19 A. Again, there was a fair bit of discussion about this  
20 last year as well. I suppose I tried to defend it and  
21 I defended it basically by saying, "Well, it was about  
22 major surgery", that's what this was all about, and  
23 carefully monitoring patients during major surgery.  
24 Q. And what did all of you define, you four anaesthetists  
25 signing-off on this, as major surgery?

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1 Q. Exactly. It's different in this particular respect. It  
2 says in the middle paragraph:  
3 "Furthermore, the now known complications of  
4 hyponatraemia in some of these cases will continue to be  
5 assessed in each patient and all anaesthetic staff will  
6 be made aware of these particular phenomena and advised  
7 to act accordingly."  
8 Did you know about that, that that was a statement  
9 going forward?  
10 A. Honestly, I just can't remember. I think I probably saw  
11 an earlier version of that, but I can't put my hand on  
12 my heart and say, yes, I saw that. I just don't  
13 remember.  
14 Q. Well, did you know that the coroner was being told that  
15 all anaesthetic staff will be made aware of these  
16 particular phenomena and advised to act appropriately?  
17 Whether you actually saw this draft or not, did you know  
18 that statement was being made?  
19 A. I'm not sure that I may have been aware of that at the  
20 time.  
21 Q. If that was going to happen -- and I'm thinking in  
22 particular with you in your position as sub-director for  
23 anaesthesia and ICU and a senior consultant paediatric  
24 anaesthetist -- if that was going to happen, what would  
25 be the mechanism for all anaesthetic staff being made

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1 aware of that?  
2 A. Well, there could be many ways of doing it, I guess.  
3 You would have, again, formal and informal ways. You  
4 could have it embedded into like a teaching programme so  
5 that all the trainees coming through would be  
6 specifically taught about that.  
7 Q. Did you know if that happened?  
8 A. I think Paul in his teaching -- and he came in 1997 --  
9 would probably have done that, but I don't think it was  
10 an outcome from that specific draft statement there.  
11 Q. That would have been Dr Loane towards trainees. But if  
12 this statement is going to be executed, then this  
13 applies to all anaesthetic staff. That means you would  
14 have to know about it, for example.  
15 A. Yes. I mean, I would have known about that anyway  
16 at the time. I mean, I would have known about the  
17 complications of hyponatraemia at the time in 1996.  
18 Q. You would have had to know about it and all your other  
19 colleagues, other than those who actually signed-off on  
20 the other version to the left-hand side, would have to  
21 know that that is what's going to happen, either for  
22 their own practice or, if they're more senior, for what  
23 they might be teaching others.  
24 A. There only were the three of us at the time so we all  
25 did know in 1996 --

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1 like that, you should do it. That's what I would say.  
2 I think --  
3 THE CHAIRMAN: That's exactly what worries me because the  
4 coroner was led to believe that this was exactly what  
5 was going to happen on the back of Adam's death. One  
6 can infer that he took reassurance from that at Adam's  
7 inquest and you have said quite expressly that nothing  
8 happened with that statement.  
9 A. That would concern me as well, Mr Chairman.  
10 MS ANYADIKE-DANES: Thank you. When you spoke just a little  
11 while ago about what you would expect the paediatric  
12 anaesthetists to have recognised in terms of the use of  
13 low-sodium fluids and where it's appropriate to use them  
14 and for what purpose and so forth, and I think what you  
15 said is that in your view there was a fair degree of  
16 commonality amongst you about that, when Dr Chisakuta  
17 came back he gave a paper, which is called "Recent  
18 advances in paediatric anaesthesia", and he gave it to  
19 the -- it was a paper at the inaugural meeting of the  
20 Western Society. The paper is dated 30 September 1998  
21 and it deals, in particular, in terms of the fluid  
22 management aspect of it, with a very recent paper  
23 published by Allen Arieff. If I pull out the section of  
24 the paper so you can see it, it's 283/3, pages 7 and 8,  
25 if we pull those alongside of each other.

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1 Q. Dr Chisakuta didn't know when he came back in 1997 that  
2 there was a statement like that.  
3 A. I think it was 1999 he came back. No, he probably  
4 wouldn't have been aware because, as you know yourself,  
5 the statement -- nothing really happened with it.  
6 Q. That's what I'm asking you. A statement has been made  
7 to the coroner and it's said very clearly what's going  
8 to happen in relation to all anaesthetists. And what  
9 I'm asking you is: given the position that you then held  
10 at the time, what steps were taken or could have been  
11 taken to give effect to that statement? And the reason  
12 why I'm particularly asking you now is because when  
13 I asked Dr Chisakuta whether he was aware of this when  
14 he came back to the Royal, he said, no, he wasn't.  
15 A. I think I've already conceded that I really didn't know  
16 that this was embedded in the final draft. I hadn't  
17 seen it and I don't think I was told about it  
18 afterwards. So I agree with you, I don't think very  
19 much was done with that afterwards.  
20 Q. Thank you.  
21 A. I'm not taking issue on that.  
22 Q. Thank you. If nothing very much was being done, do  
23 I take it you think it appropriate if something had  
24 been?  
25 A. Well, I mean, if you said you're going to do something

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1 Did you know he was giving a paper like that?  
2 A. Sometimes I find it hard to remember what happened last  
3 week, without going back to 1998. I'm sorry, I really  
4 just can't remember.  
5 Q. Let me put it another way. Were you aware of the paper  
6 that Arieff published in 1998?  
7 A. Yes, I was. I knew Ted Sumner quite well because we had  
8 both worked on the APA. I think that -- he was actually  
9 quite upset and disturbed with many of the events on  
10 Adam's death and, coming over here and seeing how the  
11 family had been affected, the staff and everything else,  
12 and I think he contacted Allen Arieff to see if he could  
13 write an editorial. He was the editor of the journal at  
14 that time and I think he commissioned him to write an  
15 editorial. From memory, I think it was January 1998  
16 that that editorial was written. It was just reflecting  
17 on the paper that he had written in the BMJ several  
18 years previously. I think it was really just to  
19 highlight this issue amongst paediatric anaesthetists  
20 at the time.  
21 Q. Yes.  
22 A. And it is an international journal, it's not just  
23 a journal for the UK.  
24 Q. Agreed, and that was a point I wanted to take you up  
25 with you. When you had been asked in relation to Adam's

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1 case about the link between Arieff's paper and Adam's  
2 case in the way that it was seen reflected in that  
3 statement, your view was that actually there wasn't  
4 a link because Arieff wasn't talking about the situation  
5 that had given rise to Adam's difficulties.

6 A. That's correct, yes.

7 Q. And that's why I wanted to ask you that because it's one  
8 thing to say the chances of there being children out  
9 there who will be undergoing paediatric surgery, surgery  
10 that could expose them to the sort of thing that Adam  
11 had, it's one thing to talk about them; it's a whole  
12 different issue to talk about the possible dangers of  
13 low-sodium fluids in perhaps elective surgery that's not  
14 major or even healthy children, which is what Arieff's  
15 1992 paper was about.

16 You had said, I think, earlier when I asked you  
17 about that, that major surgery was only happening in the  
18 Royal, so maybe that's an explanation for why that  
19 statement didn't travel, if I can put it that way.

20 But the sort of work that is being described by  
21 Arieff and his colleagues in the 1992 paper and then  
22 Arieff in this 1998 paper, that is not a circumstance  
23 that's likely to be confined within the Children's  
24 Hospital; that's correct, isn't it?

25 A. Yes.

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1 structures were very informal. In fact, there weren't  
2 even informal structures at that time to do things like  
3 that.

4 Q. Well, it sort of comes back to the point that the  
5 chairman was asking you. If you go to conferences and  
6 seminars and you have this learning that personally  
7 enhances your own career and your own contacts, but then  
8 there is a possibility for sharing that and the  
9 Children's Hospital is the regional centre and district  
10 hospitals, other hospitals, could perhaps look to it as  
11 being able to disseminate specialist learning, if I can  
12 put it that way, and I'm just asking why any of you who  
13 were in the position of a quasi-management role didn't  
14 say, "Look, we could do this, we could have a seminar  
15 where we discuss this, maybe we would just suggest that  
16 the CMO or department do something because there are now  
17 two papers out from Allen Arieff, and he's not the only  
18 person to write on it, talking about the potential risk  
19 of low sodium. We happen to know it's something that  
20 paediatricians up and down the country are using". Why  
21 wasn't the opportunity seized?

22 A. I understand the inquiry is focused on hyponatraemia,  
23 but there were other areas of things that we would be  
24 looking at in regard to paediatric anaesthesia as well.  
25 If you look at the numbers round the province, in

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1 Q. If we can accept that, then the point that I want to ask  
2 you is: did the Children's Hospital give any thought to  
3 at least disseminating that message?

4 A. I don't think we specifically went out there to put  
5 forward the concepts that Allen Arieff had in his 1992  
6 paper, no.

7 Q. But you had a good opportunity to do that because there  
8 was quite a bit of publicity generated by Adam's  
9 inquest. There was press reporting and so forth. In  
10 fact, that particular statement, at least parts of it,  
11 found their way into the media. So that would have been  
12 a very good opportunity to say, "Look, major surgery may  
13 be one thing, but here's something all of you ought to  
14 be alive to and there's potential danger for a much  
15 broader class of children in the inappropriate use of  
16 low-sodium fluid". So what I'm asking you is why the  
17 Children's Hospital didn't seize that opportunity?

18 A. I can't disagree with you. I think that if there has  
19 been more formal links and structures at that time it  
20 would have been much easier to do something like that  
21 because the links and structures would have been there.  
22 But at that time there weren't. Maybe we should have  
23 thought of trying to do something through the Department  
24 of Health to disseminate this information, but I don't  
25 think there were the formal links at the time. All the

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1 Altnagelvin, for example, then there were about 2,500  
2 children having operations every year. Similarly,  
3 in the Ulster and Craigavon. So there was a big body of  
4 work being done there and, as a consultant, I have to  
5 keep up-to-date with what I do and the consultants there  
6 would have to keep up-to-date with what they were doing  
7 as well. One way of doing that is attending meetings  
8 and reading journals and things like that. I would like  
9 to think that they had taken this journal in their own  
10 hospital and maybe reflected on what was written there.

11 The following year, in 1999, I did try to set up --  
12 and I think I put this into a Raychel governance  
13 statement.

14 THE CHAIRMAN: In Adam's case?

15 A. No, it's one I've just done recently. Can I talk about  
16 that?

17 THE CHAIRMAN: Yes.

18 A. In 1999, I was involved in setting up a peer-review  
19 scheme in the UK and it's really where one department of  
20 anaesthesia in a Children's Hospital reviewed another  
21 hospital against a set of standards that had been  
22 basically set up by the Association of Anaesthetists and  
23 the College of Anaesthetists. I thought it would be  
24 a pretty good idea if we could do something locally and  
25 set up a group together and try to discuss issues like

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1 that, but it's not an easy thing, actually, to do  
2 because you're viewed -- if you like, "You're the  
3 specialist centre, you're telling us what to do", and  
4 there were tensions there at that first meeting.  
5 THE CHAIRMAN: Doctor, the reason this is significant is  
6 because in Raychel's case, Dr Nesbitt has effectively  
7 raised a concern or complaint that there were things  
8 going on in the Royal about which word didn't get out to  
9 places like Altnagelvin, for instance, about the use of  
10 Solution No. 18.  
11 A. Yes.  
12 THE CHAIRMAN: And he's also said, "We should have been told  
13 about previous incidents because, had we know about  
14 previous incidents and/or had we known about issues  
15 about Solution No. 18, it may have led Altnagelvin to  
16 improve their practices and potentially avoided  
17 Raychel's death".  
18 A. I think sharing knowledge is very important. I don't  
19 think we did very -- a very good job 10/15 years ago.  
20 THE CHAIRMAN: Can I ask you this, not to leave it hanging,  
21 is a better job done now?  
22 A. I think so, definitely. I think there's better  
23 communication. I'll just give you an example here: if  
24 you had a child coming down from another hospital and  
25 you had any cause for concern about any aspect of

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1 death. He rang around a number of hospitals to see what  
2 their practice was. He was a bit concerned about what  
3 had happened in his hospital in relation to her fluid  
4 management, I would understand. The upshot of that was  
5 that he wrote a letter to his own medical director. He  
6 did that on 14 June. We don't need to pull it up, but  
7 what he said in that letter was that:  
8 "The Children's Hospital anaesthetists have recently  
9 changed their practice and have moved away from  
10 Solution No. 18 to Hartmann's solution, and that change  
11 occurred six months ago ..."  
12 That is why I gave you the date of the letter:  
13 "... and followed several deaths involving  
14 Solution No. 18."  
15 For reference purposes that letter is 026-005-006.  
16 So that's what he was saying very shortly after  
17 Raychel's death. He also did mention that other  
18 anaesthetists, for example anaesthetists in Craigavon,  
19 had been trying to change the fluid but had not been  
20 successful. So I think his point was that the Royal had  
21 done it and there seemed to be knowledge about the  
22 wisdom of doing that, it just hadn't found its way to  
23 Altnagelvin. So the first question to ask is whether  
24 he's correct on that, but let me help you with something  
25 else. When he made his PSNI statement, which is

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1 a child's care, the first thing you do is you would  
2 phone them up and say, "Look, I'm not happy about this,  
3 what I'm going to be doing is I'm going to be filling in  
4 an incident form, your hospital will be getting a copy  
5 of the incident form. Look, this is about learning,  
6 it's about learning from things that maybe haven't gone  
7 as well as you might hope to. Let's work together on  
8 this and see if we can improve this". It's done  
9 immediately. People nowadays don't even know or  
10 remember a time when there wasn't incident reporting.  
11 You would say to them, "You mean we didn't have this  
12 a number of years ago?" It's a surprise to them because  
13 it's now so embedded in what happens nowadays. So  
14 I like to think there have been some changes to improve  
15 things over the years, Mr Chairman.  
16 THE CHAIRMAN: Thank you.  
17 MS ANYADIKE-DANES: Now that the chairman's mentioned that,  
18 that was the next point I was going on to because there  
19 is an issue we're trying to bottom out as to when the  
20 Royal changed, if it did, its practices. I gather from  
21 how you addressed the chairman that you are aware of the  
22 concern that Dr Nesbitt has expressed.  
23 A. Yes, I am.  
24 Q. If you are, you will know that he has expressed it in  
25 two ways. It happened very shortly after Raychel's

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1 considerably later than that, 14 March 2006, he's then  
2 able, at 095-010-033, to identify the person that he  
3 spoke to in the Royal who gave him that information, and  
4 he spoke to Dr Chisakuta. What he says he was told was  
5 that the use of Solution No. 18 in post-operative  
6 children, they had changed that. They had been using  
7 the same regime as Altnagelvin, but they changed it  
8 six months previously because of concerns about the  
9 possibility of low-sodium fluids.  
10 So whatever it is, it's centred around the potential  
11 risks presented by the use of low-sodium fluids for  
12 post-operative children. Were you aware of that  
13 happening, which would have been either the beginning of  
14 2001 or the end of 2000?  
15 A. That there was -- just let me get that right, that there  
16 was a change in the fluids we used post-operatively in  
17 children?  
18 Q. There was a change in the use of Solution No. 18.  
19 A. No, but I've seen that graph of --  
20 Q. We'll come to that in a minute. Were you aware of that?  
21 A. I can't say I was aware of -- I can't remember.  
22 Q. If you take the first reason he gave. The first reason  
23 he gave is because there had been several deaths  
24 involving Solution No. 18. Were you aware of that  
25 in the Children's Hospital?

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1 A. Deaths where?  
2 Q. In the Children's Hospital?  
3 A. That's rubbish, that's not correct.  
4 Q. So whoever told him that is incorrect?  
5 A. There may have been deaths worldwide, but that  
6 doesn't ... That's a surprise to me if that was the  
7 case. I knew nothing about that.  
8 Q. Okay. Then let's go to the graph. The graph is at  
9 319-087c-003. I think, when you were answering earlier  
10 about the use of Solution No. 18, I think you said that  
11 really didn't happen, that kind of major change,  
12 until March 2007 or thereabouts. You said partly the  
13 reason for that was a resistance on the part of the  
14 paediatricians --  
15 A. I'm not sure, if I said that, that's quite what I meant.  
16 Q. Ah.  
17 A. Maybe you'd need to go back and see what the question  
18 was. It was about using hypotonic solutions for  
19 replacement fluid.  
20 Q. Yes.  
21 A. I mean, to me, nowadays the way I thought about this is  
22 half-normal saline is every bit as bad as fifth-normal  
23 saline.  
24 Q. Okay, sorry. If I re-frame the question so we're quite  
25 clear about what I'm interested in, which is the

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1 the way the anaesthetists in Raychel's case did when  
2 they were managing her for an appendicectomy. It wasn't  
3 the sort of solution that was being used as much during  
4 the procedure any more.  
5 Q. Leaving aside as much during the procedure because  
6 sometimes, as we heard in relation to Raychel's case,  
7 anaesthetists can also prescribe for the immediate  
8 post-operative period. Had your use of it in that phase  
9 changed over time?  
10 A. I just can't remember. I mean, I -- the only way,  
11 really, to find this out is to pull charts and find out  
12 what people were actually doing at the time. I just  
13 really don't remember what I was doing at that time.  
14 THE CHAIRMAN: Doctor, if this graph is right, and  
15 I think --  
16 A. It is right, I'm sure.  
17 THE CHAIRMAN: But if the graph -- if it is confirmed by the  
18 Trust that the trends shown on this graph continued,  
19 then the National Patient Safety Alert which followed  
20 would have had little or no effect on the Royal, would  
21 it, because Solution No. 18 had already virtually  
22 disappeared from use?  
23 A. I suppose so, but I don't remember this happening in  
24 many ways. It is a bit of a surprise to me, I have to  
25 say.

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1 incidence and use of Solution No. 18. Were you aware of  
2 there coming a time when that became less used, if I can  
3 put it that way?  
4 A. I don't remember this acute drop-off.  
5 Q. You don't?  
6 A. No. I know that -- I mean, I remember the NPSA thing  
7 that came out in 2007, we had to take it away altogether  
8 apart from certain wards, and that was a diktat from on  
9 high. But this is a surprise. It is a surprise.  
10 I wasn't -- sometimes when you look back at things,  
11 you're surprised by what you see, but I'm surprised.  
12 That's what I'm saying, really.  
13 Q. Aside from when the alert came out, are you aware of its  
14 use being reduced at all before then?  
15 A. Not from memory. I don't ...  
16 Q. Had your practice changed in relation to the use of  
17 Solution No. 18?  
18 A. My practice had changed quite a bit in the use of fluids  
19 generally.  
20 Q. Yes, but if we can just stick with Solution No. 18. Had  
21 you yourself over the years used it less?  
22 A. Yes, I think intraoperatively, certainly with Paul's  
23 views and Tony coming back from Great Ormond Street,  
24 I think that we would tend to -- there was a tendency to  
25 move away from it intraoperatively, for example, just

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1 THE CHAIRMAN: Thank you.  
2 A. I just don't remember anything like that occurring.  
3 MS ANYADIKE-DANES: Then if we can move on now to Lucy's  
4 case more directly. Lucy is admitted under your name;  
5 is that correct? 061-013-037. She's admitted on  
6 Thursday the 13th under your name.  
7 A. That's correct, yes.  
8 Q. Is there a reason why she was admitted under your name  
9 as opposed to under Dr McKaigue's name?  
10 A. Yes.  
11 Q. Which is?  
12 A. The reason is, basically, from a number of years before  
13 that -- and I think other people have maybe mentioned  
14 this to you as well -- to designate a direct ICU  
15 admission from another hospital or directly from A&E, my  
16 name was put on the forms to show that the patient came  
17 in directly from those wards. That's actually something  
18 that happened in the adult intensive care unit.  
19 Q. How long did that practice continue?  
20 A. I stopped working in intensive care in March 2005 and it  
21 did continue after that time as well.  
22 Q. Because when I asked Dr Chisakuta about that -- who was,  
23 I think, lead at the time Lucy was admitted -- he was of  
24 the view that really she ought to have been admitted  
25 under Dr McKaigue as a consultant.

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1 A. That name on the yellow flimsy was nothing more, really,  
2 at the time than just a signpost as to where the child  
3 was going. I think one of the issues as well at the  
4 time was that often we would have to accept patients to  
5 the intensive care unit before they touched base with  
6 maybe a surgeon or a paediatrician. Because the child  
7 was so critically ill, they wanted advice from the  
8 intensive care staff about resuscitation and ongoing  
9 care until the child arrived with us and then it was  
10 maybe easier to try and sort out something after that  
11 time.  
12 Q. That was one of the things I wanted to ask you about.  
13 Because it's not entirely clear whether these concepts  
14 are different. A person -- and it will always be  
15 a consultant -- who has overall responsibility for  
16 a child's care, somebody who is providing specialist  
17 input, maybe significant specialist input into the  
18 management of a child's care, and then a situation where  
19 maybe more than one consultant are jointly managing the  
20 child's care. They all potentially seem to be different  
21 concepts.  
22 A. They are different concepts, yes.  
23 Q. Can you help with what they mean?  
24 A. Okay. You could have a child coming into the hospital  
25 with bronchiolitis -- it's a respiratory illness --

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1 place.  
2 Q. But is it going to be recorded anywhere? Because I can  
3 imagine that there could be circumstances where  
4 literally at the time the clinicians who are all working  
5 on that child recognise who's got the lead position, if  
6 I can put it that way. But that may not be the case if  
7 subsequently one looks back at the files and one wants  
8 to know who is the consultant that we go to who bore  
9 ultimate responsibility for the management and planning  
10 of that child's care.  
11 A. No, you're right, it should be completely unambiguous,  
12 but I don't think that maybe happened the way it should  
13 have done years ago. Again, if we look at what's  
14 happening now, I think things are much, much better and  
15 the lines of command, if you like, are much more  
16 structured there. Certainly people would be writing in  
17 the notes a lot more. Communication would be much, much  
18 better than it was in the past, I feel. I do think that  
19 that has been tightened up and I know the directorate  
20 has really been looking at this quite hard in recent  
21 times.  
22 Q. One of the reasons I wanted to ask you that is we had  
23 obviously asked Dr Hanrahan his view on who had overall  
24 responsibility. The answer that we got -- and I will  
25 give you the reference for it, it is his witness

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1 comes under the named consultant and is discharged and  
2 it's simple for that consultant to manage that child.  
3 You could have a child that comes in with  
4 a respiratory illness and, on examination, you hear  
5 a heart murmur, so you would get a consult to the  
6 cardiologist, the cardiology service, to have some input  
7 into the management of that child.  
8 You could have a child who comes in with  
9 a respiratory illness, but has complex needs -- he's  
10 being seen by the orthopaedic surgeons, the  
11 developmental team, the gastroenterology team, many  
12 different teams in the hospital could be involved, but  
13 he has come in with a respiratory illness as well. So  
14 there are three different scenarios there.  
15 Q. Yes, but at any given time how do you know who has  
16 overall responsibility for a child's care?  
17 A. The complex kids are pretty easy because there would be  
18 normally be a paediatrician looking after them that way.  
19 You would have specialist ones as well. For example if  
20 it was a neurology case or a cardiac case, they're  
21 pretty well-defined in who's looking after them as well.  
22 I suppose things can get a bit blurred if a child's  
23 status changes in the hospital, just like with Claire,  
24 things get a bit blurred and people are maybe doing  
25 different things and those discussions maybe don't take

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1 statement, 289/2, page 2. He says in terms:  
2 "I am unsure who was in charge of Lucy's care when  
3 she was a patient in PICU. I do not recall formally  
4 assuming responsibility."  
5 Which suggests that there is some process that he  
6 believes he would have to go to for him to be in that  
7 position, much -- and you mentioned Claire -- as in the  
8 same way Dr Steen acknowledged that unless she had  
9 formally transferred care to Dr Webb then the consultant  
10 responsibility for Claire's care resided with her.  
11 So do you recognise Dr Hanrahan's position that he  
12 didn't have responsibility in the way that I've just  
13 been describing it unless he had formally assumed it in  
14 some way?  
15 A. Well, there was no transfer of care to him from anyone,  
16 really. I mean, he may have felt possibly that there  
17 was no formal process at the time, and maybe there  
18 wasn't, but by his actions I think that everyone thought  
19 he was the consultant in charge of this case.  
20 Q. So you mean he had involved himself sufficiently for him  
21 to assume that responsibility?  
22 A. Well, that's what I thought at the time, yes.  
23 Q. You see, he regards himself as having been brought in by  
24 you to provide specialist input. In fact, you had  
25 recorded it in the notes that you wanted him to have --

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1 I don't know that you'd necessarily identified him, but  
2 you felt that it was necessary for a neurologist to look  
3 at her. It's in your typed-up note at 061-018-065.  
4 It's right at the end when you say that you're waiting  
5 for the faxes of her notes. Then you say:

6 "She is to be reviewed by a paediatric neurologist  
7 this morning."

8 And it's also something that's picked up in the  
9 nursing notes as well, that that is to happen. In fact,  
10 it's their record of your conversation with the parents.  
11 We can see that at 061-031-096:

12 "Dr Crean explained that at present he was unsure as  
13 to what had happened to Lucy. Lucy, however, is showing  
14 signs that something has happened within her brain and  
15 that is a very worrying thing. Further tests will be  
16 done today and also the neurologist will come to review  
17 Lucy."

18 Dr Hanrahan's position seems to be he was being  
19 called in to provide a specialist opinion, if I can put  
20 it that way, in much the same way, actually, as Dr Webb  
21 had been asked to do that, to provide that by the  
22 registrar for Claire. And he did do that, and he  
23 involved himself on a number of occasions, seeing  
24 Claire, but nonetheless it was not believed that in  
25 doing so the care of Claire or the responsibility for

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1 that's what they would then do. So they are  
2 automatically informed, "Listen, we have a patient that  
3 came in at 3 o'clock this morning, you're the consultant  
4 on call, we're notifying you that you're now that  
5 child's consultant", and they will come round and review  
6 the child. If they feel they need to bring in anyone  
7 else, they can do so.

8 THE CHAIRMAN: In a way, that's not far removed from what  
9 happened with Lucy. She was admitted under your name  
10 for the reasons you've explained: you were in PICU from  
11 about 9 o'clock that Thursday morning and Dr Hanrahan  
12 was then asked to become involved. So is there now  
13 a formal system for deciding or for the equivalent of  
14 you and Dr Hanrahan to agree, "Yes, she is now my  
15 patient", or, "She's still your patient"?

16 A. That's the point I'm trying to make, because the patient  
17 automatically becomes the patient of the consultant on  
18 call, unless they decide otherwise that the patient  
19 should be referred to another consultant. So they would  
20 then make the decision, "Look, I'm not the most  
21 appropriate here". And they would formally transfer the  
22 care to someone else and it would be a formal process.

23 THE CHAIRMAN: So the equivalent of "Dr Hanrahan formally  
24 accepts the transfer of care"?

25 A. That's correct, yes.

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1 her care had transferred to him; he was always just  
2 providing specialist input. That is why I'm asking you:  
3 could that be what happened here?

4 A. Certainly it was my perception and the perception of  
5 others that by his actions, as I've already said, that  
6 he was taking a lead role in her management and care.

7 Q. Did you want him to do that?

8 A. Yes, I mean, he would have been the most appropriate  
9 person to do that.

10 Q. So if you'd wanted him to do that, why didn't you  
11 formally put that in the notes, as opposed to just  
12 asking for an opinion or a review?

13 A. You're right, it should have been made clear at the  
14 time. I can't say it shouldn't be. I would acknowledge  
15 what you're saying.

16 Q. Thank you.

17 THE CHAIRMAN: Could I just ask you, if you can tell me  
18 quickly, when you say that system has been tightened up  
19 so the notes will always now show who is responsible and  
20 there would be no doubt within a hospital about who's  
21 responsible?

22 A. I can speak for the intensive care unit, for example, so  
23 whatever paediatrician is on for that 24-hour period,  
24 they're automatically contacted for all admissions to  
25 PICU. If they wish to call in another specialist,

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1 THE CHAIRMAN: And what is missing here is a formal  
2 transfer?

3 A. I would agree with you, yes.

4 THE CHAIRMAN: Okay. But it's now done on a formal basis?

5 A. Yes, Mr Chairman.

6 MS ANYADIKE-DANES: I'm going to ask you a little bit about  
7 what you considered your role still to be.

8 In your witness statement for the inquiry at 292/2,  
9 page 3, you say that Lucy was jointly managed by the  
10 consultant anaesthetists in PICU and Dr Hanrahan. And  
11 in fact, I think Dr Chisakuta also was of the view that  
12 there was joint management between the intensivists or  
13 anaesthetists and the paediatric neurologist in this  
14 case. His view was invariably in PICU there were two  
15 consultants: there would be the anaesthetist or  
16 intensivist, and then there would be another, maybe  
17 a surgeon, whatever was considered to be the other  
18 appropriate discipline. So what I wanted to ask you is:  
19 in view of the fact that you have acknowledged to the  
20 inquiry that Lucy was actually being jointly managed,  
21 she wasn't solely the responsibility of Dr Hanrahan, you  
22 were the consultant anaesthetist on duty for that first  
23 day of her admission, on Thursday; what did you consider  
24 your role to be in the management of her care?

25 A. I think Dr MacPaul, in his report that he gave to the

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1 inquiry, properly states it much better than I could  
2 in that generally, at that time, in 2000, the  
3 anaesthetists were there, looking after the ABCs -- the  
4 airway, breathing, circulation -- they were there for  
5 the day-to-day management, I'm not a paediatrician,  
6 I don't have an in-depth knowledge of general  
7 paediatrics and certainly not specialist paediatrics.  
8 They would be there to kind of investigate and that  
9 would be their role and the follow-up and things like  
10 that. So we were there really to try and look after the  
11 ABCs, improve the clinical situation of the child.  
12 We would do kind of routine investigations, but the  
13 paediatricians would be doing a lot more in-depth  
14 detailed investigations. I can order chest X-rays and  
15 U&Es, but when it comes to kids with complex metabolic  
16 problems I have no idea, I'm just totally out of my  
17 depth.  
18 Q. But if there was a fluid issue, is that within your  
19 competence?  
20 A. I agree, and that is why I'd be doing U&Es, urine and  
21 electrolytes, things like that. But if you're looking  
22 at the complex paediatric patients that we have and  
23 things like that, that's when they come into their own.  
24 I think it's working together and understanding what  
25 each other's strengths are.

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1 to pull this up, 292/1, page 3 -- you say that you think  
2 it's likely that you spent some time during the initial  
3 part of the day stabilising Lucy. I think it was  
4 Dr McKaigue said he believed that she had become rather  
5 unstable during the course of her transfer from the  
6 Erne Hospital to the Children's Hospital and he had  
7 wanted Dr Chisakuta to insert a central line to help,  
8 and you therefore were trying to further stabilise her;  
9 is that correct?  
10 A. Yes, I was here on Thursday and on Friday morning, so  
11 I heard that being said. For people who don't work in  
12 this environment, it can be hard to take on board what  
13 happens some days. It's like a battle zone, that you're  
14 walking into these things, and you're just trying to  
15 resuscitate and stabilise patients and get things on an  
16 even keel before you can even draw breath. I can't  
17 remember the details of all this, but I'm sure I walked  
18 in, had to do all this stuff, and there's a real  
19 pressure for you to try and feed back to the parents as  
20 well. Because if you have a child who's been  
21 transferred from another hospital and they've collapsed,  
22 the parents are going mad with worry about what's  
23 happened there and you're trying to get an idea of  
24 what's happened and then get back to them and have some  
25 words with them to let them know what's going on. So

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1 Q. Sticking with Lucy, and because you have mentioned  
2 Dr MacFaul, we have two references for what he says, the  
3 first is 250-003-019, and he says that:  
4 "In life, doctors Hanrahan, Crean and Chisakuta were  
5 jointly responsible for Lucy's care."  
6 He thought that you and Dr Chisakuta were  
7 responsible for her stabilisation and withdrawal of  
8 therapy after brainstem tests, and he considered,  
9 though, that the responsibility for her diagnostic care  
10 and the continuity of care rested with Dr Hanrahan, and  
11 he also thought that Dr Hanrahan was responsible for the  
12 post-death management.  
13 A. Yes, that was the bit. I thought he put that very well.  
14 That's the section I was sort of alluding to.  
15 THE CHAIRMAN: But is your summary of that point that you  
16 accept that summary, but it does leave a degree of  
17 ambiguity, but in some circumstances a degree of  
18 ambiguity is unavoidable?  
19 A. I think it is. Unfortunately, yes.  
20 THE CHAIRMAN: Thank you.  
21 MS ANYADIKE-DANES: If we come now to actually what happened  
22 as Lucy was admitted. I want to deal with the period of  
23 when she arrives and your ward round and certain aspects  
24 of your discussion with her parents, although not overly  
25 so. In your witness statement -- again, we don't need

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1 there's a lot of things happening, a lot of pressure,  
2 and you also have other kids in the ward that you have  
3 to get round and see. You're kind of, "This is what  
4 I have to do first", so you're kind of triaging all the  
5 different things that need to be done.  
6 Q. I understand. Dr McKaigue says he had to go off and  
7 attend to just the sort of thing you have mentioned, an  
8 emergency with another child.  
9 A. Yes.  
10 Q. He said he communicated the relevant information to you  
11 and to Dr Chisakuta. I'm going to ask you about that,  
12 but in particular what I want to ask you is. Were you  
13 aware of Dr O'Donohoe being there at the time you come  
14 on? You come on just before 9 o'clock --  
15 THE CHAIRMAN: Let's say "Dr Jarlath" and "Dr Dara" because  
16 we're going to get hopelessly mixed up between  
17 O'Donoghue and O'Donohoe. Okay?  
18 MS ANYADIKE-DANES: Okay.  
19 Dr Jarlath in the Erne. Were you aware of him still  
20 being there in the Children's Hospital when you came on  
21 duty?  
22 A. I'm really struggling to try and remember all these  
23 events. I'd have to say I just can't remember.  
24 I really can't remember.  
25 Q. If he was there, would you have wanted to speak to him?

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1 A. I'm sure I would have wanted to speak to him just to  
2 find out exactly what was going on. I could have got  
3 some information from him and the local team in the  
4 intensive care unit as to what they had done so far  
5 because I think Lucy had been in for a few minutes  
6 before I came in at that time.  
7 MS ANYADIKE-DANES: Mr Chairman, I'm looking at the time.  
8 I'm about to go on to a lengthy section.  
9 THE CHAIRMAN: We'll take a short break.  
10 (11.40 am)  
11 (A short break)  
12 (12.00 pm)  
13 MS ANYADIKE-DANES: Just before we had that short break, you  
14 said that if Dr Jarlath had been available to you, you  
15 would have wanted to talk to him. What exactly would  
16 you have been wanting to find out or what information  
17 would you want from him?  
18 A. I guess it would just been a fairly brief handover just  
19 to get the salient details of what had happened, just to  
20 get the specifics, what had she come in with, what  
21 basically was going on, what did he think was going on  
22 with the events leading up to her acute collapse. It  
23 would have just been fairly brief, I'm sure.  
24 Q. Do you think at that stage you would have read the  
25 transfer letter and be asking him on foot of that, "What

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1 they did repeat U&Es. You don't see that until you see  
2 an entry made by Dr McLoughlin at about 9 o'clock. But  
3 what Dr Jarlath is saying is that when he came, and  
4 he was having a verbal handover -- and Dr Chisakuta and  
5 Dr Stewart all acknowledge that they did discuss with  
6 him that he relayed the repeat electrolytes, the 127,  
7 during the course of that. Do you remember anything  
8 like that, having that information?  
9 A. I don't remember, but it looks as though it was in the  
10 notes pretty soon after that anyway, I think. It wasn't  
11 going to make any difference to her management between  
12 8.30 and 9 o'clock, I think.  
13 Q. No, but it might explain why she got to where she was,  
14 which at some point in time is a conversation to be had  
15 with the parents.  
16 A. You mean the sodium of 127?  
17 Q. Yes.  
18 A. Do you want to get into that?  
19 Q. I'm going to get into that, but when you say it wouldn't  
20 have made any difference, it had its significance in  
21 terms of explaining how she got into the condition that  
22 she did. So it might have had some significance for  
23 that.  
24 A. Um ... The significance to me, I think at the time,  
25 would have been that her sodium was low, a bit low.

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1 else can you tell me?"  
2 A. I don't even think I would have -- I might have done.  
3 It depends what I had to do immediately when I came in.  
4 I mean, I have noted on my note there -- I was just  
5 looking at it and you brought it up just before the  
6 break -- that she was on an adrenaline infusion, so her  
7 circulation was poor, she needed that to maintain her  
8 blood pressure, she had a metabolic acidosis, and that  
9 was all about tissue perfusion. She wasn't -- things  
10 weren't going very well at that time and I think she  
11 probably needed quite a bit of work just to get  
12 stability. So it depended -- I know that I was taking  
13 over from Dr Chisakuta. He probably was in the  
14 operating theatre that day. It would depend on so many  
15 things. I would have liked to get a brief handover if  
16 Dr Jarlath had been there and hopefully I would have had  
17 a glimpse of the notes as well, but --  
18 Q. Dr Jarlath has said in his inquiry witness statement --  
19 the reference is 278/2, page 5 -- that he believes he  
20 relayed the repeat electrolyte results in a verbal  
21 handover on arrival. The issue, as you probably know,  
22 is in the transfer letter there is a reference to her  
23 serum sodium results when she was admitted, or at  
24 least the first testing after her admission, and there's  
25 nothing else in the transfer letter about the fact that

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1 A bit low. I mean, I think other people have said this  
2 as well, that those sort of sodium levels are commonly  
3 seen in children all the time.  
4 Q. I'm going to come to that.  
5 A. I just wasn't sure how you wanted me to comment.  
6 Q. All right. I picked that up simply because you said  
7 that it wouldn't have made any difference to your  
8 ongoing management, which is true, but it doesn't mean  
9 that it's an irrelevance, if I can put it that way.  
10 If we pull up your ward round notes, 061-018-065.  
11 You haven't timed it, but in your evidence you think  
12 that it would be about 9 o'clock.  
13 A. No, I'm not --  
14 Q. Sorry, let me give you the reference to where you say  
15 that, 292/1, page 3. It would have been usual to start  
16 the ward round at about 9 o'clock?  
17 A. Yes. Because I couldn't remember I was stating what  
18 usually happened. But I think -- for me to have walked  
19 in there and started the ward round at 9 o'clock with  
20 all that was going on at that time, I don't think that  
21 I would have done that. I think I would have probably,  
22 that morning, had to stabilise her. The bit I've said  
23 here:  
24 "In the early hours of this morning, mother noticed  
25 her breathing became erratic and she developed

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1 a seizure."  
2 I mean I think I got that information from the  
3 mother before I started the ward round. That's really  
4 what I'm trying to come to. I noticed that in the  
5 nursing notes we have, as you know, got a communication  
6 section about whenever people talk to the parents and  
7 I think that was timed around 10 o'clock by the nursing  
8 staff. So I think after stabilising her, what I would  
9 have wanted to have done is go and have a word with mum  
10 and dad to let them know what was happening and started  
11 the ward round after that time.  
12 Q. Is it possible that you actually discussed with the  
13 parents and that note of approximately 10 am -- you're  
14 right that's what it says; the reference for it is  
15 061-031-096 -- is something that actually happened after  
16 your ward round; is that possible?  
17 A. What happened after the ward round?  
18 Q. That explaining to the parents about Lucy's condition to  
19 the extent that you were able to do so is something that  
20 actually happened after the ward round; is that  
21 possible?  
22 A. I doubt it because I think that information that I've  
23 got there -- I think I got some of that information from  
24 mum and dad. I've said here:  
25 "The parents say it took three-and-a-half hours to

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1 Q. Is there a reason why you didn't put it like that in  
2 your witness statement?  
3 A. I just hadn't seen it that way until I was just reading  
4 it through there. It became aware to me just as we were  
5 speaking now that that's maybe what happened.  
6 THE CHAIRMAN: Doctor, as you're giving your evidence this  
7 afternoon and this morning about this, would you please  
8 indicate to me if there's any specific point which you  
9 do remember?  
10 A. Yes.  
11 THE CHAIRMAN: Because I gather from what you're saying  
12 that, for some understandable reasons, you're trying to  
13 reconstruct what happened on that Thursday and perhaps  
14 the Friday. So if there's some point at which you  
15 specifically remember something, please tell me, and  
16 I will take it that otherwise your evidence is your best  
17 attempt to reconstruct; okay?  
18 A. Yes. Thank you, Mr Chairman.  
19 MS ANYADIKE-DANES: Thank you. So then if you're seeing  
20 Lucy a little bit later on than the customary start of  
21 the ward round, seeing her in the context of a ward  
22 round, if I can put it that way, that means that you  
23 look at her notes, do you, as part of the ward round?  
24 A. Yes, whatever notes are available to you at the time,  
25 yes.

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1 establish an IV line and during that time she was fairly  
2 unresponsive."  
3 I would only got have that information from the  
4 parents.  
5 Q. So the way that would work, you would have spoken to  
6 them first, from what you're now thinking, and then you  
7 would have conducted your ward round?  
8 A. I think so, because as I've said before, the parents --  
9 there has been a catastrophe, as far as they're  
10 concerned and the last thing I would want to do is leave  
11 them waiting. I would want to get out to speak to them  
12 as soon as I can just to let them know what's happening,  
13 what we're doing, what we're thinking at that time.  
14 Q. But if you speak to them first, before you have done a  
15 ward round and examined her or done anything in  
16 particular --  
17 A. I would have assessed her initially as part of my  
18 stabilisation and then I would have wanted to have had  
19 a few words with them before doing the ward round  
20 because, remember, the ward round isn't just about her,  
21 there would be other children as well, so I would want  
22 to, after I have assessed her, have nipped out and speak  
23 to the parents. That's what we often did. Then you  
24 would have the formal ward round being conducted after  
25 that time.

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1 Q. In that case what would have been available to you would  
2 be the quite long note, timed at 8.30, that  
3 Dr McLoughlin makes. We don't need to pull it up, it  
4 starts at 061-018-058. That's informed by the transfer  
5 letter, by the discussion with Dr Jarlath and by  
6 a discussion with the parents. So you'd have had that.  
7 You'd have had the entry that she makes at 9 o'clock,  
8 which is following the contact by, we now know,  
9 Dr Auterson, the anaesthetist from the Erne, who rings  
10 in the repeat U&Es, so you know that her serum sodium  
11 level fell while she was at the Erne from 137 to 127.  
12 And you would have had the information on the transfer  
13 letter and also on the transfer sheet; is that correct?  
14 A. That's correct, yes.  
15 Q. Can I ask you, just for the location point of view, who  
16 accompanies you on that ward round?  
17 A. There will be usually the senior nurse, you may have two  
18 nurses doing the ward round with you. There will be the  
19 patient nurse at each bedside as you go round, and  
20 usually all the medical staff would be there as well,  
21 unless one of them has to be called away to another  
22 patient that needs something fairly acute to happen at  
23 that time. But it would normally be the medical team,  
24 the senior nursing team would do the ward round.  
25 Q. And is that a multidisciplinary team, if I can put it

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1 that way?  
2 A. It can be, yes. You could maybe have the  
3 physiotherapist there as well. I'm not sure if we had  
4 pharmacy doing the ward round at that time. But it  
5 would be multidisciplinary, there would be a few people  
6 there.  
7 Q. So Dr Dara could be there?  
8 A. I would assume he could be there.  
9 Q. Dr McLoughlin, could she be there?  
10 A. I think she was on the night before so she may well have  
11 left. They may well have done a handover, you see, and  
12 then she would have gone --  
13 Q. And Dr Stewart, could she have been there?  
14 A. She was the neurology fellow?  
15 Q. The neurological registrar.  
16 A. No, she wouldn't have been there.  
17 Q. She wouldn't be there?  
18 A. I wouldn't have thought so, no.  
19 Q. Then if we look at what you actually recorded as  
20 a result of that, you've got that, "She was pyrexia, she  
21 was vomiting". Then:  
22 "IV access was difficult and the parents say it  
23 took 3.5 hours to establish an IV line."  
24 Would you have thought that to be significant?  
25 A. It can be difficult to get an IV in a child.

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1 Hospital in Canada and it's pretty well-known, those  
2 sorts of facts.  
3 Q. If you were looking at the information that was  
4 available to you, not necessarily saying that you would  
5 have done it all at the ward round, but in due course  
6 you would have wanted to take stock, if I can put it  
7 that way, of the information that you've received and  
8 its potential significance. If you were looking at it,  
9 you would have seen that she had a slow capillary  
10 refill. I'm talking about before you actually got the  
11 notes now. On the transfer letter it refers to it being  
12 greater than 2 seconds. Might that have indicated to  
13 you perhaps some level of dehydration?  
14 A. It would have done. Certainly from the history, she had  
15 been unwell for two or three days. I think mum was  
16 giving her boiled water and she wasn't keeping that  
17 down. I'm sure her intake had been severely diminished  
18 over the last 24/48 hours. I mean, she was well behind  
19 in fluids at that time.  
20 Q. Yes. Well, in due course it turns out that her tongue  
21 was moist, so maybe she wasn't that dehydrated, but in  
22 any event, dehydration might be something that you would  
23 have noted, the possibility of it, and if you had noted  
24 that, would the fact that they hadn't managed to get an  
25 IV line in for her, in other words to get fluids into

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1 Q. Sorry, I beg your pardon, I meant the period of time  
2 within which she had not been receiving IV fluids.  
3 Would you have thought that could be significant?  
4 A. It's quite long really to leave the child, that's all  
5 I'm really saying, yes. What was significant to me as  
6 well -- I think mum says somewhere that she'd had --  
7 there were 11 attempts to get an IV up. It's painful  
8 sticking a needle through your skin and what's clear  
9 there is that she was pretty unresponsive at that time.  
10 And we've always taught that the unresponsive child, the  
11 quiet child, is a very ill child, and I'm not sure that  
12 people maybe realised how ill she was at that time. But  
13 you have to be very, very careful about the  
14 unresponsive, quiet child. It's certainly taught widely  
15 now about recognition of the ill child. I think I was  
16 pretty concerned about the way she was earlier in the  
17 evening when she was admitted to the Erne Hospital.  
18 Q. Is there any reason to suppose that, in 2000,  
19 a consultant paediatrician wouldn't appreciate that the  
20 unresponsive child is a child that one has to be  
21 particularly alive to in terms of the potential  
22 seriousness of their condition?  
23 A. I think I would have thought most consultant  
24 paediatricians would appreciate that. It was something  
25 that was taught to me when I was in the Children's

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1 her for a period of about 3.5 hours, have been something  
2 that you would have also been noting?  
3 A. Well, I did note it, that they took 3.5 hours to  
4 establish the IV.  
5 Q. The significance of it, I mean.  
6 A. It shows that there was a delay there in getting the IV.  
7 Obviously they wanted to get an IV up and there was  
8 a delay in getting it up because it took  
9 three-and-a-half hours.  
10 Q. If you were looking at her transfer letter, you would  
11 see that she starts off with a serum sodium level of 137  
12 when she's admitted and, in combination with the note  
13 that Dr McLoughlin adds, you would see that that at some  
14 point -- I don't think you'd have known when at that  
15 stage -- but at some point that has dropped to 127. You  
16 would know that she had some unspecified IV fluids  
17 starting at 2300 hours, and that she developed watery  
18 and profuse diarrhoea and that she, at about 3 o'clock,  
19 had what might be considered to be a fit and collapsed  
20 and that her pupils were noted to be fixed and dilated,  
21 and that she receives mannitol, which produces a brisk  
22 diuresis. You would also have known just from the  
23 transfer form at the top of it, it says -- the only  
24 reference to fluids at that stage would have been 500 ml  
25 of normal saline at 30 ml an hour. And you would have

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1 known when she came to the Royal, the Children's  
2 Hospital, that her pupils were still fixed and dilated  
3 and that she was unresponsive to pain.  
4 A. That's right, yes.  
5 Q. If you put all that together, how do you at that stage,  
6 even ahead of getting her notes, interpret the  
7 significance of any of that in terms of her condition?  
8 A. I think that my feeling at the time with the  
9 unresponsiveness and everything else -- because I felt  
10 that there was some acute neurology going on with this  
11 child from the time she came in and, whatever had  
12 happened, she had further deteriorated.  
13 Q. Yes.  
14 A. And something progressive was going on there. I mean,  
15 at that time we didn't have a CT scan, she could have  
16 had encephalitis, she could have had a brain tumour,  
17 I just had no idea what was going on at this stage.  
18 Q. You may see many transfer letters from children being  
19 transferred from other hospitals to PICU. Would  
20 you have wanted more information or different  
21 information in that transfer letter?  
22 A. The more information that you can get, the better, but  
23 at the same time something acute happened at about  
24 3 o'clock in the morning.  
25 Q. Mm-hm.

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1 expectations were because in previous statements  
2 you have expressed a degree of frustration that she  
3 didn't come with her notes and that her notes weren't  
4 faxed ahead. In fact you have expressed yourself as  
5 simply not being able to understand why they didn't fax  
6 her notes ahead.  
7 A. Well, certainly with some of the kids that we've had  
8 transferred up from other hospitals, we have had notes  
9 faxed through or they've been photocopied, but I guess  
10 it all depends on local circumstances and what resources  
11 and staffing they have there at the time.  
12 Q. You also said in your witness statement to the inquiry  
13 at 291/1, page 5, that:  
14 "As part of her initial resuscitation [Lucy's  
15 that is] it would have been helpful to have full  
16 knowledge of her fluid regime as well as the rest of her  
17 clinical history."  
18 A. Yes, it would have been.  
19 Q. Yes. But when I was asking about what else you wanted  
20 to know, forgive me if I missed it, but I didn't hear  
21 you say, "Actually, I would have liked to know what her  
22 fluid regime was"?  
23 A. You would have liked to know all the events.  
24 Q. Her fluid regime is something that wouldn't have taken  
25 very long to write down in the transfer letter because,

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1 A. All the staff were doing their best at the time to try  
2 and resuscitate and stabilise the child. Dr Jarlath had  
3 been up most of the night. The people were tired. It's  
4 trying to understand from their perspective what was  
5 going on as well. Often you would like the notes to be  
6 photocopied, but then at night-time you've almost got  
7 a skeleton staff as well. So you're looking to get  
8 someone, can they go off and find a photocopier that's  
9 working, get notes photocopied -- I believe they did the  
10 best they could with the resources at the time.  
11 I believe they were tremendously concerned about what  
12 had happened to Lucy and their focus was on Lucy at that  
13 time.  
14 Q. Would you have expected her notes, or a copy of them, to  
15 accompany her or to be faxed?  
16 A. A copy was faxed. You know, they probably left --  
17 I don't know, it's about an hour and a half to get up  
18 from the Erne --  
19 Q. They left about 6 o'clock.  
20 A. It's maybe not something that was on their radar at the  
21 time. Their focus is basically towards Lucy, getting  
22 her up to Belfast, trying to get her stabilised, trying  
23 to find out what is wrong. I wouldn't condemn them for  
24 not doing that task.  
25 Q. I'm not asking you to do that. I'm asking you what your

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1 as it turns out, prior to her collapse, she hadn't had  
2 very much else other than her IV fluids. So you might  
3 have wanted to get information on what actually had been  
4 done to this child from when she was admitted until she  
5 collapsed to try and get some sort of view as to what  
6 might be responsible for her collapse.  
7 A. You're right, it's pretty usual to get a lot of the  
8 basics in a transfer letter. You would have expected to  
9 have basic things like that about IV fluids, the amount  
10 they've had, any other medications they've had, the  
11 status the child was on admission, and you're right it  
12 wouldn't have taken very much to put those details down  
13 in a letter. That could have easily been done on two  
14 sides of A4.  
15 Q. And just so that you help us, when you see in the  
16 transfer letter that the response to the mannitol is  
17 a brisk diuresis, how did you interpret that? Did that  
18 indicate anything about her hydration status?  
19 A. No, it doesn't, that is just what happens, it's an  
20 osmotic diuretic, it pulls fluid out through the  
21 kidneys. I wouldn't have drawn any significance from  
22 that at that time.  
23 Q. Why is it being administered?  
24 A. I think that when they contacted Dr McKaigue, she had  
25 some acute neurological collapse. With fixed dilated

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1 pupils in a situation like that you think of brainstem  
2 coning and what you would normally do in a situation  
3 like that is give mannitol, half a milligram per kilo of  
4 mannitol, and that would be the normal practice.  
5 Q. Yes, he thought cerebral oedema and that's something  
6 that could have been produced by an inappropriate fluid  
7 regime. In fact, if an inappropriate fluid regime had  
8 produced a hyponatraemia that had in turn produced  
9 cerebral oedema, mannitol is one of those things that  
10 you would, in fact, be administering.  
11 A. Yes, but from looking at the notes and looking at how  
12 things were described to me at the time, I would have  
13 been thinking about some acute neurology at that time.  
14 I know, as an anaesthetist, you're into fluids in a big  
15 way, but that is not the first thing that would have hit  
16 me back then. It really would not have.  
17 Q. Let's go to when you --  
18 A. From a clinical point of view, that is not something  
19 that would have bounced out at me there.  
20 Q. Let's go to when you do receive the notes because you do  
21 receive the notes at some point. There's a slight  
22 uncertainty about the time they were faxed because they  
23 have a different time at the bottom than they do at the  
24 top. If you go with when they're faxed, the top one is  
25 8 something or other and the bottom one is 9.51. But

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1 So it's quite clear they're for you. If you're  
2 awaiting that kind of communication and you clearly want  
3 to have it to help you in your understanding of what's  
4 going on, how do those notes get to you?  
5 A. It could be that I'm waiting for the secretary to bring  
6 them round. The fax machine was in the secretary's  
7 office, in the intensive care unit, and it may be that  
8 I was waiting for those to be brought to me. It may be  
9 that I went round myself to pick them up. It could be  
10 various ways of getting those to me at the time.  
11 Q. We asked that question of Dr Stewart and see if you  
12 agree or disagree with her view of how it happens. It's  
13 in her witness statement of 282/2 at page 5. It says:  
14 "The fax machine was in the clinical area of the  
15 PICU unit and [this is quoting from her statement] there  
16 was usually a ward clerk present in PICU for general  
17 administrative duties during normal working hours. He  
18 or she would have managed the fax machine. A member of  
19 staff would have been told when the fax they were  
20 expecting had arrived."  
21 A. No, that's not correct. The fax machine is in the  
22 secretary's office and that is not in the clinical area.  
23 There's a doctor's office to the right and the  
24 secretary's office is to the left and it has always been  
25 the secretary's office.

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1 leaving that aside, shortly before it's timed that  
2 you're speaking to the parents, the faxed notes come in.  
3 In your note, you're wanting her notes. I think you've  
4 either been told they are going to be faxed, since you  
5 are awaiting them, or you have issued some sort of  
6 instruction that they should be faxed to you. Quite  
7 apart from that being included in your note, it's also  
8 included in Dr McLoughlin's note that that is what is to  
9 happen. She says:  
10 "Erne notes requested for further information."  
11 And then you say when you type up your note:  
12 "I am awaiting a fax of her notes from the  
13 Erne Hospital."  
14 The latest fax, if we use the latest time on the  
15 bottom, that indicates that got to the hospital at just  
16 before 10 o'clock.  
17 A. If the clock is correct, yes.  
18 Q. Yes, if the clock is correct. If the other clock is  
19 right, they got there even earlier, but leaving that  
20 aside, they are addressed to you personally. We see it  
21 on the fax cover sheet, 061-017-042, you at the ICU  
22 in the Children's Hospital. And it's clear that they  
23 are:  
24 "Details of notes for Lucy Crawford on admission as  
25 requested by telephone."

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1 Q. Are you then alerted to it or whoever is the clinician  
2 alerted to the fact that it's come in?  
3 A. Not necessarily. You may have to wait for it to come  
4 through, you may have to go round yourself. The  
5 secretary may bring the fax to you. It depends if the  
6 secretaries are in the office at the time it comes in  
7 and what they consider to be the urgency of the fax.  
8 Q. In any event, you do see those notes at some point.  
9 A. I have seen those notes at some point, yes.  
10 Q. Some point that day?  
11 A. Yes.  
12 Q. But you can't recall whether you saw them before you  
13 spoke to the parents or after you spoke to the parents?  
14 A. I thought they said that I had said to them that  
15 I was waiting for the notes, so it would have been after  
16 that, I think.  
17 Q. I beg your pardon. It would have been afterwards.  
18 A. Yes.  
19 Q. You did say that. When you see them --  
20 A. Can I just say also that what has happened is that I've  
21 obviously, whenever the neurologist came to see Lucy,  
22 he's requested to get a CT scan? We haven't got one  
23 in the Children's Hospital. I don't think we got one  
24 until the following year. So what we would have had to  
25 do is take Lucy across to the neuroradiology department,

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1 and that's in the main Royal, and that means organising  
2 an ambulance, bring her across there, getting the scan  
3 done, organising an ambulance to bring her back. So  
4 I probably was out of the ward for maybe a couple of  
5 hours. It's usually the consultants -- in fact it was  
6 nearly always the consultants -- who had to do those  
7 sort of transfers at that time. I probably wasn't back  
8 until maybe 1/1.30 in the afternoon.

9 Q. The time when you come back and you might be seeing her  
10 notes at that stage you will have already seen the  
11 results of the CT scan or have known --

12 A. You'd have seen the notes of the CT scan at that time.

13 Q. So you'd have known essentially she has coned?

14 A. You'll know that there's gross cerebral oedema and the  
15 coning is basically just a clinical diagnosis.

16 Q. Yes.

17 A. I mean, I think she coned at 3.30 that morning.

18 Q. Yes, but in any event you'd have known that that is what  
19 you're dealing with, if I can put it that way?

20 A. Yes, and we were looking for the cause of why this all  
21 happened.

22 Q. And then you were going to look for what had produced  
23 that.

24 A. That's correct.

25 Q. A number of other people have gone through the notes.

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1 A. Okay.

2 Q. Let me put it this way to you. Does 100 ml of  
3 Solution No. 18 an hour make sense to you?

4 A. If you let me go through the calculations as to what  
5 I would have done at the time.

6 Q. Yes.

7 A. Lucy, I think, was just over 9 kilograms when she came  
8 in and she was dehydrated.

9 Q. What had you assessed as to her level of dehydration?

10 A. I think that she was more than minimally dehydrated, she  
11 wasn't severely dehydrated, so it was somewhere in the  
12 middle.

13 Q. Why did you think she was more than minimally  
14 dehydrated?

15 A. Any child that hasn't been drinking properly for  
16 a couple of days would have been quite far behind in  
17 their fluids and the fact that her capillary refill time  
18 was more than 2 seconds would give you concerns about  
19 her circulation.

20 Q. Wouldn't you have been encouraged to note that her  
21 tongue was recorded as being moist or her mouth was  
22 moist?

23 A. But that isn't necessarily a hugely important factor  
24 when you're assessing dehydration. It is something that  
25 you would take into consideration, but I think she was,

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1 Dr Auterson gave evidence on Friday. I think you said  
2 you were here when you gave his evidence.

3 A. No, I left at lunchtime. I met him before I left.

4 Q. In his view, the problem was obvious: Lucy had received  
5 an inappropriate fluid regime. That was the problem.  
6 And he thought that was almost so obvious, it hardly  
7 needed stating. Dr Chisakuta also thought that the  
8 fluid regime, in common with Dr Stewart, at the Erne was  
9 problematic, and it was that because the 100 ml an hour  
10 of Solution No. 18 just didn't make sense to them, and  
11 they thought there might be a difficulty in relation to  
12 the fluid regime that she had received. In fact, they  
13 thought there was a reasonably common agreement amongst  
14 the clinicians that there was a problem with the fluid  
15 management at the Erne; would you accept that?

16 A. No, I wouldn't accept that at all. I would completely  
17 disagree with that.

18 Q. Ah.

19 A. Certainly at no time did I ever hear from anyone that  
20 they felt that the fluid management caused the cerebral  
21 oedema to occur.

22 Q. I didn't put it in those terms. I said that they  
23 thought that the fluid regime that she had been on at  
24 the Erne was problematic because the rate and type did  
25 not seem to make sense to them.

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1 looking at her, quite dehydrated. Certainly her urea  
2 was elevated as well when she came in.

3 Q. If we just pause there on the dehydration point because  
4 Dr Sumner reaches a view about that. It's 013-036-139.  
5 Have you seen his report before?

6 A. I have seen his report.

7 Q. He's dealing with trying to assess how dehydrated Lucy  
8 may have been at that time. And you see he says:  
9 "It is difficult to judge exactly how dehydrated she  
10 was on admission to hospital. A capillary refill time  
11 in excess of 2 seconds is one sign of approximately  
12 5 per cent dehydration. However, this sign is likely to  
13 be hard to interpret in a febrile child. At this level  
14 of dehydration, mucus membranes are dry, but it was  
15 noted that Lucy's tongue was moist. I think, on  
16 balance, that she was mildly dehydrated, perhaps  
17 somewhat less than 5 per cent and involving a fluid  
18 deficit of approximately 350 ml."

19 Do I take it that you take issue with that?

20 A. Yes, I think Dr Evans in his report as well thought she  
21 was moderately dehydrated. So there wasn't exactness on  
22 this. This is a very, very difficult area. You're  
23 making an assessment, a judgment, and you're basing your  
24 fluid management on that, and the fluid management that  
25 you would come up with is not exact and precise because

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1 you have to take it in conjunction with the response the  
2 child has to the fluids. Often what you're looking for  
3 is for the urine output to improve, for the child to get  
4 better fairly quickly as well. So it's a ballpark  
5 figure that you start with and you're looking for the  
6 response at that time.

7 Q. Does that mean that you make an initial assessment as to  
8 think what you think might be an appropriate rate and  
9 you adjust that depending on what happens with the  
10 child?

11 A. I think so, yes.

12 Q. Does that mean it would be inappropriate to say  
13 something like 100 ml an hour of Solution No. 18 and  
14 just leave it open-ended like that, that would be  
15 inappropriate?

16 A. That might be appropriate if nothing else is changing,  
17 but if for example if the child starts having loads and  
18 loads of loose bowel motions and the losses start to  
19 increase during this period you may have to reconsider  
20 what you are doing.

21 Q. That might be appropriate? Okay. I wonder if you can  
22 help: we pulled together a bit of a schedule from the  
23 information that we have received about the fluid  
24 management in a dehydrated child. If we pull up  
25 325-010-001.

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1 MS ANYADIKE-DANES: Of course. Sorry, Dr Crean.

2 A. When Lucy came in, I think that I would have assessed  
3 her dehydration as being moderate. And moderate  
4 dehydration means that there has been a 10 per cent  
5 reduction in body weight. That's what it means. So if  
6 she was just over 9 kilograms whenever she was  
7 dehydrated, it would mean that her body weight normally  
8 would have been about 10 kilos. So if she has lost 10  
9 per cent of that weight, it would be 10 per cent of  
10 10 kilograms. That's the way I would have done it. And  
11 I would have based her maintenance fluid on her normal  
12 body weight of 10 kilograms.

13 Q. What would that have given you?

14 A. She's 10 kilograms, so her maintenance fluid would have  
15 been 100 ml per kilogram per day, and that would have  
16 been 1 litre. She would have had a 10 per cent deficit,  
17 again that would have been another litre. So in the  
18 first 24 hours, we would normally give the maintenance  
19 and replacement fluid over a 24-hour period and you give  
20 them together. That basically to me would work out at  
21 around 80 ml or so per hour.

22 Q. In total?

23 A. Yes, in total.

24 Q. So far as you're concerned, would that all have been  
25 Solution No. 18?

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1 So there it is. Lucy's weight for the purposes of  
2 this was assumed to be 9.14 kilograms and her  
3 maintenance rate, in terms of the Holliday-Segar  
4 formula, was 914 ml a day, which works out at 38 ml  
5 an hour; would you accept that?

6 A. Sorry? Just run that past me again, please.

7 Q. You can see it at the top, it's in the blue. Her  
8 maintenance rate --

9 A. I wouldn't have done it that way. Lucy was dehydrated;  
10 I would have --

11 Q. At the moment we're just getting her maintenance rate;  
12 forget about the dehydration point.

13 A. Yes, and if I can maybe --

14 MR McALINDEN: This line of questioning started with the  
15 witness being asked about what fluid regime he would  
16 have considered reasonable. He then started to try and  
17 explain the fluid regime that he would have implemented  
18 and then we got sidetracked in terms of whether the  
19 child was moderately or slightly dehydrated and now  
20 we're being sidetracked again. In my submission,  
21 it would be fair to the witness if he was allowed to  
22 give his evidence in relation to the fluid regime that  
23 he would have implemented having regard to the child's  
24 weight and his assessment of the child's level of  
25 dehydration.

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1 A. If I can bring -- can I bring something up on this, on  
2 the computer, to show you what the sort of practices  
3 were back in that time?

4 THE CHAIRMAN: You can bring it up on the computer if  
5 we have it. Do you have a reference?

6 A. I have a reference here, 319-065-002, and it's  
7 a document, it's the Paediatric Medical Guidelines, it's  
8 the second edition, pages 85 and 86.

9 MS ANYADIKE-DANES: Can you tell us what year?

10 A. 1999, so this was the year before Lucy came in. And  
11 basically this is a document produced for the trainees  
12 in the Children's Hospital so that they can look after  
13 various aspects of clinical care in children. The  
14 section I've brought you to is the management of acute  
15 diarrhoea. You can see the assessment there, "mild,  
16 moderate and severe". And if we go on to -- and also,  
17 the shock, if shock is present you're using 20 ml per  
18 kilo of colloid and repeating if necessary. If we go on  
19 the next page, you've got it there.

20 That is as I've described. For the first  
21 10 kilograms it's 100 ml per kilogram and subsequently,  
22 if the child is heavier than that -- for Lucy, she would  
23 have been receiving 100 ml per kilogram per day.  
24 If we then look at the dehydration, as I have said for  
25 10 per cent dehydration, that would have been 100 ml per

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1 kilogram, and that would have been given over a 24-hour  
2 period.

3 Within this guideline, with a normal serum sodium,  
4 you treat shock if present and then use fifth-normal  
5 saline/4 per cent dextrose as the infusion fluid, and  
6 the fluid may be replaced over 24 hours. What I'm  
7 trying to say to you is this was the practice at that  
8 time. With a low serum sodium, you treat shock if  
9 present and you would then use half-normal saline if  
10 their sodiums were low. So that was a commonly-used way  
11 of managing dehydration --

12 Q. Was it your way? Is that what you would have done?

13 A. Let's look at the way paediatricians do it because  
14 I didn't look after children with gastroenteritis. This  
15 is the way children were commonly being managed on the  
16 wards. If I could go back to what Dr McCord said in his  
17 evidence that he gave on 13 March, and it's pages 34 and  
18 35, I think the chairman was asking him about children  
19 with gastroenteritis, about the frequency of doing  
20 electrolyte estimations. And basically, he's talking  
21 about the fluids that he would use, and it says here  
22 quite clearly:

23 "No. 18 seemed to get most of them over their  
24 illness, which was short-term."

25 And he says that it's only rarely that he would have

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1 replaced that?

2 A. That is not the way I would have chosen to manage  
3 a child with dehydration. However, you must realise  
4 that this was the common way of doing it --

5 Q. Yes, I am going to come to that point --

6 A. -- so I did not have any concerns that when I saw that  
7 fluid regimen --

8 THE CHAIRMAN: Let me interrupt. How on earth did  
9 Dr Chisakuta tell me last week that there was an early  
10 shared concern in the Children's Hospital about Lucy's  
11 death and the treatment she had received in the Erne?

12 A. That doesn't ring true to me, Mr Chairman. I am  
13 surprised when I heard this and I heard what you said on  
14 the Thursday morning when I was here and I share your  
15 concerns about that.

16 THE CHAIRMAN: Dr Stewart also said that there was a general  
17 view in PICU that the Erne fluid treatment of Lucy had  
18 been inappropriate.

19 A. Based on what? I have no memory of anything like that  
20 ever having taken place.

21 THE CHAIRMAN: You see, the point is, doctor, that they do.  
22 The two doctors who gave evidence last Wednesday, who  
23 both were involved to some extent in Lucy's treatment,  
24 both specifically remembered that there was a view  
25 within the Royal, from a fairly early stage, that Lucy's

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1 had to use anything stronger than that. What I'm trying  
2 to suggest to you is this was the practice at that time,  
3 this is what was commonly used, not only in the  
4 Children's Hospital but elsewhere. And we would often  
5 see children coming in on this type of fluid regimen.  
6 I'm not saying it's the way I would have done it, but  
7 I'm an anaesthetist, I look after children in the  
8 operating theatre, I look after children in the  
9 intensive care unit, but I'm not involved with these  
10 sorts of children, so we accepted at that time: this is  
11 the way children are managed.

12 Q. Can I put two points to you? First of all, can I just  
13 ask you: is this the fluid regime that you would have  
14 put Lucy on?

15 A. I can't -- that's a very unfair question for you to ask  
16 me because I don't manage children with gastroenteritis.  
17 I have little --

18 Q. Leave the gastroenteritis. Would you have used  
19 Solution No. 18 to replace a 10 per cent deficit?

20 A. I did not treat children with gastroenteritis, and that  
21 was not the normal way of managing them. Look, let me  
22 go --

23 Q. Sorry, Dr Crean, it's a simple question. If you've got  
24 a child who is dehydrated to the level of 10 per cent,  
25 would you, in 2000, have used Solution No. 18 to have

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1 treatment in the Erne had been inappropriate and that  
2 there was a concern about the fluids she had received.

3 As I understand it, you're saying to me, "I really  
4 can't remember very much about that Thursday. It's  
5 a long time ago, I'm looking after other children", and  
6 I accept all that. But what I find very hard to  
7 understand is how they specifically recall that view,  
8 which they say was not personal to them, but was  
9 a common view in the Children's Hospital, and how you  
10 say, "Not only do I not remember it, but it wouldn't  
11 strike me on working my way through the notes".

12 A. This is a common fluid regimen that many of the  
13 paediatricians used at that time. Looking at that,  
14 I don't think I would have considered that inappropriate  
15 for them. It's not what I would have done, and I would  
16 say to you that we often had discussions around fluid  
17 management in the ward about patients like Lucy coming  
18 in, and we would have said to the trainees at the time,  
19 "Listen, fifth-normal saline is probably best to use  
20 only for maintenance", and that is something that I know  
21 Paul Loane would have said at that time.

22 MS ANYADIKE-DANES: Why do you tell them that?

23 A. Because we thought that this was a better way  
24 of managing children.

25 Q. Why do you tell them that? Why is it significant that

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1 you tell them that?  
2 A. Because you're replacing the deficit fluids with a more  
3 appropriate fluid.  
4 Q. Exactly. So even if the paediatricians in certain  
5 hospitals were not doing that, you recognise that there  
6 might be risks in actually replacing the more  
7 sodium-rich gastric losses with a low-sodium fluid. You  
8 recognise that. So irrespective of whether that was  
9 something that was commonly done, if you saw a child  
10 coming to you in a certain state and you knew what the  
11 fluid regime was -- and not saying it from the point of  
12 view of trying to apportion any blame, but trying to  
13 understand what might have produced that -- you, with  
14 your greater appreciation of the effect of these things,  
15 might have thought that the fluid regime was  
16 problematic.  
17 A. I don't think that that is something that concerned me  
18 specifically on that day.  
19 Q. On that day? Let me help you with something else. On  
20 that day, according to Dr O'Donohoe -- and you don't  
21 deny it in particular because you don't have a clear  
22 recollection of that day -- you phone Dr O'Donohoe to  
23 find out -- that's Dr Jarlath -- you phone Dr Jarlath to  
24 find out more about Lucy's fluid regime. One assumes  
25 that you did that, having received her notes, because of

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1 child, giving 100 ml for the first hour and 30 ml  
2 thereafter. That just does not make sense.  
3 Q. Does the 30 ml an hour make sense?  
4 A. None of it makes sense. No, it doesn't. 30 ml an hour  
5 does not make sense.  
6 Q. If the 30 ml had been normal saline, would that have  
7 made sense?  
8 A. It wouldn't have made sense either, no.  
9 Q. But you know that she's on 30 ml of normal saline  
10 because that what it says on her transfer sheet. Right  
11 at the top --  
12 A. No, no, no, what he's said here is that --  
13 Q. I know that; I'm talking about a regime that makes no  
14 sense. You have just said that if she had been on  
15 normal saline at 30 ml an hour, that would have made no  
16 sense to you. But if you look at 061-016-041, right  
17 at the top, that's exactly what you're being told she  
18 was on.  
19 A. That makes sense then.  
20 Q. That does make sense?  
21 A. At that stage, that makes sense to me, because a child  
22 with an acute neurological collapse, we would have  
23 always put them on to normal saline and we would have  
24 run them at about two thirds maintenance fluid, so that  
25 to me makes sense.

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1 what you say to him. We can pull it up, it's  
2 027-010-024. It's the bit down at the bottom, dated  
3 retrospectively, 14 April. It says here:  
4 "Yesterday, Dr Peter Crean rang from PICU Children's  
5 Hospital to enquire what fluid regime Lucy had been on.  
6 I told him a bolus of 100 ml over one hour followed by  
7 Solution No. 18 at 30 ml an hour. He said he thought  
8 that it had been Solution No. 18 at 100 ml an hour. My  
9 recollection was of having said a bolus over one hour  
10 and 30 ml an hour as above."  
11 If that's your conversation with Dr Jarlath on the  
12 Thursday, that means you're having an exchange with the  
13 consultant paediatrician who had actually not wanted her  
14 to be on the regime that it appears that she was on or  
15 is noted to have been on when she came to you, had  
16 recognised that he wanted her to be on a different  
17 regime, and he prescribed one thing, according to this,  
18 and she's getting something else. Faced with that  
19 information, would you not be a little bit concerned as  
20 to what her fluid regime had actually been?  
21 A. That would have concerned me, obviously, and that fluid  
22 regime that he's suggested there makes absolutely no  
23 sense at all.  
24 Q. His fluid regime makes no sense?  
25 A. That makes absolutely no sense at all in a dehydrated

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1 Q. And does what she is recorded as having actually  
2 received make sense to you? What she's recorded as  
3 having actually received is 100 ml an hour of  
4 Solution No. 18 and then an hour's worth of 500 ml of  
5 normal saline. Does that regime make sense?  
6 A. Can I just say something about -- you have said it  
7 already today and it's in the nursing notes as well,  
8 that Lucy had a stiffening episode about 3 am on the  
9 14th, which was the Thursday morning, and the nurses  
10 called the doctor.  
11 Q. Yes.  
12 A. And what happened then was the doctor examined Lucy,  
13 they did a blood sugar, the stiffening episode could  
14 have been a febrile convulsion. I think they were  
15 concerned about her low blood sugar as well. At 3.15,  
16 it says, I think, the blood sugar was 13 or so and what  
17 the doctor ordered was for the infusion to be changed to  
18 normal saline at that time, at 3.15.  
19 Q. It's not entirely clear that that's what happened;  
20 that's part of the problem with the notes. If one looks  
21 at 061-017-048 --  
22 A. Well, I'm looking at 061-017-050.  
23 Q. If we look at this one, this is 3.20. This is the  
24 nursing note. Dr O'Donohoe comes to see the patient who  
25 had developed respiratory arrest. Then you see she's

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1 passed a large, foul-smelling stool:  
2 "Normal saline, 500 ml given over 60 minutes."  
3 If you look at that, it's not entirely clear when  
4 that 60 minutes relates to.  
5 A. Okay. But this is the point I'm trying to come to: if  
6 you look at the note on page 061-017-050, it clearly  
7 states that the blood sugar at 3.15 was 13.4.  
8 Q. Yes.  
9 A. IV fluids were changed to normal saline and run freely  
10 into the IV line. You can see at 3.20 that there was  
11 decreased respiratory effort and that's when she started  
12 to cone. At 3.30, if not sooner, I think you said on  
13 Friday, her pupils were fixed and dilated, and that's  
14 when she coned. She was brain-dead then.  
15 Q. Yes.  
16 A. So no matter how much fluid she had after that, in my  
17 mind, it's completely and utterly immaterial. And I'll  
18 tell you, it probably took a few minutes for them to get  
19 the fluid changed over, and the fluid may not have  
20 started until maybe 3.20 in the morning, and it was at  
21 that time she started to cone.  
22 Q. The problem is -- and we'll hear his evidence in due  
23 course -- when Dr Jarlath comes, by the time he arrives,  
24 because he is summoned after Dr Malik, 500 ml of normal  
25 saline has run in, so there is a problem on the notes as

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1 problem was due to her fluid regime. And Dr Jenkins  
2 also formed a view that her problem was largely due to  
3 her fluid regime. So all those people have formed that  
4 view from simply looking at what the notes record she  
5 was given as for that matter did Dr Chisakuta and  
6 Dr Stewart. So I'm asking you, if all those clinicians  
7 could, why were you not in a position to form a view --  
8 and you can say why you didn't -- but to form a view  
9 that her fluids may be implicated in her condition?  
10 THE CHAIRMAN: What's wrong with the question?  
11 MR McALINDEN: I think that the witness has actually  
12 answered the question. If my learned friend had  
13 listened to what he was saying, he's saying that if the  
14 normal saline started at 3.15 and that the coning  
15 started at 3.20, the administration of normal saline  
16 certainly had no causal effect in relation to this  
17 child's state.  
18 MS ANYADIKE-DANES: No, Mr Chairman, but the administration  
19 of Solution No. 18 might have and that's the point.  
20 THE CHAIRMAN: It's the view of doctors Auterson, Sumner,  
21 Jenkins, Chisakuta and Stewart that it did; isn't that  
22 right? Dr Crean, you're not compelled to accept their  
23 view, but isn't it correct that the doctors I've just  
24 listed attribute Lucy's problems to the fluid regime  
25 which she received in the Erne?

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1 to exactly when the 500 ml goes in in relation to her  
2 collapse.  
3 The point that I'm asking you, before we get too  
4 bogged down into that, is -- I was exploring with you  
5 your view that the fluid regime that she was actually  
6 on, whether you considered that to be appropriate.  
7 A. Well, what I'm trying to tell you is that often we saw  
8 children on similar regimes. It's not the way an  
9 anaesthetist would have written it up, but we didn't  
10 look after these children; they were looked after by  
11 paediatricians and they were common fluid regimens that  
12 we saw and we accepted that.  
13 Q. It's not that point that I'm trying to get at. What I'm  
14 trying to explore with you is, even if you recognised  
15 that that was something that paediatricians may use,  
16 that regime --  
17 A. That's what they did use.  
18 Q. -- at that time, nonetheless you with your greater  
19 expertise in fluid management could see better than they  
20 the implications of such a regime. That was the point  
21 that I was raising with you. And in fact, Dr Auterson  
22 saw the implications of it because he thought, even  
23 before Lucy was transferred to the Children's Hospital,  
24 her problem was down to her fluid regime. Dr Sumner,  
25 when he reviewed her notes, formed the view that her

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1 A. Mr Chairman, we all know now that that's what it was,  
2 but I'm just trying to say to you that at the time  
3 I don't ever recall anyone saying to me or me saying to  
4 anyone else, "Listen, I have major concerns that this  
5 could have been implicated in her death".  
6 THE CHAIRMAN: Just let me understand your evidence. When  
7 you say to me, "We all know now that that's what it  
8 was", what you're saying is that we all know now that  
9 what doctors Auterson, Chisakuta and Stewart thought  
10 at the time was correct?  
11 A. No, sorry, what I was saying is that we all know now  
12 that her deterioration was caused by acute dilutional  
13 hyponatraemia related to her fluid balance. What I'm  
14 trying to say to you is that back in 2000, I don't think  
15 that's what I thought at the time.  
16 THE CHAIRMAN: And I understand your view is that that's not  
17 what you thought in 2000. Dr Sumner comes in later,  
18 Dr Jenkins comes in later. But in 2000, the view which  
19 was later agreed to by doctors Jenkins and Sumner was  
20 formed contemporaneously by doctors Auterson, Chisakuta  
21 and Caroline Stewart?  
22 A. Well, Mr Chairman, I honestly have to say I was  
23 completely unaware of this. I have no recollection of  
24 that discussion having taken place.  
25 THE CHAIRMAN: Whether you were aware of it or not, you have

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1 heard the evidence that they have said that that was  
2 their contemporaneous view.  
3 A. I accept what you've said to me today, yes.  
4 THE CHAIRMAN: It's not what I've said; I'm summarising what  
5 they have said and what you picked up from last  
6 Wednesday's and Friday's hearing.  
7 A. Yes.  
8 MS ANYADIKE-DANES: Just in fairness to Dr Chisakuta, what  
9 he said in his evidence on 29 May was that firstly -- I  
10 think it's at page 72 -- he thought there was  
11 a questionable standard of treatment in the Erne; that's  
12 in relation to Lucy's fluid regime. Then he goes on to  
13 say that he believed that you had a similar concern, and  
14 I think he says that at page 73, and he would have been  
15 surprised if you had not expressed or had that concern  
16 at handover to him, and he says that at page 91. Does  
17 that mean that you disagree with that?  
18 A. I have no recollection of anything like that having been  
19 said. Listen, there was no reason for me to do anything  
20 like this if that's what you're suggesting. The  
21 following year, for example, whenever Raychel came in,  
22 we phoned the coroner up immediately; it was evident  
23 exactly what had happened. There was no reason not to  
24 do that. But to me, it sounds absolutely preposterous  
25 where I would take a line like that and not follow it up

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1 particular sodium, leading to undesirable fluid shifts.  
2 The volume of fluid given would have depended on the  
3 patient's maintenance requirements and the degree of  
4 fluid deficit. A fluid deficit would normally have been  
5 replaced with normal saline."  
6 Whatever fluid deficit she had was not being  
7 replaced by normal saline.  
8 A. Yes, that is my view, that was my view, and it is still  
9 my view. The point I'm trying to make is that that is  
10 not the way the paediatricians practised when they were  
11 giving IV fluids to children with gastroenteritis.  
12 Q. Sorry, Dr Crean, you're answering a question that I'm  
13 not putting to you. I'm not asking you what  
14 paediatricians normally did. The point I am trying to  
15 get at is whether you could see from the regime that she  
16 had been on the potential risks in that for her, which  
17 is not a question about what normal paediatricians do;  
18 it's a question of your own understanding about fluid  
19 management.  
20 A. Well, I would never have considered a problem with the  
21 fluids with a sodium of 127 back in 2000. I would just  
22 not have considered that.  
23 THE CHAIRMAN: As you said to me a few moments ago, that we  
24 all know now that that's what it was, what doctors  
25 Auterson, Sumner, Jenkins and so on said it was, when

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1 if that's my concern. That's not the way I am.  
2 Q. Well, Dr Crean, nobody did very much. That's the whole  
3 point, that's why I'm asking these questions --  
4 A. But --  
5 Q. If you bear with me, I'll just put to you what you put  
6 in your witness statement to the inquiry because we  
7 asked you about this. This is worth pulling up, 292/1  
8 at page 6. The question is:  
9 "Did you have a view as to the appropriateness of  
10 that fluid regime?"  
11 That is the fluid regime that we've just been  
12 talking about that is recorded, for Lucy, as having been  
13 received:  
14 "Please give reasons for your answer."  
15 Then you say that you can't remember:  
16 "However, I anticipate that on looking at the Erne  
17 fluid balance chart now, I would have had specific  
18 concerns regarding the administration of boluses of  
19 hypotonic fluids to children. It would appear from  
20 Dr Jarlath's note that he wished to give a bolus of  
21 fluid to Lucy. Fluid boluses would normally be given to  
22 improve circulation. It would have been normal practice  
23 to use normal saline as the bolus fluid. The  
24 administration of large volumes of hypotonic solutions  
25 may produce very low concentrations of electrolytes, in

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1 did you reach that view?  
2 A. I think I reached that view at the time of her inquest.  
3 Certainly whenever I was asked to review the notes by  
4 the coroner back in 1993.  
5 THE CHAIRMAN: At the time of Lucy's death then in 2000 --  
6 A. Sorry, 2003.  
7 THE CHAIRMAN: At the time of Lucy's death in 2000, why did  
8 you think she died?  
9 A. I didn't know. I was involved with Lucy on the Thursday  
10 and at that time we were looking at some form of acute  
11 neurology at that time. I just looked after her for  
12 that day and I wasn't in the intensive care unit the  
13 following day. So my --  
14 THE CHAIRMAN: So any question the following day about  
15 referral to the coroner would not have been in  
16 conjunction with you?  
17 A. I wasn't involved with that, Mr Chairman.  
18 THE CHAIRMAN: Dr Hanrahan had already noted on the Thursday  
19 that if she died, it was a case for referral to the  
20 coroner.  
21 A. Yes, that's right, yes.  
22 THE CHAIRMAN: Did you discuss that with Dr Hanrahan on the  
23 Thursday?  
24 A. That the child was going to be referred to the coroner?  
25 THE CHAIRMAN: Yes.

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1 A. I honestly can't remember, but it was definitely in the  
2 notes that that was going to happen, Mr Chairman.  
3 THE CHAIRMAN: Yes.  
4 MS ANYADIKE-DANES: Then let's go to the point that you were  
5 making --  
6 THE CHAIRMAN: It's 1.05. We'll resume at 2 o'clock,  
7 thank you.  
8 (1.05 pm)  
9 (The Short Adjournment)  
10 (2.00 pm)  
11 (Delay in proceedings)  
12 (2.07 pm)  
13 MS ANYADIKE-DANES: Dr Crean, you gave evidence at Lucy's  
14 inquest about her fluid regime and your views on it.  
15 If we pull up 013-021-074. Firstly, you say that in  
16 your view the position was irretrievable. Then you say:  
17 "On admission to the Erne Hospital, her sodium level  
18 was within normal limits. It then dropped 10 to 127  
19 within a short period. The rate of fall is the crucial  
20 factor."  
21 And in answer to Mr Fee, you also return to that  
22 and, having dealt with the business about her notes, you  
23 say:  
24 "The drop from 137 to 127 would ring alarm bells."  
25 And why is that?

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1 and other people were involved with and I think in the  
2 early 2000s there was a lot more written about this and  
3 I was trying to find evidence of this --  
4 Q. We're going to come back because you've helpfully turned  
5 up an exchange between Arieff and Ellis on the point.  
6 A. Oh, yes.  
7 Q. I don't want to get into that exchange right now; I want  
8 to ask you: are you saying that when you saw Lucy's  
9 notes in 2000, and you realised that at some time after  
10 7.30 -- let's call it 8-ish because that's roughly when  
11 she might have had her bloods taken -- that she has  
12 a serum sodium level of 137 and then, at some time later  
13 on, a few hours later on in fact -- let's say at about  
14 3.30 -- she's got a serum sodium level of 127, did you  
15 conclude or have a view at all about that fall?  
16 A. No, I think this is a very important point because,  
17 certainly in 2000, I would have had no realisation of  
18 anything to do with rate of fall. If I could try and  
19 tell you what my knowledge was at that time. I had seen  
20 the Arieff paper, 1992, that was in the BMJ. I was  
21 aware of the editorial that Ted Sumner had got for the  
22 Journal of Paediatric Anaesthesia, but I don't think  
23 in the editorial for example he had mentioned rate of  
24 fall and I don't think in the BMJ paper he had talked  
25 about rate of fall either. So this was not something

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1 A. To try and put this into context, Lucy died in 2000, and  
2 this was four years later. There had been a lot more  
3 published in the literature. I had received the expert  
4 witness reports. There wasn't very much written in the  
5 literature at the time regarding rate of fall, but it  
6 was alluded to, I think, by Dr Sumner in his expert  
7 witness report and it seemed to answer the mechanism  
8 about what happened at that time for me.  
9 Q. Sorry, can we just be clear about this? Sorry to cut  
10 across you, but I just wanted to be clear what you're  
11 talking about. When you were answering questions at the  
12 inquest, you were not answering what may or may not have  
13 rung an alarm bell in 2000; you were answering, am I to  
14 understand you, what would have rung an alarm bell if  
15 Lucy had presented herself to you in 2004?  
16 A. Yes, absolutely, yes.  
17 Q. Did you make that clear in your evidence to the coroner?  
18 A. I think that it was clear to me that that's what I was  
19 trying to say at the time. I don't think there was much  
20 in the literature at that time around 2000 where people  
21 were talking about rate of fall. It's only something  
22 I picked up subsequent to that. Remember I was working  
23 with the Department of Health working group, looking at  
24 fluids. You have mentioned yourself a lot more papers  
25 that became available in the literature that Des Bohn

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1 that I was aware of at that time.  
2 Q. You had seen the 1992 Arieff paper?  
3 A. Yes, I had, yes.  
4 Q. If we pull up 220-002-203. If you go to "Brain  
5 adaptation to hyponatraemia in children", he is exactly  
6 dealing with that point. If you see the bottom third of  
7 that paragraph, just before you get to "Effects of  
8 physical factors":  
9 "Furthermore, neither the actual concentration of  
10 serum sodium nor the rapidity of development of  
11 hyponatraemia seemed to predict the ultimate outcome in  
12 these 16 children."  
13 A. I didn't pick that up from the paper, but I can see what  
14 you're saying now.  
15 Q. It's a pretty significant thing have said because it's  
16 sort of counter-intuitive that no matter how quickly it  
17 goes or at what rate it falls, that's not well  
18 correlated with the degree of cerebral damage.  
19 A. That's right, yes. That's why, when I --  
20 Q. Sorry, just focus on this. But you are saying that you  
21 read that paper, which was a fairly innovative paper in  
22 and of itself and you didn't pick that point up?  
23 A. That's correct, that's what I'm saying.  
24 Q. Because if you had picked that point up, then the fall  
25 from 137 to 127 wouldn't necessarily have meant anything

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1 to you at all and you certainly wouldn't have been  
2 saying to the coroner the rate of fall is a crucial  
3 thing.  
4 A. Yes, neither would any of the other experts at the time  
5 because, if you remember, it was Ted Sumner that alluded  
6 to that and he talked about that rapid drop as well. We  
7 all did and I don't think any of us were aware of that  
8 concept at the time. I no more than anyone else did and  
9 I actually picked this thing up about rate of fall from  
10 the experts at that time.  
11 Q. No, but Dr Sumner talks about rate of fall because he  
12 has given that some consideration and he believes that  
13 to be significant. What you were telling the chairman  
14 a little while ago is you didn't think it was  
15 significant in 2000.  
16 A. I didn't know that it could have been significant in  
17 2000. I didn't say I didn't think it was significant --  
18 Q. Did you think it had any relevance at all?  
19 A. I don't know, I hadn't thought about that at the time.  
20 Q. You have two parameters, it drops 10. Do you not at  
21 least raise a query and say, "Let me discuss that with  
22 my colleagues. Maybe that's significant, maybe it's  
23 not?"  
24 A. I disagree with what you're saying. I didn't discuss it  
25 with my colleagues, I didn't think about it at the time.

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1 legal people at that time. I think it was January 2004.  
2 And I found this just a few months ago on the inquiry  
3 website. And it says there in that that basically he  
4 came in and the normal saline was running at that time.  
5 THE CHAIRMAN: That's Dr Auterson?  
6 A. No, it was the Dr Jarlath down in the Erne Hospital. It  
7 was alluded to by Ted Sumner in his --  
8 MS ANYADIKE-DANES: Sorry, what was alluded to?  
9 A. The fact that there was a chance that the sodium level  
10 had been taken at a later stage.  
11 Q. But you can see that in the nursing note. The very  
12 nursing note you took us to to show one point that you  
13 were trying to highlight precisely addresses that very  
14 question. I don't want to spend an over amount of time  
15 with it, but one can see it if we go to 061-017-050.  
16 Halfway down, exactly where you were:  
17 "IV fluids changed to normal saline and run freely  
18 into IV line."  
19 If you have picked up from the note that Dr Malik  
20 had written, he says she's had an hour of it. But  
21 leaving that aside, Dr Jarlath is then in attendance,  
22 "repeat U&Es ordered". So whatever you want to make of  
23 how much normal saline has been run in, certainly the  
24 sequence of events is there, on the face of the document  
25 that was faxed to you, which is that she gets her normal

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1 I also didn't think a sodium level of 127 per se was  
2 a problem. We saw it so, so frequently that -- I'm not  
3 saying I discounted it, but I didn't give it a lot of  
4 relevance at the time.  
5 Q. Did you think there was any possibility that actually it  
6 might not have been 127, that it might have been lower?  
7 A. At the time I didn't. I never thought about this  
8 because whenever the blood test was done, at about 3.15  
9 in the morning, I guess my assumption was that that's  
10 when bloods were done.  
11 Q. Sorry?  
12 A. I guess that that was my assumption that that's when the  
13 investigations were carried out. I assumed it was  
14 a blood sugar and maybe a U&E was done at that time as  
15 well.  
16 THE CHAIRMAN: Well, do you now understand the notes to  
17 indicate that the second U&E, which produced a result of  
18 127, was given after Lucy had received a considerable  
19 amount of normal saline?  
20 A. Yes, I do, and where I -- I think I have given  
21 a reference to it. It was on the -- it was in the  
22 coroner's papers somewhere. It's somewhere -- I've  
23 given a reference to it -- and it was actually a letter  
24 from Dr -- I have forgotten his first name, in  
25 Enniskillen. It was a letter that I had sent to his

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1 saline and then the blood is taken for U&Es.  
2 A. You have obviously noticed this. I've been through this  
3 chart so many times and I hadn't noticed that until you  
4 just pointed it out to me, and I have spent a lot of  
5 time looking at this and I had not noticed that before.  
6 This is the first time I have seen that.  
7 Q. Right. Dr Hanrahan has that point put to him. In fact,  
8 in his PSNI interview, they're discussing that, and he  
9 concedes that you can see that from the sequence of  
10 events from the nursing notes that were faxed over. He  
11 says that in his PSNI interview, the reference is  
12 116-026-017.  
13 He can see that. It's certainly there in the  
14 nursing notes and you've been asked to -- you had time  
15 to look at those notes to try and form a view as to what  
16 had happened to Lucy.  
17 A. I didn't have time to conduct a forensic investigation  
18 of the notes. I would say to you that I was in that  
19 ward that day, I was looking after several patients and  
20 I would not, I think, have been able to go through the  
21 notes in huge detail at my leisure. My life in  
22 intensive care was never like that.  
23 THE CHAIRMAN: Would you have had the chance to look at her  
24 notes in advance of the inquest when you were assisting  
25 the coroner?

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1 A. Yes, Mr Chairman. I've actually looked through these  
2 notes so much recently, I'm just saying I hadn't noticed  
3 that.  
4 MS ANYADIKE-DANES: Could that have made a difference to her  
5 serum sodium level at the point of collapse?  
6 A. I thought intuitively it would do.  
7 Q. Sorry?  
8 A. I thought intuitively that it would do and I put it in  
9 my witness statement. I thought that would probably  
10 have meant that if the sodium level had been checked  
11 before she had got a half-litre of normal saline that  
12 it would probably be much, much lower, less than 120,  
13 for example. And that's intuitively what I -- and if  
14 I'd known that at the time, if I'd picked that up at the  
15 time, I may have thought, "Oh my goodness, this was  
16 a really low sodium here", but I didn't pick that up  
17 at the time.  
18 Q. Well, Dr Jarlath says he communicated that to  
19 Dr Hanrahan, and I am wondering if part of the issue  
20 here is that even though there were a number of  
21 consultants attending to Lucy's care, there may not have  
22 been the best communication amongst them all, when she  
23 had died, to try and find out what people thought was  
24 the cause of death.  
25 A. Can I ask you a question back?

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1 THE CHAIRMAN: That's not clear. What appears to have been  
2 told to Dr McKaigue is what the repeat test result  
3 was --  
4 A. Thank you.  
5 THE CHAIRMAN: -- not the point at which the repeat test was  
6 taken.  
7 MS ANYADIKE-DANES: That's correct, Mr Chairman. What he  
8 then goes on to say in his witness statement, 278/1 at  
9 page 12, was that:  
10 "[He] relied on the entries in the fluid balance  
11 chart to inform the receiving clinicians as to the  
12 nature, quantities and timings of any fluids  
13 administered to Lucy."  
14 Then if you put that together with the nursing  
15 notes, his view, I suspect, would be you could have  
16 worked out from that that the serum sodium tests came  
17 after she received normal saline. But you're saying you  
18 didn't see that?  
19 A. What I'm saying to you -- I ... Coming up to this day,  
20 I have gone through these charts so much. I suppose  
21 what happens when you look at things, you look at  
22 specific things that you feel are important and you are  
23 maybe missing things. This is the first time I've seen  
24 that or I don't recognise having picked that up  
25 previously.

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1 Q. Sorry?  
2 A. Just for clarification. When in fact did Dr Jarlath  
3 tell Dr Hanrahan?  
4 Q. I took you to it earlier this morning: during the  
5 handover. That's his evidence. During the handover --  
6 sorry, if it wasn't Dr Hanrahan, it was --  
7 A. Dr --  
8 Q. If it wasn't Dr Hanrahan, it would have been  
9 Dr McKaigue. Sorry, let me find the place for you now  
10 that you have asked me. Yes, it would have been  
11 Dr McKaigue. He says it in his witness statement,  
12 278/2, page 5. He states that he believed he relayed  
13 the repeat electrolyte results at the verbal handover on  
14 arrival.  
15 A. I remember you telling me that earlier. He told him  
16 what the values were, but that's not the same as telling  
17 him when he did the blood test. Am I picking that up  
18 correctly from you?  
19 Q. We can move on.  
20 THE CHAIRMAN: Sorry, I think to be fair to the witness,  
21 that's right. It's not clear from the information which  
22 we have that, when Dr Jarlath said what the repeat blood  
23 test result was, he indicated that the repeat blood test  
24 came after the administration of normal saline.  
25 A. And he told that to Dr McKaigue at the time?

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1 Q. Yes. This is the first time that you've seen that's  
2 what it said in the note?  
3 A. That's the first time I've picked that up in the nurse's  
4 notes there.  
5 Q. When did you first appreciate there might be an issue as  
6 to whether her 127 was actually a record of her serum  
7 sodium level at the point of collapse? When did you  
8 appreciate that that might be an issue?  
9 A. I think I first considered that when I read Ted Sumner's  
10 note. Because if you look at his report -- if you look  
11 at Dr Evans' report, he didn't mention it, but I think  
12 Ted Sumner did in his report towards the end of it. He  
13 basically said something like "and there's a possibility  
14 of". So even when he was doing his report, as you  
15 clearly say there, it's there and evident for all to  
16 see, but he was just speculating, I think, in his  
17 report. That's where I kind of got that notion in my  
18 head as well. So many of us have probably not picked  
19 this up at the time.  
20 Q. Well, others will speak for themselves. Can I ask you  
21 about a point that I had just picked up before we  
22 started to think about what the source of that point  
23 might be?  
24 A. Okay.  
25 Q. And that's to do with discussing Lucy's case with the

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1 other clinicians. Another clinician that you had  
2 available to you to discuss is Dr Hanrahan. You had  
3 brought Dr Hanrahan in to review Lucy. Did you discuss  
4 with Dr Hanrahan his thoughts or views, having reviewed  
5 her?  
6 A. I'm sure I would have at the time because I was -- my  
7 mind was blank when she came in as to what was going on,  
8 and he ordered a lot of investigations when he reviewed  
9 her at that time. So I'm sure there was some discussion  
10 at that time about that.  
11 Q. What would have been the upshot of that discussion?  
12 A. Me going over to the CT scanner with her to try and find  
13 out what the CT scan of her brain -- because that would  
14 have had to be organised immediately.  
15 Q. And so when you come back and you know what the CT scan  
16 shows, but I take it from what you said you're none the  
17 wiser as to why she's in that condition, so then are you  
18 not trying to understand why she is and discussing with  
19 the very person that you brought in to provide  
20 a specialist view?  
21 A. The thing is, though, it's not like snapping your  
22 fingers and you get an answer immediately. We had to  
23 get a blood ammonia done, the metabolic screen that had  
24 to be done does take time. They did a toxicology screen  
25 as well to see if there were any substances in there

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1 in those circumstances?  
2 A. I have no idea. I'm not a neurologist and I wouldn't  
3 like to speculate on what was going through his mind  
4 at the time.  
5 Q. But you knew inappropriate fluid regime can cause  
6 cerebral oedema?  
7 A. I knew that and I've said that, but that's not something  
8 that would have come on my radar with a sodium of 127.  
9 There's just no way I would have thought that and  
10 I wouldn't have told him something just because I knew  
11 it. There had to be a reason for saying it. And with  
12 127, I just wouldn't have thought it.  
13 Q. So at this stage neither you nor he have a really clear  
14 view as to why Lucy is in that condition?  
15 A. That's what I've told you already today.  
16 Q. Sorry, so that's yes?  
17 A. Yes.  
18 Q. Did it occur to you, given that the notes are not the  
19 clearest, let's get on the phone to the Erne, there's an  
20 anaesthetist there who stabilised her and he's the one  
21 who rang through results, let's talk to him, or let's  
22 see if we can talk to the consultant paediatrician  
23 again? Did that occur?  
24 A. Well, I did talk to the --  
25 Q. I said again.

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1 that could have caused this collapse as well. These  
2 blood tests do take time to come back. Some of the  
3 tests didn't come back several days after she had died.  
4 I know that a rotavirus was grown in her stool. That  
5 didn't become evident until 4.15 on the following day,  
6 in fact it didn't become evident until she had died.  
7 A lot of these tests do take time to come back; you're  
8 not going to get an answer immediately about this.  
9 Q. Yes, I appreciate that. What Dr Hanrahan has -- and he  
10 inserts it in the notes before you have put your note  
11 in, so I presume it's there for you to see, it's at  
12 061-018-063. That's his differential diagnosis. You  
13 see it roughly halfway down the page, starting about  
14 a third down where he says:  
15 "Infectious? Herpes? Haemorrhagic shock?  
16 Encephalopathy? Metabolic?"  
17 A. "Urea cycle defects."  
18 Q. Yes:  
19 "Cerebral oedema for another cause?"  
20 A. "Other cause", yes.  
21 Q. That's a query, and he doesn't know exactly what it is,  
22 but those are the things on his radar, if I can put it  
23 that way.  
24 A. Yes.  
25 Q. What could have been the other cause of cerebral oedema

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1 A. I'm not sure at that time I would have -- I'm not sure  
2 at that time, at 10.30 -- I think the note was dated, or  
3 at the time the note was dated, I'm not sure at that  
4 time I would have even seen the faxes. I think probably  
5 after the ward round or even maybe after coming back  
6 from the CT scanner. That's speculation, but I don't  
7 think at the time --  
8 Q. Let's grant you that.  
9 A. Okay.  
10 Q. When you bring her back from the CT scan, you see she's  
11 got cerebral oedema, in all probability she's coned,  
12 although the brainstem death tests are still to be  
13 carried out, but I think, in your view, there was no  
14 coming back. But you didn't know what was the cause of  
15 that. Would it not have been helpful to see if you  
16 could speak to the anaesthetist at the Erne?  
17 A. I don't think so, no, not the anaesthetist.  
18 Q. Why not?  
19 A. Tom Auterson is not a paediatric anaesthetist. He would  
20 have very, very rarely been looking after children.  
21 Q. But he did get the right answer.  
22 A. I didn't hear what he said yesterday. If he had  
23 concerns about it, he had concerns about it, but from my  
24 knowledge of the general anaesthetists in DGHs, they  
25 just -- if there are any children there, they don't take

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1 a lot in dealing with them. They really just secure the  
2 airway and, if they have been involved in the transfer,  
3 they would bring them back up to Belfast.  
4 Q. He had made the effort to contact the  
5 Children's Hospital and, on his evidence on Friday, he  
6 had actually worked out what was the problem, and in  
7 fact he thought it was quite straightforward, what the  
8 problem was. So if you had contacted him ... but  
9 anyway.  
10 A. It would have been more relevant to contact the  
11 consultant paediatrician, I believe, and I still would  
12 believe.  
13 Q. And when you contacted the consultant paediatrician and  
14 realised that there had been some mix-up over her  
15 fluids, did that not concern you?  
16 A. Of course it concerned me. It means that the fluids  
17 that she got were not planned, they didn't plan to give  
18 them that way.  
19 Q. Yes.  
20 A. One of the issues that I saw that there was no written  
21 evidence that they had actually assessed the amount of  
22 dehydration, there were no fluid calculations there.  
23 There was no fluid prescription in the chart either.  
24 Q. That would have meant, if you'd heard that from her  
25 consultant paediatrician, that you would have had

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1 her fluid regime had been identified as problematic, to  
2 put it gently, you said to me that you had no  
3 recollection of that and that you were concerned to hear  
4 the evidence which they'd given on Wednesday. You have  
5 just told me that, on that Thursday in April 2000, you  
6 did have a concern about her fluids and the way they  
7 were managed in the Erne. Which is it?  
8 A. The point I'm making is that I would have obviously had  
9 concern about the clarification of that or else  
10 I wouldn't have made the phone call. Look, I'm not  
11 trying to defend what happened there.  
12 THE CHAIRMAN: What happened in the Erne and the treatment  
13 which Lucy received is not the subject of this inquiry.  
14 What is the subject of this inquiry is that I am told  
15 there was nothing learnt by anybody in the Erne or the  
16 Royal as a result of Lucy's death. And that is in the  
17 face of the evidence, which I have already heard from  
18 doctors in both hospitals that the problem which brought  
19 about her death was recognised at the time. And to put  
20 it bluntly -- let me spell it out -- there are people  
21 who believe there was a cover-up and that the cover-up  
22 was that it involves the Royal, not just in covering-up  
23 what happened in the Royal, but being willing to  
24 cover-up what happened in a completely different  
25 hospital. I have to spell that out to you. I'm not

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1 a concern about the fluid regime. Because the notes  
2 perhaps didn't lend themselves, so far as you were  
3 concerned, you might not have worked out exactly what  
4 the role of that was, but you would have had a concern  
5 about her fluid regime.  
6 A. Listen, I'm not trying to defend the actions of the  
7 paediatricians in the Erne Hospital. I'm not trying to  
8 say that they did everything that was right. They made  
9 many mistakes.  
10 Q. No, Dr Crean, I'm simply asking you: with that  
11 information, would you not have had a concern about her  
12 fluid regime at the Erne?  
13 A. I had a concern about her fluid, the way her fluids were  
14 managed in the Erne, because they were not doing what  
15 I just suggested a couple of minutes ago.  
16 THE CHAIRMAN: Sorry, when you say:  
17 "[You] had a concern about her fluids, the way they  
18 were managed in the Erne."  
19 Is that a concern which you had in April 2000?  
20 A. I think that's why I phoned them up, just to get  
21 clarification as to what was going on. Mr Chairman --  
22 THE CHAIRMAN: Sorry, doctor, when I raised with you this  
23 morning, the fact that this concern was, according to  
24 doctors Chisakuta and Stewart, recognised fairly quickly  
25 after Lucy's admission to the Children's Hospital, and

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1 saying that's the view that I hold or the view that I  
2 will conclude having heard all the evidence, but I am  
3 pretty sure that is a view, which is held by some of the  
4 families who have lost children, the loss of which has  
5 led to this inquiry.  
6 A. From my point of you, to do something like that would be  
7 absolutely crazy. There's absolutely no sense behind  
8 it.  
9 THE CHAIRMAN: I'm afraid, doctor, I have already heard  
10 evidence in this inquiry, which suggests to me that when  
11 doctors make mistakes, there is a reluctance -- or there  
12 was a reluctance in the mid-1990s -- for other doctors  
13 to face up to that and to encourage the doctors who had  
14 made mistakes to face up to it. So if this happened in  
15 Lucy's case, it would, on one interpretation of the  
16 facts, be an extension of what had happened before.  
17 A. I agree with you, but the following year, Mr Chairman,  
18 with Raychel, I informed the coroner. I was critical of  
19 what had happened then.  
20 THE CHAIRMAN: Yes.  
21 A. And I don't think my attitude had changed dramatically  
22 from one year to the next. I think that the same thing  
23 follows on.  
24 Look, I'm not trying to defend what fluids she  
25 received. All I was trying to say earlier, before

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1 lunchtime, was that the fluids she received that day,  
2 that evening, were not planned for. But based upon what  
3 paediatric practice was at that time, I didn't see them  
4 doing her any harm either. That was my opinion at the  
5 time.

6 MS ANYADIKE-DANES: Then one final question for you,  
7 Dr Crean, on this point. It's in your witness  
8 statement, 292/2, page 3. This question is:

9 "You have indicated that you remember having  
10 concerns about Lucy's fluid management at the time  
11 [that's at the time of her admission to PICU]. What do  
12 you think those concerns were?"

13 And then you say:

14 "Although I have difficulty remembering what my  
15 specific concerns were at this far remove from that  
16 time, I anticipate that my concerns would have been  
17 in relation to the lack of fluid prescription [which is  
18 a documentation point you have made] with appropriate  
19 calculations documented."

20 Then you go on to say, if we go over the page:

21 "The administration of volumes of hypotonic fluid in  
22 excess of maintenance requirements ..."

23 That is not just a recording issue; that's an issue  
24 that you have about what was administered to her. And  
25 according to this answer that you gave to the inquiry,

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1 things like this would happen, we were, on a regular  
2 basis, phoning the paediatricians up and saying, "Look.  
3 I think it would be better if we just restricted  
4 hypotonic solutions to maintenance fluid". There was  
5 a great reluctance to change. And you'll probably come  
6 to this when you're doing the part of the inquiry to do  
7 with the Department of Health, because I'm sure you have  
8 the minutes there --

9 Q. Let's stick with this for the moment. You said that you  
10 were phoning --

11 A. I said we would phone on a regular basis when we got  
12 children like this. Where consultant paediatricians  
13 were administering hypotonic solutions above  
14 maintenance, we would often feed back to them: this is  
15 maybe not a good idea, maybe you might wish to consider  
16 A, B and C. This is something that was happening all  
17 the time. I know that I did that, I know that Dr Loane  
18 did it on a regular basis.

19 Q. Did anybody do that in Lucy's case with the Erne?

20 A. I know that I phoned Dr O'Donohoe up at that time.  
21 I know that he said to me that from what he has written,  
22 "I gave a bolus of fifth-normal saline". I can't  
23 remember if I said to him at that time, "Actually it's  
24 not a very good idea to give a bolus of No. 18 Solution  
25 over the maintenance fluid", but that is what we were

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1 that was part of a concern you had at the time.

2 A. Yes, but at the time, although ... I think that the  
3 majority of children coming from medical wards to the  
4 intensive care unit, we did have concerns about their  
5 fluid management. And it was giving hypotonic fluids in  
6 excess of maintenance. But what I'm trying to say  
7 is that at that time that was the norm. We all had  
8 concerns about it, and in fact those concerns -- my  
9 concerns are the same for Dr Evans in his report.

10 That's what he's done as well in his report. He's  
11 suggesting that best practice at that time is to give  
12 a hypotonic solution, which is half-normal saline with  
13 glucose, for both the maintenance and the replacement of  
14 deficit. I have concern about that. I had concern with  
15 the practices that happened in Northern Ireland right up  
16 to 2007 and 2008, and it's only then that things have  
17 changed. I always had a concern of any child receiving  
18 more than maintenance of a hypotonic solution.

19 Q. If you had those concerns and you know that  
20 paediatricians up and down the country were doing that  
21 very thing, then it really does raise the question why  
22 the experts in the Children's Hospital could not have  
23 been getting that information out.

24 A. It's not just the experts in the Children's Hospital,  
25 it's anaesthetists everywhere. I'll tell you, whenever

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1 doing all the time with the trainees and others. But  
2 I can't put my hand on my heart that I exactly had that  
3 conversation with him 13 years ago, but we were doing  
4 that on a pretty regular basis.

5 Q. Well, if you could think to do that before Lucy had even  
6 been declared dead, if I can put it that way, the  
7 consultants who were there when she did die, is that  
8 something you would expect them to be doing?

9 A. Sorry, you'll need to ask me --

10 Q. You made contact with Dr Jarlath on the 13th.

11 A. Yes.

12 Q. Lucy actually died on the 14th. You weren't on duty  
13 that day.

14 A. No.

15 Q. Dr Chisakuta was on duty that day as the anaesthetist  
16 and Dr Hanrahan as the neurologist. What I'm saying is,  
17 given that this is the practice that you say the  
18 Children's Hospital was doing, would you have expected  
19 one or other of them to have contacted the Erne and  
20 said, "Lucy, unfortunately, has now passed away and our  
21 considered view is that there was something  
22 inappropriate in her fluid regime"?

23 A. Well, if they had considered that themselves, then they  
24 should have done that, and they should have informed  
25 the coroner about that as well.

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1 THE CHAIRMAN: Just before we move on, on the occasions when  
2 you and Dr Paul Loane were ringing other hospitals about  
3 the fluid management of children who were coming into  
4 ICU, how many of those children died?  
5 A. They didn't die.  
6 THE CHAIRMAN: So they hadn't died before Lucy?  
7 A. No.  
8 THE CHAIRMAN: But Lucy died.  
9 A. Lucy died.  
10 THE CHAIRMAN: So the type of concern that you say you and  
11 Dr Loane have been ringing a number of hospitals about  
12 over a period of time about fluid management, none of  
13 those involved, in cases in which a child died?  
14 A. That's correct.  
15 THE CHAIRMAN: So Lucy's the first case in which a child  
16 died coming into the Children's Hospital from another  
17 hospital with issues about fluid management who died?  
18 A. I'm not saying they had issues about fluid management  
19 and that's why they came into the hospital. They came  
20 into the hospital and these were the fluids they were  
21 receiving and we would take that as an opportunity to  
22 feed back to them and say, "Look, I think you might wish  
23 to consider just restricting your No. 18 Solution to  
24 maintenance only and consider normal saline for the  
25 replacement". It was, I suppose, like an ongoing

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1 of was Ted Sumner in his report.  
2 MS ANYADIKE-DANES: Were you surprised when there was no  
3 inquest in the circumstances that you have just been  
4 relaying to the chairman?  
5 A. I'm not trying to say it actually went off my radar,  
6 I just don't remember what I thought after that time.  
7 I wasn't involved after that day and I wasn't exactly  
8 sure what happened thereafter.  
9 Q. Then let me ask you this. If at the time when Lucy  
10 actually died you had been asked to complete a death  
11 certificate, would you have done that?  
12 A. I didn't know what she died from. I couldn't have done  
13 it.  
14 Q. So would you have issued a death certificate for Lucy?  
15 A. When I reviewed her notes in 2003, the death  
16 certificate, what was written --  
17 Q. I'm going to come to the actual death certificate.  
18 A. I'm trying to come round to this. When I saw what was  
19 written on her death certificate, what was written on  
20 the chart, it didn't make any sense. That's the point  
21 I'm trying to make.  
22 Q. So would you have been able to write one when --  
23 A. Absolutely not, no.  
24 Q. Thank you. That was the point I was asking you.  
25 And then it turns out that she's not going to have

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1 educational thing that we were trying to do and trying  
2 to change practice.  
3 THE CHAIRMAN: Okay. But in Lucy's case, tragically, any  
4 change of practice was too late to save her.  
5 A. It was, I agree with you. Mr Chairman, I've struggled  
6 with this over the years as well.  
7 THE CHAIRMAN: Doesn't that make it all the more blindingly  
8 obvious that this was a case for the coroner?  
9 A. I thought it was going to be a coroner's case. To me,  
10 it was an unexplained death at the time. I didn't know  
11 on that day that that -- what the cause of her demise  
12 was.  
13 THE CHAIRMAN: It also fits in with Dr Chisakuta and  
14 Dr Stewart saying there was a concern from fairly early  
15 on the Thursday.  
16 A. About her fluids?  
17 THE CHAIRMAN: Yes.  
18 A. I think we were constantly concerned about fluids  
19 managed in this way, Mr Chairman. I'm not trying to  
20 defend the use of No. 18 in this way. We were critical  
21 of it all the way through and we were -- I would be  
22 critical of any hypotonic solution used in this way.  
23 I would be critical of Dr Evans' use of hypotonic  
24 fluids, the way he did. And he was one of the expert  
25 witnesses. The only person here I wouldn't be critical

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1 an inquest and the decision is that she will --  
2 THE CHAIRMAN: I think, to be fair to the witness, that's  
3 not something that you specifically recall registering  
4 with you?  
5 A. What's that, I'm sorry?  
6 THE CHAIRMAN: The fact that she wasn't going to have an  
7 inquest.  
8 A. No.  
9 THE CHAIRMAN: Your memory at this remove is that you don't  
10 recall the lack of an inquest registering with you and  
11 you wondering, "How on earth can she not have an  
12 inquest, we don't even know why she died?"  
13 A. I didn't follow the things up because I assumed they  
14 were going to be waiting for -- informing the coroner,  
15 waiting for some of the results and things that they had  
16 sent off to see what was going to come back on that.  
17 MS ANYADIKE-DANES: According to Dr Stewart, you were one of  
18 the consultants who agreed the working pathogenesis that  
19 would go on the autopsy request form. There wasn't  
20 going to be an inquest. Dr Hanrahan and Dr Chisakuta  
21 were of the view that, for some of the reasons you have  
22 just said, we need an autopsy, post-mortem, to help us  
23 with why she died and what Dr Stewart says is the  
24 working pathogenesis on the autopsy form was:  
25 "Dehydration and hyponatraemia, cerebral oedema,

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1 acute coning and brain death."  
2 And I will give you the reference for where she says  
3 is, 115-022-002. She says:  
4 "This was the working pathogenesis agreed by  
5 Dr Hanrahan and the anaesthetists in the absence of  
6 a definite aetiological diagnosis."  
7 And then she is asked subsequently by the inquiry as  
8 to:  
9 "Who were the anaesthetists?"  
10 And she says -- sorry, this is 282/1, page 12:  
11 "The anaesthetists involved in looking after Lucy  
12 were Dr McKaigue, Dr Crean and Dr Chisakuta, and there  
13 may have been others working in PICU who I can't  
14 remember."  
15 And she goes on to say:  
16 "I do not recall if I was personally present when  
17 the working pathogenesis was agreed. From my reading of  
18 her notes, it is likely I was there as I recorded the  
19 clinical facts and the general thoughts about Lucy's  
20 condition from Dr Hanrahan and from the anaesthetists.  
21 My role as the registrar was to transcribe the  
22 conclusions of any discussions between the professionals  
23 in whatever notes I had made to the best of my ability  
24 and knowledge. These were not my own personal opinions  
25 and I do not remember specific details apart from what I

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1 for the autopsy request form, then you can only be  
2 having an autopsy request form if you're not having an  
3 inquest because otherwise the coroner would direct it.  
4 A. I think there's some ambiguity about this. I was here  
5 last week, as I have mentioned, and I remember  
6 Mr Chairman, you saying just because she has talked  
7 about "the anaesthetists involved", she may have been  
8 referring to the anaesthetists involved in Lucy's care.  
9 That wasn't necessarily the anaesthetists that put this  
10 working pathogenesis together. That's really what I'm  
11 saying. I did hear you say that last week. It is  
12 ambiguous, so I don't know. Looking at the working  
13 pathogenesis, Caroline has identified the sorts of  
14 issues that were there at the time. What I don't see  
15 there, for example, is some of the other differential  
16 diagnoses that Dr Hanrahan came up with. Because  
17 I don't think results from the metabolic screen and  
18 other things had come through at the time, so I don't  
19 think they could have been excluded.  
20 Q. In any event, there is a very clear answer to that.  
21 She's absolutely clear that that is something that  
22 Dr Hanrahan had agreed irrespective of who the other  
23 anaesthetists might be.  
24 A. But the other thing is that if you're going to get  
25 a hospital post-mortem, you should be able to write the

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1 have written."  
2 That is how she is saying she got to the working  
3 pathogenesis that she inserts into the autopsy request  
4 form. You can find that at 061-022-075. You see it  
5 there, list of clinical problems. It says "in order of  
6 importance", and in fairness to her, she says she wasn't  
7 putting them in order of importance, she was putting  
8 them in order of presentation. You see:  
9 "Vomiting and diarrhoea; dehydration; hyponatraemia;  
10 seizure and unresponsiveness leading to brainstem  
11 death."  
12 When she was asked in her evidence about that link  
13 between the hyponatraemia and the seizure, and indeed  
14 the dehydration, her view was that what probably should  
15 have gone in there is that it was the response to the  
16 dehydration which was inappropriate which led to the  
17 hyponatraemia, which in turn led to the seizure, what  
18 she would call the cerebral oedema, the "Seizure,  
19 unresponsiveness leading to brainstem death". So that's  
20 the line of causation, if I can put it that way, that  
21 she says, and that's the rationale for it.  
22 The reason I've put it to you is because you had  
23 answered previously that you weren't aware that there  
24 wasn't going to be an inquest, but if she has got you as  
25 one of those who were agreeing a working pathogenesis

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1 death certificate immediately.  
2 Q. Sorry?  
3 A. If you're getting a hospital post-mortem, you should  
4 already be able to write the death certificate.  
5 THE CHAIRMAN: Before the results of the post-mortem come  
6 back?  
7 A. Yes. Really, what the post-mortem is for is to learn  
8 from this. There may be additional information you wish  
9 to provide, but you can only write a post-mortem if you  
10 know the cause of death.  
11 THE CHAIRMAN: Yes.  
12 A. You can't do it and stick it in afterwards.  
13 THE CHAIRMAN: Sorry, you can only write a death  
14 certificate --  
15 A. If you know the cause of death. If you don't know the  
16 cause of death, it has to be a coroner's post-mortem.  
17 MS ANYADIKE-DANES: That was one of the issues that we were  
18 putting, and the short answer seemed to be that there  
19 were circumstances -- certainly in this jurisdiction,  
20 and maybe in others -- where you await the outcome of  
21 the post-mortem and then you write the death  
22 certificate. Now, that is something that  
23 Professor Lucas has criticised. It's something that  
24 Dr Keeling recognises is a possibility. Both of them  
25 are experts for the inquiry. And it's also something

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1 that Dr Hicks, who was at the Children's Hospital at  
2 that time, said did happen from time to time. So there  
3 doesn't seem to be a clear answer about that, but you're  
4 quite right, Professor Lucas is very concerned about  
5 a practice that entitles you or enables you, I should  
6 say, to wait, get the results of the post-mortem and  
7 then write up your death certificate accordingly.  
8 A. If I can maybe help you there.  
9 THE CHAIRMAN: Please do.  
10 A. Dr Hicks is a neurologist and there are occasions where  
11 the neurologists have been looking after a child,  
12 basically all their life, and they have never discovered  
13 in fact what was wrong with the child. They could have  
14 a muscle problem and become weaker and weaker and die  
15 from respiratory failure. So there could be occasions  
16 where they have to wait many months until they get  
17 results back before they put anything in. I don't know,  
18 I'm only speculating here, but things like that do  
19 actually happen.  
20 THE CHAIRMAN: I'm interested in the basic approach which  
21 you outlined a few moments ago: if you have decided to  
22 ask for a hospital post-mortem for a child, you should  
23 already be able to write the death certificate.  
24 A. Mr Chairman, that's my understanding of it. You have to  
25 have a clear idea of what's happened. There may be

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1 through last week, doesn't appear to add to the  
2 information which was already known.  
3 A. The one thing I picked up from the post-mortem, having  
4 read it through, was that there are things there that  
5 I think Denis O'Hara was trying to say and maybe didn't  
6 say it very clearly. What he did say was about the  
7 finding of bronchopneumonia. Often, pathologists find  
8 bronchopneumonia, and I think ... You have talked about  
9 SIADH quite a bit in the past. There are certain things  
10 that cause SIADH. You can get brain things like brain  
11 tumours, meningitis, encephalitis. Pulmonary things can  
12 cause SIADH on their own, things like tumours in the  
13 lungs, bronchopneumonia can as well, and there are  
14 certain tumours like -- a carcinoid tumour can do this.  
15 Although he didn't explicitly say it, I think what  
16 he was trying to say was to tie the cerebral oedema and  
17 the low sodium in with an SIADH promoted by the  
18 bronchopneumonia. But often, children that come into  
19 ICU, when they are in extremis the way Lucy was, will  
20 get a ventilator-induced bronchopneumonia. That's not  
21 really significant and she didn't have any respiratory  
22 symptoms either.  
23 MS ANYADIKE-DANES: I was just about to ask you that  
24 question. Professor Lucas said that that should at  
25 least have been a possibility, that it was

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1 additional learning from the post-mortem. There's  
2 a possibility that you could add to the death  
3 certificate, but you have to be able to write the  
4 certificate first of all.  
5 THE CHAIRMAN: There will be a debate about this over the  
6 next few weeks, but there has been criticism from some  
7 experts about the fact that the death certificate --  
8 first of all, you have already indicated that the death  
9 certificate, when you saw it, the original death  
10 certificate made no sense to you.  
11 A. Absolutely none at all.  
12 THE CHAIRMAN: The other point is the death certificate was  
13 issued before the post-mortem report became available.  
14 A. Okay.  
15 THE CHAIRMAN: Do I understand you to say that wouldn't make  
16 any sense?  
17 A. I thought, having read around this recently, that the  
18 death certificate came out about three weeks after Lucy  
19 died. And I thought they had received the preliminary  
20 report of the post-mortem.  
21 MS ANYADIKE-DANES: No, they hadn't. They had received the  
22 anatomical summary, not the preliminary report; the  
23 preliminary report comes out in June.  
24 A. Then I misunderstood that.  
25 THE CHAIRMAN: And the anatomical summary, as we went

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1 ventilator-induced; do you think that's credible?  
2 A. I would concur with that because I don't think --  
3 unless -- I don't know -- unless Lucy -- I mean, what  
4 could have happened, for example, is that whenever she  
5 had her acute deterioration, she would have aspirated,  
6 but that was at the end of the events that were  
7 happening that evening. So it would have been like  
8 a pre-terminal thing that happened, it would have been  
9 cause and effect. That's my opinion anyway.  
10 Q. That was a point I wanted to ask you. Thank you very  
11 much.  
12 Can I ask you very quickly about the discharge  
13 summary because you have mentioned that one of your  
14 practices -- and I don't think it is you alone, you said  
15 Dr Loane did it as well -- was to get on the phone and  
16 make communication with the referring hospital, if I can  
17 put it that way. Another way of doing something similar  
18 is either a discharge letter or discharge summary, some  
19 way of communicating what has happened to the child. In  
20 your Claire witness statement, 168/2, page 12, in answer  
21 to question 55 -- at the same time as saying that for  
22 administrative reasons you were quite often the named  
23 consultant, and you say your name appeared on all  
24 hospital admission slips and all hospital discharge  
25 summaries, you then go on to say that:

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1 "A hospital discharge summary from PICU would be  
2 completed if a child died."  
3 A hospital discharge summary was not completed for  
4 Lucy. We can see it, it's just blank, 061-004-011.  
5 That's it. It was in her notes, but it's blank,  
6 it's not completed. And, so far as the inquiry has been  
7 advised, no discharge summary was ever completed for  
8 Lucy.  
9 A. What that has on it, if you can see, it says:  
10 "Admission to Musgrave Ward."  
11 And Musgrave Ward is a medical ward in the hospital,  
12 and what it was doing in her notes, I'm not quite sure  
13 of. This could well have been a specific discharge  
14 summary note that came from that ward. I don't remember  
15 us using this on a regular basis.  
16 Q. Leaving that aside, you said a hospital discharge  
17 summary --  
18 THE CHAIRMAN: Sorry, it's as close as we have to  
19 a discharge summary. It's the only discharge summary  
20 that appears in Lucy's records and there is no completed  
21 discharge summary in Lucy's records.  
22 A. There's another form there that was used in triplicate  
23 that was used. I can't remember the name of it, but  
24 I think I saw it there somewhere.  
25 MS ANYADIKE-DANES: There's an "inpatient/outpatient";

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1 Q. I understand. Can I ask you: do you regard this form as  
2 being accurate in light of what you have been discussing  
3 with the chairman?  
4 A. It gives some of the detail there.  
5 Q. Is it accurate?  
6 A. It's accurate as far as it goes, but it doesn't fill  
7 in the blanks. There should be other -- it's the same  
8 as the death certificate: it doesn't give the whole  
9 story, is what I'm trying to say.  
10 Q. Is there any reason why it shouldn't give the whole  
11 story?  
12 A. Because they didn't know at the time what the whole  
13 story was.  
14 Q. But there is less on here than is on the autopsy request  
15 form, for example. That at least has some of the things  
16 which have been established as being involved in her  
17 demise.  
18 THE CHAIRMAN: And am I right, doctor, that it also has the  
19 illogical jump from viral gastroenteritis to cerebral  
20 oedema?  
21 A. It's not --  
22 THE CHAIRMAN: Illogical in the sense that there's at least  
23 one or two entries in between?  
24 A. I would agree with you there, yes.  
25 THE CHAIRMAN: So sending that to the GP is a fairly

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1 is that what you mean?  
2 A. I can't remember.  
3 Q. I'll turn that up for you. If we put that alongside,  
4 just to make sure you can compare them, 061-012-036.  
5 A. Yes.  
6 Q. Is that what you mean?  
7 A. That's it, yes.  
8 Q. So this was in lieu of the discharge summary?  
9 A. Yes. This would have been -- I mean, I still use those  
10 today. This would be filled in when the patient is  
11 discharged. It would be, for example, if you were being  
12 discharged home and you had been admitted for  
13 a respiratory illness and you were writing the drugs and  
14 things you wanted the patient to be on, they can then  
15 bring that to their GP and they know exactly what the  
16 diagnosis was.  
17 Q. Yes, but Lucy's dead, so what's the purpose of this  
18 document?  
19 A. What would happen there, it's a form that's filled in on  
20 all patients, whether they survive or not.  
21 Q. To go on the GP?  
22 A. That would go to the GP -- and also what we would do is  
23 give the GP a call as well because if mum or dad come  
24 around to the GP and he is not aware that the child has  
25 not survived, it's --

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1 meaningless exercise?  
2 A. I think probably what had happened is they phoned the GP  
3 up as well and they're just filling in bits of the form  
4 just to get it completed and out of the way.  
5 MS ANYADIKE-DANES: If you could tell the GP on the phone,  
6 why couldn't you record it on the form?  
7 A. I can't answer that. I'm not disagreeing with you.  
8 THE CHAIRMAN: It depends what you're telling them on the  
9 phone.  
10 MS ANYADIKE-DANES: Yes. There has been a comment made by  
11 the inquiry's expert, Dr MacFaul, that a discharge  
12 letter would have been appropriate, and you may recall  
13 from the Claire case that there was a discharge letter  
14 that went out to the GP. In fact there were two: one  
15 that went to the family and one that went to the GP.  
16 One consultant wrote to one and one consultant wrote to  
17 the other. We have not been able to find any evidence  
18 of a discharge letter in that way going out to the GP.  
19 A. I realise that and that --  
20 Q. Would that not have been appropriate?  
21 A. It's wrong not to do that. It's essential, not  
22 appropriate, essential.  
23 Q. Thank you. And then I have just very few questions to  
24 conclude. Did you regard Lucy's death as being an  
25 adverse incident at the time?

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1 A. At the time, on the 13th, when she came in, I didn't  
2 know exactly what was going wrong.  
3 Q. At the time of her death, did you regard that as being  
4 an adverse incident?  
5 A. At the time I didn't think it was an adverse incident.  
6 It was an unexpected and unexplained death to me at the  
7 time, but that's changed nowadays, that is not the way  
8 things are done. Any unexplained or unexpected death  
9 would become an adverse incident, and it would be  
10 managed as a serious adverse incident, it would go up to  
11 the Health & Social Care Board, the Public Health  
12 Authority, and it would be reviewed and regulated from  
13 there. These sort of events are treated very, very  
14 seriously nowadays.  
15 Q. You have very helpfully attached for us, in your second  
16 witness statement, the procedure for an adverse incident  
17 reporting form. You also attach, if you just bear with  
18 me:  
19 "Clinically-related adverse incidents which should  
20 be reported."  
21 Both those documented are dated March 2000. If we  
22 go to "Clinically-related adverse incidents which should  
23 be reported" and pull up witness statement 292/2,  
24 page 54. There we are. Here are the things that should  
25 be reported as adverse incidents:

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1 treatment or procedure?  
2 A. You see, this was just coming in at the time, and  
3 I don't think that at that time people would have  
4 reported the result of a treatment from elsewhere, to be  
5 quite honest with you. I think it would have been --  
6 you would have probably filled it in if had happened in  
7 your own hospital.  
8 Q. I beg your pardon, thank you very much. That was going  
9 to be my next question to you, which is: if all that  
10 happened at the Erne had actually happened in PICU,  
11 would you have reported that as an adverse incident?  
12 A. You would have done, yes.  
13 Q. Am I understanding you correctly: the only reason you  
14 didn't do that is because it happened in a different  
15 hospital?  
16 THE CHAIRMAN: No that's too general. That's suggesting the  
17 only reason Dr Crean didn't do that --  
18 MS ANYADIKE-DANES: I didn't mean you personally; it wasn't  
19 done.  
20 THE CHAIRMAN: Under the system that was coming in, if  
21 anybody was to report Lucy's death as  
22 a clinically-related adverse incident, it was to be the  
23 Erne, not the Royal?  
24 A. Yes. I would agree with that.  
25 THE CHAIRMAN: How would the Royal know if the Erne had done

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1 "Unexpected death as a result of treatment or  
2 procedure."  
3 That's one of the bullet points. Could Lucy's death  
4 not have been termed that?  
5 A. I don't think so because I think what they were alluding  
6 to -- my reading of this is that that would be, for  
7 example, if you were carrying out, I don't know, some  
8 sort of invasive procedure and there was a complication  
9 and the patient died or some sort of treatment and the  
10 patient died as a consequence of --  
11 Q. She did have treatment. She came in with suspected  
12 tummy bug, gastroenteritis, and a few hours later than  
13 that, she has collapsed, never to recover. I mean,  
14 Dr Chisakuta thought that was unexpected and sudden.  
15 A. It was an unexpected death, but at the time I didn't  
16 see -- certainly on the Thursday, I didn't see that as  
17 being as a result of the treatment.  
18 Q. If you leave what you thought on the Thursday out of it  
19 because you don't necessarily have to be the person that  
20 reports it. By the time you got to the fact that none  
21 of the clinicians should really have written a death  
22 certificate because nobody really knew what had happened  
23 to her and, in those circumstances, when she did die  
24 should not one of those consultants have actually  
25 reported it as an unexpected death as a result of

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1 that?  
2 A. They wouldn't have known because there wasn't that sort  
3 of crossover of information. It's different now because  
4 we have people in place and this is their job to do and  
5 they will pass that information between each other.  
6 Also, at the top, you have got the Public Health  
7 Authority, the Health & Social Care Board, and they work  
8 together, looking at all these serious adverse  
9 incidents. We got reports about serious adverse  
10 incidents now and there's an annual report. Most of  
11 them, they do do a review of what happened. Some they  
12 de-escalate and think, "We don't need to do a review  
13 here", but most of them they do.  
14 THE CHAIRMAN: If Lucy died now in 2013 in the equivalent  
15 circumstances to 2000, would the Royal complete an  
16 adverse incident report?  
17 A. Yes, I think what we would do is fill in an adverse  
18 incident report and that would be immediately escalated  
19 to a serious adverse incident report, which is a higher  
20 level, and that then would be shared with the PHA and  
21 the Health & Social Care Board.  
22 THE CHAIRMAN: Would that mean, under the system which  
23 prevails today, there would be two serious adverse  
24 incident reports, one coming from the Erne and one  
25 coming from the Royal?

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1 A. I don't think so. I think what we would probably do is  
2 send a copy of ours down to the Erne and let them know  
3 we've filled one in and share that information with the  
4 Erne. We'd phone them up obviously, and I think a copy  
5 of the report that came from the Royal, the person at  
6 that level would contact her equivalent person in the  
7 Erne and send them a copy of the form.

8 THE CHAIRMAN: Is that because the forms haven't changed but  
9 there has been a change in the way that the system is  
10 operated?

11 A. I think the system has really just got more robust.  
12 We're talking 13 years ago. This was a new thing and it  
13 was trying to introduce to people a different culture,  
14 a no-blame culture, and sharing misadventures that took  
15 place so that we could share these and improve safety  
16 for patients, and not only for patients, but for staff  
17 as well.

18 MS ANYADIKE-DANES: Yes, but the purpose of having adverse  
19 incident reporting is so that these things are  
20 investigated, there is an understanding of how they've  
21 happened, if something needs to be changed to reduce the  
22 incidence of that happening again, then that is  
23 instituted and then one evaluates and monitors the  
24 change. That's the whole purpose of it.

25 A. I agree with you.

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1 here", because the incident reporting wasn't just about  
2 what happened to Lucy.

3 THE CHAIRMAN: What I'm trying to follow up on is  
4 this: there's now a system which you tell me is much  
5 more robust and is followed much better and I'm sure the  
6 families who are listening to this are desperately  
7 anxious to hear that that is so so that lessons are  
8 learnt in a way which were perhaps not learnt in the  
9 deaths which I am investigating. But does that mean  
10 that before the introduction and increasing adherence to  
11 this adverse incident reporting system there was, in  
12 effect, no system under which deaths of children were  
13 reported where lessons could be learnt?

14 A. Mr Chairman, I'm not an expert on this, but I --

15 THE CHAIRMAN: You worked through this period that time  
16 concerned with.

17 A. I'm not sure there was at that time either.

18 THE CHAIRMAN: Okay. If that is the case, then it's fingers  
19 crossed as to whether anybody learnt any lessons?

20 A. I can't disagree with you there. But I do think -- I do  
21 have to say that I think there's been a big change in  
22 the way things are. I think I might have said earlier  
23 today, I can't remember, but people who have been  
24 appointed in the last number of years, they don't ever  
25 remember a time when this kind of reporting system

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1 Q. If you're not going to do that in your hospital because  
2 you take a view it didn't happen here, should you at  
3 least not satisfy yourself that somebody else is going  
4 to do it so that that is investigated and one does get  
5 that learning from that incident?

6 A. You're probably right, but we were in our infancy of  
7 what was going on here. We were trying to get people to  
8 buy into this process, and I think it took quite a while  
9 to get the culture to change, for people to do that.  
10 I think the worry for a lot of people was, "If I put my  
11 head above the parapet and say about this, they'll shoot  
12 me for it", and it was trying to get people to think in  
13 a different way.

14 THE CHAIRMAN: Pause a moment. Who would shoot who?

15 A. I'm just saying --

16 THE CHAIRMAN: Sorry, doctor, this is a serious point for  
17 me. Who would be regarded in a bad light in 2000 in the  
18 Royal for reporting -- or 1995 or 1996, for that  
19 matter -- for reporting inadequate treatment which had  
20 led to or contributed to a child's death?

21 A. That maybe was a bad analogy when I was trying to talk  
22 about a child's death. But if it was something to do  
23 with, say for example, lab reports going missing or  
24 something like that there, people might feel, "They're  
25 going to blame me if I say there was something wrong

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1 wasn't there. If I can reassure anyone that things  
2 definitely have changed and there's definitely  
3 a different culture out there nowadays.

4 THE CHAIRMAN: This is moving a little bit away, but it's  
5 one of the big issues that I'm concerned about looking  
6 forward. What brought about that change?

7 A. I think there was regulation. I think it was all -- it  
8 was -- Gabriel Scally in 1999 came up with the concept  
9 of clinical governance within healthcare systems and  
10 I think there was a cultural change back there, that  
11 things had to change at the highest level, and I think  
12 that's when maybe things started moving then. I don't  
13 know a lot of the legislation that happened back then,  
14 but that's something I remember, the term, the concept,  
15 that came into being back then.

16 THE CHAIRMAN: Thank you.

17 MS ANYADIKE-DANES: Thank you. There was, so we are told,  
18 a mortality meeting in relation to Lucy. There's no  
19 record that you attended it. Why is that?

20 A. I'm not sure. I don't know. If I can maybe tell you  
21 a bit about the mortality meetings. What happened, they  
22 were a half-day meeting, it was an audit mortality  
23 meeting. They would happen every month. They would  
24 happen at different times of the week and people would  
25 be free to go to those in that their clinics and

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1 operating lists would be cancelled to facilitate that to  
2 happen. For example, this year already I've missed two  
3 of the meetings, but that's because I ended up in  
4 theatre covering emergencies those days. So there is  
5 usually a reason why people can't go. If I was in the  
6 intensive care unit on a Thursday morning and that  
7 meeting happened on the Thursday morning, I probably  
8 couldn't go because you saw the sort of things I was  
9 doing with Lucy that morning. So there will be  
10 occasions when people can't go because they're not free,  
11 but if they're not busy doing emergency work, they  
12 should be free to attend or they may be on holiday, but  
13 if they're at work, they should be able to attend.  
14 Q. What would you have expected to be the outcome of such  
15 a meeting into Lucy's death or in relation to Lucy's  
16 death?  
17 A. If it was left just the way it has been described on the  
18 death certificate, I think people would have been  
19 jumping up and down asking all sorts of questions: this  
20 doesn't make sense. That's what I would have thought.  
21 Q. The date of it, just to help you with that, is said to  
22 be 10 August 2000 --  
23 A. Okay.  
24 Q. -- whereas her death certificate, I think it's 4 or  
25 5 May. So that obviously precedes that. What would

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1 that had taken place and assuming that the position was  
2 as is recorded on the death certificate, then something  
3 more is likely to have happened because the sorts of  
4 people who are attending that would have recognised, as  
5 you did and others have said, that that simply didn't  
6 make sense?  
7 A. That would certainly be my expectation.  
8 MS ANYADIKE-DANES: Thank you. Mr Chairman, that's it.  
9 THE CHAIRMAN: Thank you very much. Mr Quinn, do you have  
10 anything?  
11 MR QUINN: No.  
12 THE CHAIRMAN: Before I come to Mr McAlinden, does anyone  
13 have any questions?  
14 Doctor, thank you very much for helping us again.  
15 Unless there's anything you want to say before you  
16 finish that we haven't covered, you're free to leave  
17 now.  
18 A. Okay, thank you.  
19 MR QUINN: Mr Chairman, there is one point that I should  
20 have covered with my learned friend, which I was going  
21 to cover with Ms Anyadike-Danes at the interval, and  
22 it's in relation to the make-up of the death  
23 certificate, which my solicitor has alerted me to just  
24 today. Perhaps if we could have two or three minutes  
25 now to go over this with my friend. It may be relevant

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1 you have expected to be the outcome of that meeting?  
2 THE CHAIRMAN: In other words, if people were jumping up and  
3 down because what they were told about Lucy's condition  
4 and death and then were told about the death certificate  
5 just didn't add up, what's the practical consequence?  
6 Do people just walk away saying, "That's all a bit of  
7 a mess", or do they actually do something?  
8 A. I have tried to look into where I was that day, so I was  
9 able to see the list of people who were on that. And  
10 there are some pretty senior people on there.  
11 Elaine Hicks, for example, was there and she was the  
12 clinical director there and she's not the sort of person  
13 who would turn her back on something. So if people  
14 looked at this at the time and said, "This doesn't add  
15 up or make sense", you would have done something and try  
16 to look into this, "There's something not right here".  
17 MS ANYADIKE-DANES: Could that turn itself into an adverse  
18 incident as a result of that?  
19 A. I don't know if you'd do that, but you'd certainly look  
20 into it and say, "This doesn't make sense, we haven't  
21 got to the bottom of this". If the pathologist wasn't  
22 there, "Let's talk to the pathologist", maybe, "Let's  
23 take this back to the coroner, this is not right, this  
24 doesn't add up for me".  
25 Q. So am I understanding you to say that if a meeting like

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1 to this witness.  
2 THE CHAIRMAN: I won't stop you doing that, Mr Quinn, but  
3 the doctor has said this afternoon, when he saw the  
4 death certificate, it made no sense to him and he  
5 couldn't have issued the death certificate.  
6 MR QUINN: Yes, I realise that.  
7 THE CHAIRMAN: Is there something more than that?  
8 MR QUINN: There is, because I have just been given a blank  
9 copy of the death certificate. This matter did arise in  
10 Claire's case where on the back of the death certificate  
11 you have a portion where you can add to the cause of  
12 death at a later stage. It may be relevant that this  
13 witness should be asked: was he aware of that and should  
14 the death certificate be added to later in relation to  
15 what came up at the post-mortem?  
16 THE CHAIRMAN: Or what comes out of the mortality meeting?  
17 MR QUINN: Either of those issues.  
18 THE CHAIRMAN: Are you familiar with that?  
19 MR QUINN: We don't have the reverse of the death  
20 certificate in this case.  
21 MS ANYADIKE-DANES: We do. If you give me one minute,  
22 Mr Chairman, I'll find it.  
23 THE CHAIRMAN: I'll rise until 3.30. Doctor, we'll finish  
24 this single point and you can then add whatever you want  
25 to say and we'll go into Dr Taylor's evidence.

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1 I understand Ms Anyadike-Danes is confident we can  
2 get Dr Taylor finished today.  
3 (3.18 pm)  
4 (A short break)  
5 (3.32 pm)  
6 MS ANYADIKE-DANES: Dr Crean, there is only one point, and  
7 I wonder if I could pull up 319-055-002. This is the  
8 counterfoil to the death certificate. Just as my  
9 learned friend Mr Quinn said, there is a place where you  
10 can indicate whether you can offer further information.  
11 Dr Dara completed this or signed it. His view was that  
12 putting "yes" there really meant that he was available  
13 if there were any queries or anybody wanted to ask  
14 anything more that -- so it's a passive thing, really,  
15 not suggesting that should any further information come,  
16 that that would be sent off. That's how he interpreted  
17 it. Do you yourself have much experience in completing  
18 death certificates?  
19 A. I have done a bit years ago. It was quite a long time  
20 ago.  
21 Q. At the time you were doing it, did it have this format  
22 as well that you could indicate further information?  
23 A. I can't remember, but it's something maybe we touched on  
24 just before --  
25 Q. In Claire, yes.

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1 and I'm sorry about that, is that there is the Trust  
2 policy, which is TP9/00, and is signed off by Mr McKee.  
3 And if we can pull these pages up side by side. 292/2,  
4 page 45 and 46, side by side. It's really for  
5 clarification, Mr Chairman.  
6 You'll see this is the policy signed off by Mr McKee  
7 as the chief executive. He's dated it May 2000 and what  
8 it is including is the documents that we've just been  
9 looking at. So it may be that those documents were not  
10 intended to be in use until Mr McKee provided them under  
11 cover of the adverse incident reporting policy  
12 of May 2000. So that's something we'll need to explore,  
13 but it's possible that although the documents had been  
14 created before Lucy's death, that they weren't intended  
15 for use until May or some time after her death.  
16 A. I just tried to find a lot of the documentation for the  
17 questions when I was responding to them. I have to say  
18 I wasn't exactly clear about that issue either.  
19 Q. We'll try and see if we can clarify that with the Trust,  
20 but in any event I think your answer to the chairman  
21 might be that until this policy was rolled out, I think  
22 was the expression that you used in your witness  
23 statement, there really wasn't very much in terms of  
24 formalised adverse incident reporting; would that  
25 capture your evidence?

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1 A. Just generally about death certificates, that if you  
2 felt, if you ... You have to be able to fill in the  
3 death certificate on death. You have to know what  
4 it is, but there are occasions when you would get  
5 a hospital post-mortem done as well to learn or there  
6 may be other things that have come out of that. So say,  
7 for example, something did come out of that, then you  
8 could put -- I thought then you could put the  
9 information on this section as the further information  
10 that you would add to it.  
11 Q. Does that mean if something had come out in whichever of  
12 these fora we've discussed, the mortality meeting or the  
13 receipt of the autopsy report, if something had come  
14 out, by indicating "yes" there, do you understand that  
15 to mean that would then be provided and that could  
16 perhaps lead to a change in the death certificate?  
17 A. Possibly, yes. That's the way I would read that.  
18 MS ANYADIKE-DANES: Thank you very much indeed.  
19 THE CHAIRMAN: Mr McAlinden, do you have any questions?  
20 MS ANYADIKE-DANES: I beg your pardon, there's one thing.  
21 When I was putting to you the procedure for adverse  
22 incident reporting and I had mentioned to you that that  
23 form, also with the "Clinically-related adverse  
24 incidents which should be reported", both those forms  
25 are dated March 2000. What I hadn't drawn attention to,

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1 A. I think so, yes.  
2 MS ANYADIKE-DANES: Thank you very much indeed.  
3 THE CHAIRMAN: Dr Crean, I think before the break, did  
4 I understand that you wanted to say something further  
5 before you left? You don't have to. It's a matter for  
6 you entirely.  
7 A. It's kind of hard, but can I say something to the  
8 families at this stage? Is that okay to do that?  
9 THE CHAIRMAN: Yes.  
10 A. I think I'm the oldest person left working in the  
11 Children's Hospital now, and I've been around a while.  
12 I know I looked after Adam and you heard today that  
13 I looked after Lucy. I know Raychel's mum and dad are  
14 here today and I was there with them when Raychel passed  
15 away.  
16 Friends of ours, about 10 years ago, they lost their  
17 son, it was an accidental death, and it's the worst  
18 thing I've ever seen, it was just absolutely terrible,  
19 and they've tried to get through it the best they can,  
20 and it's just been devastating. It's changed their life  
21 completely. There's not a day goes by that they don't  
22 remember him. They're still trying to keep him alive  
23 for their grandchildren now. So I can't imagine what  
24 it's like for these families, but I'd just like to  
25 extend my sympathies for the families whose children are

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1 included in this inquiry, Mr Chairman.  
2 THE CHAIRMAN: Thank you very much, doctor.  
3 (The witness withdrew)  
4 DR ROBERT TAYLOR (called)  
5 Questions from MS ANYADIKE-DANES  
6 MS ANYADIKE-DANES: Good afternoon, Dr Taylor.  
7 A. Good afternoon.  
8 Q. Dr Taylor, we've been through your CV previously, so I'm  
9 not going to go through it, apart from to highlight some  
10 points that are relevant to what I am going to ask you  
11 here today. The reference for your CV is 306-019-001  
12 and then I should like to ask you if, subject to the  
13 evidence that you give here this afternoon, whether you  
14 adopt your inquiry witness statements? For the record  
15 I'll read out what they are. They're the series 280,  
16 the first is dated 2 November 2012, and the second is  
17 dated 15 January 2013; do you adopt those?  
18 A. Yes.  
19 Q. And before you prepared those witness statements and  
20 indeed before you came this afternoon to give your  
21 evidence, with the exception of your legal team, have  
22 you discussed your evidence with anybody or the  
23 circumstances of Lucy's case with anybody?  
24 A. With my family and with Professor Michael Shields, who  
25 I had occasion to contact about the -- he handed over

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1 Q. So you were a member, but not chairman, at the time when  
2 Lucy died?  
3 A. That's correct.  
4 Q. Thank you. And for that matter, a member at the time  
5 when Raychel died.  
6 A. Yes.  
7 Q. If I may quickly ask you, because you're lead clinician  
8 and director of PICU just after Claire's death, probably  
9 in the year when the post-mortem report would be coming  
10 back and then possibly coming up to -- if not exactly,  
11 but very close to, depending on when in 2000 you  
12 stopped -- when Lucy died, what did lead clinician and  
13 director of PICU mean to you?  
14 A. It meant attending meetings, it meant meeting with the  
15 senior nurses in the intensive care, the sisters, to  
16 ensure that we weren't -- that the medical staff were  
17 communicating well with all the nurses, that we weren't  
18 expecting -- we were expecting the degree of nursing  
19 care that we would expect and they would expect the  
20 degree of medical care that they would expect. A lot of  
21 the time was meeting about the junior medical staff of  
22 PICU, the trainees who were attached through the  
23 paediatric training committee, and I do recall part of  
24 my time there negotiating with the postgraduate council  
25 to get a fellow in PICU. So this is instead of the

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1 mortality, if you remember, from -- previous audit  
2 facilitator to me. And after I read Dr MacFaul's  
3 statement, I had reason to contact Professor Shields to  
4 ensure that my understanding of the handover and of the  
5 recording of the mortality was accurate to previous  
6 evidence I have given and evidence I would like to rely  
7 on for this element of the inquiry.  
8 Q. I understand.  
9 A. Apart from that, nobody else.  
10 Q. You also are a member of the Paediatric Intensive Care  
11 Society.  
12 A. Yes.  
13 Q. And how long have you been a member of that society?  
14 A. I think, like Dr Crean, I was there for the very first  
15 meeting at the Institute for Child Health in Great  
16 Ormond Street in 1988, just before I went to Toronto.  
17 Q. And you also were lead clinician and director of the  
18 paediatric intensive care from 1997 to 2000; is that  
19 correct?  
20 A. Yes.  
21 Q. Just for reference purposes, but not to be pulled up,  
22 it's 306-019-011. And you were a member of the clinical  
23 audit committee from 1997 to 2006 and its chairman from  
24 2003 to 2006; is that correct?  
25 A. That's correct.

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1 trainees coming for three months and just when you are  
2 beginning to get them utilised, to knowing how the  
3 protocols work, how the ventilator works, how you could  
4 actually trust them to look after the ICU every night  
5 and allow yourself to go home to get some sleep. That  
6 does require a degree of trust with people who were only  
7 in for a few months. So I was very keen, as were my  
8 colleagues, I hasten to say, that we could get somebody  
9 for a full year, and I successfully negotiated the  
10 various strands of the medical education system and the  
11 paediatric SAC letters to encourage manpower planning,  
12 so that not only could we have somebody, I suppose,  
13 being selfish, that would provide a service for us, to  
14 let us sleep more peacefully at night and our patients  
15 to be safer, primarily, but also that person would be  
16 seen as a future consultant that we could train up and  
17 meet this, what you have heard about, difficulty in  
18 recruiting and retaining paediatric intensivists and  
19 paediatric anaesthetists. And that was something that  
20 was going on in England, that fellows, longer-term  
21 trainees were encouraged to spend time if they were  
22 interested in paediatric intensive care so they would be  
23 fruit for the future.  
24 Q. I can see from what you have said, and for that matter  
25 from what Dr McKaigue said when he gave his evidence,

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1 that that whole utilisation of resources was quite an  
2 important issue for the person in your position to try  
3 and manage?  
4 A. Yes.  
5 Q. When you mentioned communication there and you were  
6 doing it in the context of between the nurses and the  
7 doctors, to some extent in the questions that I was  
8 putting to Dr Crean today, one might think it was  
9 important to ensure that there was adequate  
10 communication between the clinicians actually to make  
11 sure that people knew who had the primary responsibility  
12 for the child's care.  
13 A. Yes.  
14 Q. And that they shared their ideas where the actual cause  
15 of a child's problem wasn't immediately apparent. Did  
16 you have any role in trying to facilitate that or to see  
17 how that might be better improved?  
18 A. Yes. During my time as the lead clinician in PICU, we  
19 developed a problem at the PICS meeting, the UK  
20 Paediatric Intensive Care meeting. I spoke to  
21 colleagues about, and that was children, long-term  
22 ventilated children, children there for 3, 6 months  
23 a year. And they were capable of being looked after  
24 outside intensive care, they were on what we call home  
25 ventilators, so they didn't need all the technology and

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1 York Hill and Glasgow, had a very well-developed package  
2 for long-term ventilated infants and children and I in  
3 fact -- one of the developments was to get two of the  
4 leads, the nurse and the doctor, who led their long-term  
5 ventilation patient group over to Belfast. We arranged  
6 a conference and I would say within days of that  
7 conference we had community services, hospital services,  
8 and departmental level starting to agree that these  
9 children will be better managed in their home  
10 environment, in the community environment, and that's  
11 a successful --  
12 THE CHAIRMAN: Did you have 12 beds in PICU; is that right?  
13 A. No, six.  
14 THE CHAIRMAN: So this meant that five out of six were  
15 regularly occupied?  
16 A. It was a constant form of pressure, not only between  
17 doctors and nurses within the unit, but I would also say  
18 with doctors in the DGHs when they phoned up at night to  
19 say they wanted a patient to be admitted under emergency  
20 circumstances, there would be occasions when we would  
21 have to say that we were full and the child would have  
22 to go to Dublin or another intensive care.  
23 MS ANYADIKE-DANES: If I just ask you about some of the  
24 other things you might have been able to achieve in that  
25 role. I'm not suggesting whether you should have, but

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1 the bells and whistles that needed intensive care, but  
2 they could for their own neurodevelopmental well-being  
3 and for families' well-being -- families were coming  
4 quite long distances across the Province to visit them  
5 every day and some of the communications with different  
6 doctors every day was difficult.  
7 So what one of us would do is take on a lead role  
8 with that family and that child so that we could work  
9 through with the paediatrician who also developed a lead  
10 role and one of my major challenges -- and I have to  
11 say, it was successfully concluded -- was to develop  
12 protocols, guidelines, training, care pathways to allow  
13 these children to transition out of PICU to the wards  
14 and actually to community care.  
15 The savings were of the order -- I think I did  
16 a calculation at that time that these children were  
17 costing, in terms of resources, £1,600 per day in PICU  
18 and the community would be about £100 a day, so there  
19 was a major element of resource issues. There was also  
20 the difficulty that five of them were occupying most of  
21 the PICU beds, so that made PICU beds unavailable for  
22 children who perhaps could benefit from that, and also  
23 the most important thing, rather than cost and  
24 resources, is the families wanted to have these children  
25 in their home. And I knew from English and Scottish --

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1 what that role gave you a possibility to do, if I can  
2 put it that way, is the Paediatric Intensive Care  
3 Society produced standards and you've told us about the  
4 development of protocols and so forth, admittedly for  
5 a particular purpose.  
6 A. Yes.  
7 Q. But I wonder, being an active member of it, whether you  
8 sought to see which of those standards might usefully be  
9 introduced into the Children's Hospital.  
10 A. Yes.  
11 Q. You know the document I mean.  
12 A. Absolutely.  
13 Q. For reference it is 315-015-001.  
14 A. I find the document very useful -- I'm trying to think  
15 of a diplomatic term -- but to encourage the management  
16 of the Trust, who were cutting resources by 2, 3,  
17 4 per cent per year to actually spend money to save  
18 money and, for instance, things were -- technology was  
19 increasing, guidelines were introduced. One of the  
20 guidelines, I think I showed earlier, was dose  
21 calculators, dosages for reducing drug errors in  
22 intensive care. This was a common occurrence. It's now  
23 a less-common occurrence and is now the subject of major  
24 incident, adverse incident reporting. But one of the  
25 things I developed was a dose calculator, it was

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1 a little bit of complicated maths, but you typed in the  
2 child's body weight and the printer churned out an A4  
3 page with all the drugs calculated to that patient's  
4 body weight, and that included dangerous infusions such  
5 as adrenaline, noradrenaline, dopamine and so on.  
6 That's something I also, through the Sick Child Liaison  
7 Group, which I'm sure you'll enquire of me, I shared  
8 with doctors who were looking for such a resource for  
9 their hospital units and it ran on a disc, it ran on  
10 a spreadsheet, so it was compatible with most computer  
11 systems. That was one of the standards that was  
12 recommended. Just an example of one of them that we  
13 tried to meet that quite aspirational document Dr Crean  
14 called it.

15 A lot of those recommendations and standards did  
16 require a fairly major investment of resource and, like  
17 Dr Crean said, resource was not easy to achieve in the  
18 1990s or 2000s, or even today.

19 Q. But in terms of some of your work, I think you were  
20 telling the chairman that some of those protocols would  
21 actually enable cost savings.

22 A. Well, I certainly felt, and as I say, I did  
23 a back-of-an-envelope calculation to say that if  
24 children were discharged from ICU who did not need to be  
25 in intensive care, in fact they could have been

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1 If one looks at it in your CV, you were on the  
2 working party for neonatal and paediatric transport SAC,  
3 which is a special advisory committee, paediatrics, in  
4 1995. Just for reference purposes, 306-019-011.

5 And if I pull this up, maybe Dr Taylor, you can help  
6 us with this, there's a minute of a meeting on  
7 12 November 1996, so that's not so far after that  
8 paediatric intensive care section 2 came out. The  
9 reference for that is 320-050-001.

10 It's not coming up, okay. This is the minutes of  
11 the meeting of the specialty advisory committee,  
12 paediatrics, held on 12 November 1996, and that's  
13 a meeting at which the CMO would chair, am I right  
14 in that?

15 A. I don't think she chaired the working party.

16 Q. No, the minutes of the meeting, not the working party.

17 A. Sorry?

18 Q. She would chair that meeting?

19 A. I presume so.

20 Q. Yes. And then when we finally do get this up and  
21 running, I will give you the reference for the actual  
22 place where your work is discussed, it's 320-050-003.  
23 And it's headed up in the minutes:

24 "Paediatric intensive care transfer arrangements."  
25 And:

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1 emotionally, physically and psychologically better  
2 in the home environment, and if that could save the poor  
3 taxpayer money as well, surely that would be  
4 a no-brainer. But that took more than just the  
5 calculation argument to do; it took a lot of work with  
6 community teams.

7 Q. The section 2 of that standard, which was thought to be  
8 a new section, dealt with the standards of practice for  
9 the transportation of the critically-ill child, which  
10 turned out to be quite an important thing insofar as the  
11 development of paediatric intensive care services was --  
12 so far as I understand it, the idea was that these  
13 specialisms that you had in the lead centre, or the  
14 regional centre as the children's hospital would be,  
15 that would extend back into the referring hospital and  
16 try and ensure that that degree of expertise was brought  
17 to bear before the child was actually transferred or at  
18 least if they couldn't go out and do it, that guidance  
19 was given to the referring hospital to try and make sure  
20 that the child came in the best possible state to enable  
21 the specialist equipment and expertise to give that  
22 child the best chance of survival or quality of life  
23 when admitted to PICU. That seems to be the idea behind  
24 the transport services. And I noted from your CV that  
25 you were on actually a group looking at that very thing.

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1 "Professor Halliday tabled a paper which he had  
2 prepared with Dr Bob Taylor, which examined the need for  
3 and problems associated with the transportation of ill  
4 neonates and children. Dr Jenkins, also present,  
5 pointed out that present services were based on  
6 inadequate transport facilities. There was a need to  
7 develop a dedicated regional retrieval service as  
8 existed in some regions of the UK."

9 And:

10 "Dr Trevor Brown stressed that this issue should be  
11 considered a clinical priority."

12 So you had prepared a paper for that; is that  
13 correct?

14 A. I can't remember from that time, sorry.

15 Q. Do you remember the issue that you were dealing with?

16 A. Of course. It's still present today.

17 Q. Yes. And then what I wanted to ask you about is, apart  
18 from being able to provide guidance to the transferring  
19 hospital, did you also seek to ensure that the child  
20 came with all relevant -- not necessarily all, but the  
21 relevant notes, charts, X-rays and so forth to put the  
22 receiving hospital in the best position to treat?

23 A. Yes.

24 Q. Thank you. There was another document then that came  
25 out, and it's "Paediatric intensive care: a framework

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1 for the future". You'll remember that.  
2 A. Yes.  
3 Q. The reference for that is 315-016-001. And was that  
4 a development of the idea of trying to develop  
5 specialisms around intensive care and also some  
6 consistency as to how those services were to be  
7 provided?  
8 A. Yes. This was the Troop report. Pat Troop, deputy CMO,  
9 had a public inquiry. This was a result of the public  
10 inquiry into the death of Nicholas Geldard, who was  
11 a child who died in England, being transported between  
12 hospitals in the north-west of England, and is a tragedy  
13 that happened. There was a public inquiry, and the Trip  
14 report looked at the centralisation rather than  
15 regionalisation of children's intensive care services  
16 and discussed the need for children not to be looked  
17 after in adult intensive cares. It proposed a smaller  
18 number of larger paediatric intensive care units  
19 throughout England and Wales. It didn't apply to  
20 Northern Ireland. I believe this was written for  
21 England and Wales, but I was very keen that the managers  
22 and the senior people in the Royal Belfast Hospital for  
23 Sick Children would look at this in the light of the  
24 need: why should Northern Ireland have a lower standard  
25 than that which would have been needed for the rest of

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1 so far as clinical audit is concerned, some wider  
2 comparisons to ensure that the highest possible  
3 standards are being achieved and maintained."  
4 Within the terminology of this report, that lead  
5 centre, that was going to be the Children's Hospital?  
6 A. I would imagine, yes.  
7 Q. Yes. And then shortly after that, a few years after,  
8 you see 093-035-110n, this is a memo dated  
9 9 February 1999, all this, of course, pre-dating the  
10 transfer of Lucy and Raychel. You refer to:  
11 "... the clinical implications and implementation of  
12 the recent 'Framework for the future' document [that was  
13 the one we've just been looking at] for paediatric ICU.  
14 In particular, I would like to consult widely on agreed  
15 guidelines for admission, initial management and  
16 transfer of critically-ill infants and children."  
17 And then you are trying to set up a meeting to do  
18 that thing, and there's a series of people that you CC  
19 on that or are targeting, and you can see those from  
20 Altnagelvin. There's Dr Corrigan, consultant  
21 paediatrician from Altnagelvin. Did matters progress  
22 from there and, if they did, where had they reached by  
23 the time of Lucy's transfer and Raychel's?  
24 A. This was the embryonic first letter that went out from  
25 the Sick Child Liaison Group.

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1 the UK?  
2 Q. Is that not in the what happened, that although it  
3 related to England, some of those recommendations were  
4 nonetheless taken up in Scotland, Wales and by the  
5 Children's Hospital?  
6 A. We would have tried to aspire to these standards and the  
7 workload and the issues that came through this document  
8 because it was the matter of a public inquiry.  
9 Q. If I pull up just two pages to put side by side,  
10 315-016-049 and alongside of that, admittedly out of  
11 order, 315-016-054. Paragraph 94 says:  
12 "A coordinating group recommends that protocols  
13 should be developed setting out which types of care for  
14 critically-ill children can be provided in which  
15 hospitals within the area and when the transfer of  
16 children should take place."  
17 So that is very much part of what you had been  
18 thinking about before. And then if we look to the other  
19 side, the second bullet:  
20 "The lead centre should assist in assessing training  
21 needs across the geographical area in consultation with  
22 the professional staff involved."  
23 And under "Audit and research", it refers to:  
24 "... requiring interaction between the health  
25 authorities and hospitals within each defined area and,

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1 Q. This turned into the Sick Child Liaison Group?  
2 A. I think at our first meeting we said we -- if you look  
3 at the top left hand corner, it says "SCLG", which is an  
4 abbreviation for Sick Child Liaison Group, so I think  
5 the clinicians attending said the title of "Clinicians  
6 with an interest in the care of the critically-ill  
7 child" was a bit unwieldy and they thought it should be  
8 the Sick Child Liaison Group. It was suggested by  
9 others and I adopted it.  
10 Q. I'm going to ask you about that in a little minute. But  
11 in any event -- because I want to come back more  
12 specifically to other things you were doing in the Sick  
13 Child Liaison Group -- did you actually progress towards  
14 reaching any standards, protocols, in relation to the  
15 transfer of children?  
16 A. Yes, and I think they've already been sent in previous  
17 statements to the inquiry.  
18 Q. I see.  
19 A. One was a meningococcal guideline for Northern Ireland  
20 and --  
21 Q. Yes, I saw that.  
22 A. -- one was a bronchiolitis guideline and one was a --  
23 Q. Sorry?  
24 A. A bronchiolitis, "Care of the child with bronchiolitis".  
25 And I think another one was -- the nurses' Benchmarking

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1 group asked us to ratify a document that they had  
2 produced, which was a transfer checklist, transfer  
3 sheet, which we were happy to do.  
4 Q. In light of the work you were doing and what you were  
5 trying to achieve, if one looks at Lucy's case  
6 particularly, what would you have expected her to be  
7 transferred with if I can put it that way?  
8 A. Well, at the moment -- in the context of 2000, there was  
9 no retrieval service. We were the only  
10 Children's Hospital in the UK -- and still are --  
11 without a 24/7 dedicated paediatric retrieval team.  
12 Northern Ireland is the only service. The Republic of  
13 Ireland doesn't have a 24/7 paediatric retrieval service  
14 either. Every other hospital in the UK has a paediatric  
15 intensive care retrieval team who will go out, assist  
16 with the resuscitation and management, initial  
17 management of a patient, and decide whether to retrieve  
18 that patient to PICU or to perhaps not retrieve that  
19 child.  
20 Q. In the absence of that, without having a system where  
21 you could physically go out, is there any way that you  
22 can do the best you can by offering guidance and having  
23 perhaps a more detailed conversation over the phone that  
24 you might otherwise have?  
25 A. Exactly, and therefore to continue from my last point,

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1 A. No, everybody knew that there was a paediatric  
2 anaesthetist in the Royal 24/7, who was available at the  
3 end of a phone or the unit, the PICU, would have no  
4 hesitation, I can tell you, in giving them my home phone  
5 number. Those were the days before mobile phones. But  
6 certainly I would have had a phone call beside my bed  
7 any hour of the day or night from a concerned  
8 anaesthetist or paediatrician.  
9 Q. Then was there a bit of a culture perhaps that had to be  
10 got over with people maybe being reluctant to not  
11 exactly seek help, but discuss in that way with the  
12 regional centre, with the suggestion that maybe in some  
13 way they can't manage their own patient themselves;  
14 could that have been an element in the reluctance?  
15 A. I can't comment on that. You'd obviously have to ask  
16 the doctors out there. I certainly would have a very  
17 good relationship with doctors and they would have never  
18 been discouraged from phoning me at any time of day or  
19 night. I don't know the reasons why they would fail to  
20 lift the phone.  
21 THE CHAIRMAN: Okay.  
22 MS ANYADIKE-DANES: Thank you.  
23 Then on that theme of maybe disseminating learning,  
24 giving guidance and so forth, just making use of the  
25 resource of your expertise at the Children's Hospital,

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1 it would be incumbent upon an anaesthetist and/or  
2 paediatrician or both to resuscitate and manage the  
3 patient, and we would always have been, as a group --  
4 and certainly I as an individual would always have been  
5 sympathetic to that person. We may have done very  
6 little paediatric management to assist them with the  
7 choice of drugs, with the dose of drugs, which I've  
8 already alluded to, and I would certainly say if they  
9 had difficulty calculating the dose in drugs in  
10 children, there's a reckoner calculator that we can send  
11 them. So we would have opened our communication line  
12 for them to tell us how the child was, what drugs  
13 we would recommend that they give, what fluids we would  
14 recommend they give -- obviously that's the relevant bit  
15 you're interested in -- and even down to who should  
16 accompany the child.  
17 Q. Is that a service that you would have been offering  
18 in April 2000?  
19 A. Well, absolutely. I think all the intensivists --  
20 we were busy people, but our phones were constantly  
21 ringing and I have to say that I would have received  
22 much fewer calls for help than perhaps there should have  
23 been.  
24 Q. Is that because the fact that you offered that kind of  
25 service wasn't particularly well-known?

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1 in your first witness statement in relation to Adam, the  
2 reference for it is 008/1, page 9, the first substantive  
3 paragraph talks about the Sick Child Liaison Group, it's  
4 the penultimate paragraph that I want to draw your  
5 attention to:  
6 "From 1991, I met twice a year with other  
7 consultants in paediatric intensive care at organised  
8 conferences of the UK Paediatric Intensive Care Society.  
9 At these conferences fluid management of critically-ill  
10 children was discussed on several occasions. At  
11 a meeting in Great Ormond Street in October 1999 a whole  
12 session was devoted to the subject of the optimum fluid  
13 for such children."  
14 And I'm going to put to you a question which I put  
15 to Dr Crean. When you had the benefit of meeting with  
16 those sorts of people who were also experts in their own  
17 fields and received that kind of information, what was  
18 the mechanism by which that could get translated into  
19 practice if that's what you thought was appropriate  
20 at the Children's Hospital when you came back?  
21 A. Well, some of my colleagues would go to the APA,  
22 the Association of Paediatric Anaesthetists, someone had  
23 to stay at home and hold the fort. I tended to be the  
24 one who missed out on the APA meetings, but the  
25 recompense was to go to the PICS meetings, so I ended up

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1 choosing or following the PICS line, but maintained my  
2 anaesthesia CPD as well as PICS. So we would have  
3 various meeting, either informally in the coffee room or  
4 formally where I would feed back information.

5 Now, before 1999, the major fluid controversy was  
6 the use of albumin versus saline and there was a major  
7 fuss about a Cochrane review about albumin versus saline  
8 and it concluded that albumin increased the mortality of  
9 children significantly over normal saline. This was  
10 a very hot topic. Roberts, who wrote the paper, was  
11 brought in front of the PICS meeting and was given  
12 a fairly torrid time about choosing the meta-analysis  
13 and some of the papers he chose were not deemed to be  
14 academically correct. The whole idea of albumin being  
15 an unsafe fluid compared to saline was really rejected  
16 by the consensus at that meeting and I brought that back  
17 and said to my colleagues that, "Guys, no matter what  
18 you read, the consensus is that albumin is still a safe  
19 fluid to use, that's what other intensive care doctors  
20 are using and that's what, if you want to use -- and  
21 there's since been a major study called "The safe study:  
22 saline versus albumin for infusion", and that  
23 concluded -- a big study that concluded that albumin was  
24 as safe as saline for fluid resuscitation.

25 Q. I don't know if you got to see Dr Chisakuta's paper that

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1 as the safe and reliable fluid for children. So there  
2 were two philosophical beasts. They came together  
3 in the Children's Hospital and there was respect given  
4 to each side prior to the death of Raychel, certainly,  
5 and I think, although there was an evolving situation,  
6 I would say prior to the death of Raychel, where perhaps  
7 hypotonic fluids were being seen as not as safe as they  
8 should be. That's just my impression.

9 Q. We've asked a similar question to the witnesses that  
10 we've had so far in this part of the hearing, and  
11 Dr Chisakuta, for example, said that he had actually  
12 tailed off his use or his prescription of  
13 Solution No. 18 pretty much by the time he returned back  
14 from Great Ormond Street and Altnagelvin to work in the  
15 Children's Hospital and I think Dr Stewart is not  
16 entirely sure when she started to reduce, but it  
17 wouldn't have been so far away, round about 2000,  
18 something of that sort, I think maybe early 2000.

19 What we were trying to find out is whether any of  
20 you could help with a statement and a letter that  
21 Dr Nesbitt produced, which, if you were here this  
22 morning you would have heard me refer to Dr Crean, and  
23 you may have already seen the statement and the letter  
24 Dr Nesbitt produced. The upshot of it was that he was  
25 of the view that he was being told that the Children's

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1 he presented in September 1998.

2 A. Yes.

3 Q. In fact, immediately after the section where he deals  
4 with hypotonic fluids, he also deals with a paper that  
5 was published in the BMJ in 1998, which is exactly that,  
6 "Human albumin therapy during resuscitation of a child",  
7 and he's got that under that same section of  
8 controversies; were you aware of that?

9 A. Yes, that was the biggest fluid controversy at the time.

10 Q. If you then wanted to, in some way, introduce or make  
11 use of the concerns that were being expressed  
12 in relation to low-sodium fluids, or at least, rather,  
13 the risks they presented, if I can put it that way, how  
14 did that feature in the practice at the  
15 Children's Hospital?

16 A. I think that anaesthetists of all -- whether paediatric  
17 or adult -- were philosophically used to giving balanced  
18 salt solutions intraoperatively. We all trained in  
19 adult anaesthesia before we developed into paediatric  
20 anaesthetists. So the anaesthetists came from  
21 a background of people who would use a balanced isotonic  
22 salt solution. On the other side, paediatricians went  
23 straight into paediatrics, tended to go straight into  
24 paediatrics after their houseman's year and they were  
25 philosophically programmed, if you like, to see No. 18

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1 Hospital, some six months or so before Raychel's death,  
2 had actually stopped using Solution No. 18. And not  
3 only that, which he said Altnagelvin didn't know about,  
4 but not only that, but some other anaesthetists in other  
5 hospitals -- and he mentioned in particular Craigavon --  
6 had sought to do that, although with not entire success,  
7 but nonetheless the feeling was there was a mood of  
8 change in relation to the use of low-sodium fluids.

9 We weren't able to actually pin down when that  
10 happened or see the evidence of it until we got a chart  
11 showing the supply of Solution No. 18 to the Children's  
12 Hospital from the pharmacy. If I just pull that up and  
13 very quickly see if you can help us with it.  
14 319-087c-003. You can see the tail-off and you will  
15 have heard the evidence in relation to that, certainly  
16 today. Dr Crean wasn't really able to help us with  
17 that. Can you help us with why there should be  
18 a tail-off that starts just before, really, Raychel's  
19 death, which might fit in with the idea of a reduction  
20 six months previous? Can you help with that?

21 A. I can't explain those figures.

22 Q. The other thing that Dr Nesbitt said is that that change  
23 had been prompted by two things. He said one, in his  
24 letter to his medical director, was several deaths.  
25 Obviously we're going to ask, but at this stage it's not

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1 quite clear when those deaths were happening, but  
2 that is put as the trigger for it. The other, which he  
3 says in his PSNI statement, is a concern about  
4 low-sodium fluids, perhaps the risks they pose. Were  
5 you aware of any deaths in or around this time in which  
6 Solution No. 18 might be implicated?

7 A. No.

8 Q. If there had been something like that, would you have  
9 been aware of it?

10 A. Yes.

11 Q. For this tail-off in use, if I can put it that way, to  
12 happen, what in your experience would have had to happen  
13 in the hospital to produce that reduction in use?

14 A. Well, I didn't know much -- most of the No. 18 would  
15 have been used on the wards, the medical wards,  
16 I presume, and there is a blip each winter, and that  
17 reflects the fact that infectious diseases are more  
18 common in the winter months. I would certainly see  
19 a blip in the winter months. I think this is too short  
20 a graph to get a full picture for the prescribing.  
21 There perhaps was a worry -- I remember at the  
22 millennium bug around December 1999/January 2000, and  
23 there was a panic situation going on where people might  
24 want to stockpile -- people were predicting all sorts of  
25 end-of-the-world scenarios and ordering may not happen,

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1 reduce their use of it in response to the emerging  
2 literature, if I can put it that way?

3 A. I don't know what papers you mean that I circulated.

4 Q. Well, sorry, you've referred to going to the Paediatric  
5 Intensive Care meeting -- particularly the one in Great  
6 Ormond Street in October 1999 -- where you say a whole  
7 session was devoted to the subject of optimum fluids for  
8 such children and you refer to Dr Bohn publishing  
9 several papers on hyponatraemia and speaking at that  
10 meeting.

11 A. Yes.

12 Q. So is it possible that as the information percolates, if  
13 I can put it like that, from the increasing literature  
14 on the subject of low sodium, the incidence of  
15 hyponatraemia and so on, that people start to adjust  
16 their practice and use of it?

17 A. I can't disagree with that.

18 Q. Then if I can ask you about the Sick Child Liaison  
19 Group.

20 A. Yes.

21 Q. In that same witness statement, you say -- we can pull  
22 it back up so you have the benefit of it, 008/1, page 9.  
23 You don't actually say when it was founded, although  
24 you have said that the memorandum you sent out was  
25 a sort of precursor to it. Do you know when it was

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1 and the shelf life of No. 18 is three years, I believe,  
2 in boxes.

3 Looking at this graph does not give a very accurate  
4 picture of the actual numbers of bags prescribed to  
5 children. It doesn't take account, for instance, of  
6 wastage. My sister is a ward sister in the children's  
7 ward in Musgrave Park Hospital and she says that if she  
8 opens a box with maybe 10 bags in it, the pharmacy  
9 refuse to take the whole box back because it has been  
10 tampered with. That's just information I happen to know  
11 because of my sister's situation.

12 So I don't know how to interpret these figures,  
13 I don't remember any point in time, as I've said in my  
14 previous written statement, at which I or anybody else  
15 was told to stop using No. 18. It is still available in  
16 our hospital, as I've written in my answer, in strictly  
17 controlled and carefully monitored situations.

18 Q. I think it is recognised that there are some conditions  
19 for which it is appropriate to have it and to administer  
20 it. What I was wondering is: in that earlier witness  
21 statement that you provided, in relation to Adam's case,  
22 and you talked about the papers that were being  
23 circulated around about optimum fluids and so forth, is  
24 it possible that doctors, leaving aside any formal  
25 policy from the Children's Hospital, simply began to

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1 actually established?

2 A. I think it was around about that time. Because I think  
3 on that statement there was a choice of dates for  
4 consultants to meet, so it would have been the date --  
5 one of those three dates, I would imagine, would have  
6 been the first meeting.

7 Q. Thank you. Then you say its purpose was:

8 "To improve the quality of care to critically-ill  
9 children being transferred to paediatric ICU mainly by  
10 better communication."

11 And that you chaired those minutes. And then  
12 you have talked about the guidelines you provided or  
13 that were produced, and one of them included advice on  
14 fluid management of children presenting with  
15 meningococcal disease. You have also provided a minute  
16 of one of the meetings on 26 June 2001. It's at  
17 093-035-110o. Then you refer to the transport of  
18 critically-ill child guidelines, so that looks like  
19 you have actually developed a guideline at that stage.

20 A. Can I just correct you there? This is a product of the  
21 Paediatric Benchmark Nurses' Project. So it was not  
22 developed, I think as I've already clarified, in my  
23 previous written answer, to that question. This was not  
24 developed by the Sick Child Liaison Group; it was  
25 brought to that group for adaptation or for comment, and

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1 the nurses who developed the Paediatric Benchmarking  
2 Group were keen that -- they'd heard about my group and  
3 they were keen that consultants in the big four  
4 hospitals --  
5 Q. And was it adapted?  
6 A. It was adapted, yes.  
7 Q. Thank you. Under the chairman's business, you see:  
8 "Hyponatraemia. BT [that is you] presented several  
9 papers which indicated the potential problems with the  
10 use of hypotonic fluids in children."  
11 Can I ask you which papers you presented?  
12 A. I think it was the paper by Bohn & Arieff and  
13 Halberthal, I think. I think they were the major papers  
14 at the time, but I don't have a copy of the actual  
15 papers I presented. They would have been the papers  
16 that would have been in publication at that time.  
17 Q. This seems to have been a forum where you could do that,  
18 and I wonder whether you had thought of doing something  
19 similar earlier, given the research, the published  
20 research that was already out there by Arieff, some of  
21 which was new to people. For example his 1992 paper was  
22 new, and his 1998 paper prompted Dr Chisakuta to include  
23 that in his presentation. Had you thought that the  
24 issue of the use of hypotonic fluids was sufficiently  
25 important to try and get some earlier dissemination of

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1 you is why you weren't prompted earlier to do it?  
2 A. I believe, looking back through our work in the Sick  
3 Child Liaison Group, that our priority before this date  
4 and after the meeting was with the meningococcal  
5 guidelines. I believe I've already answered questions  
6 to say that deemed, through mortality reviews, to be  
7 a major problem in that era before the paediatric  
8 vaccination programme started to reduce the deaths from  
9 meningococcal disease. So I believe our work in that  
10 first year of meeting was primarily to produce an agreed  
11 guideline on meningococcal disease in Northern Ireland  
12 and that was successfully concluded by that group.  
13 Q. Does that mean that this group could be a forum for  
14 looking at things that came out of mortality meetings?  
15 A. Well, the meningococcal certainly was seen to be, and  
16 I recall it being a major concern to make sure that the  
17 child who presented with severe meningococcal disease  
18 was optimally treated the whole way through their  
19 journey.  
20 Q. Yes. If I move on from there and come to the  
21 circumstances of Lucy's actual care. I want to put  
22 something to you to see if you can help us with it.  
23 Your counsel has already given an indication, but just  
24 to confirm matters. 061-039-125. That is a chronology  
25 of care that was produced by the Trust to assist the

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1 that?  
2 A. If I had thought, I would have used this as a forum to  
3 communicate that, but if you look at the date on this,  
4 I believe this was following the death of  
5 Raychel Ferguson.  
6 Q. Yes.  
7 A. And this was, I believe, the first time that this group  
8 had considered that hyponatraemia and the use of  
9 hypotonic fluids was a problem in children.  
10 Q. Well, this meeting is dated 26 June 2001, but the other  
11 dates that were being canvassed for what turned out to  
12 be the meeting of the Sick Children's Group was -- they  
13 were all March dates, but they all seem to be in 2000.  
14 A. Yes.  
15 Q. So the previous year. And I'm wondering why you didn't  
16 think to do it earlier and why you waited, if you like,  
17 for the 2001 paper and, indeed, for that matter, for  
18 Raychel's death, because that 2001 paper preceded  
19 Raychel's death?  
20 THE CHAIRMAN: I don't think it's quite fair to Dr Taylor to  
21 say that he waited for Raychel's death.  
22 MS ANYADIKE-DANES: I beg your pardon, doctor, I didn't mean  
23 that you waited for Raychel's death, but it was  
24 Raychel's death, as I think you have just said, that  
25 prompted you to discuss this. What I'm trying to ask

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1 inquiry in the events that occurred and who was involved  
2 in those events. And if you see alongside  
3 13 April 2000, your name is included as indicating that  
4 fluids were prescribed by you to Lucy.  
5 A. Yes, I see that.  
6 Q. I can pull up the chart which is said to provide the  
7 evidence of that, 061-002-004. If you see the line from  
8 7, it's a prescription, 500 ml, and then under  
9 "prescribed by (signature)", that, I think, is where the  
10 Trust got its information. Can you help with us that?  
11 A. It's not my writing and it's not my signature. I can't  
12 help you decipher who it is, I'm afraid.  
13 Q. Thank you very much. I think Dr Crean and others have  
14 said that one of the ways you know who the consultant  
15 paediatric anaesthetist, in relation to the treatment of  
16 a child, is because they have certain designated days.  
17 So for example, Dr Chisakuta is on duty on the Friday,  
18 Dr Crean was on duty on the Thursday. Do you have  
19 a designated day for being on duty in PICU?  
20 A. At that time I did. Monday.  
21 Q. Monday would be your day? Thank you. And just to  
22 complete that, did anybody ask you about that  
23 intravenous fluid prescription sheet before that  
24 chronology was drawn up?  
25 A. Not that I can recall.

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1 Q. Thank you. I wonder if I can ask you about audit now.  
2 You were, as I think you've already agreed, a member  
3 of the clinical audit committee at the relevant time, if  
4 I can put it that way, for Lucy --  
5 A. Yes.  
6 Q. -- 1997 to 2006. In your witness statement for the  
7 inquiry, 283/1, page 12, you have said that:  
8 "The goal of these meetings was to discuss every  
9 child's death for learning purposes amongst the  
10 clinicians present."  
11 And then you say you go on to say, regarding  
12 a review of Lucy's death:  
13 "It would have been my expectation that her death  
14 was presented and discussed at one of the monthly  
15 mortality meetings, which were part of the clinical  
16 audit meeting, and this would have involved  
17 a presentation by her named consultant and the  
18 pathologist, if a post-mortem was done, followed by  
19 a discussion by the clinicians present."  
20 And you can't recall what, if any, conclusions were  
21 reached.  
22 If I pause there, maybe you can help clarify  
23 something. The mortality meetings you've described are  
24 part of the clinical audit meetings. Can you help by  
25 explaining what the two sorts of meetings are doing, if

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1 although don't quote me, but there are triggers for  
2 a patient with a sodium of below 130, I believe.  
3 That is an automatic trigger in Northern Ireland for an  
4 adverse incident -- or sometimes it's called an IRL form  
5 -- to be completed by the clinician who does that blood  
6 test or who's notified by that blood test.  
7 There's also an adverse incident to be reported if  
8 a sodium solution is given with a sodium less than  
9 130 millimoles per litre. Again, don't quote me -- it's  
10 quite difficult to remember, that's why it's on a sheet,  
11 so that one can then look it up and then one must --  
12 that guides one's reporting mechanism.  
13 That's not really clinical audit, but adverse  
14 incidents is part of governance, clinical audit is part  
15 of governance, my role as audit facilitator included an  
16 element of governance. A clinical audit is where one  
17 compares one's practice this month, a snapshot, if you  
18 like, of one's practice against a preset guideline. So  
19 one would look at the hyponatraemia guideline and say no  
20 child should have a sodium solution running of less than  
21 130, so one would compare one's practice for that week,  
22 that month, depending on the numbers, and conclude that  
23 one was 98, 99 or, I would imagine, 100 per cent  
24 compliant with that preset standard. That's the  
25 clinical audit process.

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1 I can put it that way?  
2 A. I did explain this with Claire Roberts in her governance  
3 statements, so my answers in that transcript I have  
4 reviewed and I have no addition to make to that, but --  
5 Q. I understand you wanted to do again in the light of  
6 Dr MacFaul's --  
7 A. Clinical audit is a process of looking at one's  
8 practice, one's outcomes, compared to a preset national  
9 standard. So for instance, with the current  
10 hyponatraemia guidelines issued by the NPSA and the  
11 Northern Ireland Department of Health, every guideline  
12 should come with an audit tool and this one does. It  
13 means that there are audit triggers issued alongside on  
14 the laminated form in all the clinical areas of  
15 a children's hospital. With the Northern Ireland  
16 Prevention of Hyponatraemia guideline, there are  
17 triggers that should initiate a serious incident report,  
18 and there is a need to audit one's compliance with the  
19 standards set out in a guideline. So now, to my  
20 knowledge, all good guidelines must be produced, or all  
21 good standards documents, such as this standard, must be  
22 produced with an audit tool.  
23 Q. Does that mean if you don't comply with some element of  
24 the guidelines then you have to initiate a report?  
25 A. That's correct, and in -- I checked it recently,

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1 Q. When you're doing that, does that mean, depending on  
2 what periodic interval you choose -- let's do it weekly  
3 or whatever -- does that mean you gather in all the  
4 children's notes for that week to see whether any child  
5 had a result back with a serum sodium level of less than  
6 whatever it is that creates the trigger and then you  
7 compare and see whether a report exists for that  
8 incident; is that what you're doing?  
9 A. That's correct, but can I just improve your methodology  
10 by saying instead of looking back over last week's  
11 notes, one would make out a pro forma and look at the  
12 current prospective notes? But it's absolutely correct,  
13 one would look at current practice, mostly  
14 prospectively -- doctors don't like retrospective  
15 analysis because one can miss certain things, as we  
16 know, but one would look as much as possible to look  
17 prospectively over this current week or current month at  
18 how one is complying with a guideline. That's a good  
19 audit.  
20 One then looks to see if one's deficient at  
21 achieving that standard, inserts an action plan where  
22 one wants to come up to that standard and re-audits.  
23 The big thing I was teaching as audit co-ordinator was:  
24 don't stop your audit, just as you've said, by doing a  
25 snapshot of your practice; look to improve through the

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1 audit cycle or, as I was fond of saying, the audit  
2 spiral, and come back continuously to look at a re-audit  
3 of one's practice, re-action plan it, and make it better  
4 so that one increased the quality of care to one's  
5 patients. That's the audit process as I understood it.  
6 Q. If there's a deficiency and there's a plan then for how  
7 to address that, then you audit the plan as well as the  
8 continuing --  
9 A. You audit the practice after the plan has been  
10 instituted.  
11 Q. Thank you. So that's clinical audit --  
12 A. But mortality is not --  
13 Q. We're going to come to that. Is that what you were  
14 doing in the clinical audit committee?  
15 A. The clinical audit committee -- every audit facilitator  
16 on each directorate in the Belfast Trust -- it was  
17 called the Royal Trust in that day, it wasn't the  
18 Belfast HSC Trust then, it was the Royal Hospitals  
19 Trust -- and each directorate had their own audit  
20 facilitator. I was paediatrics, somebody else was  
21 anaesthetics, somebody else was medicine, somebody else  
22 was surgery. And the convenor was Dr Conor Mulholland,  
23 he was chair at that time of the clinical audit  
24 committee and he would call a meeting of all the  
25 facilitators on a monthly basis and make sure that

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1 I believe -- my understanding of it is that every  
2 maternal and child death is now returned to a central  
3 register, confidential, and that work is -- I don't know  
4 who the contact person is -- somebody in the hospital  
5 will know that -- I will -- they will collate all the  
6 deaths centrally in Northern Ireland and then that will  
7 inform the CEMACH committee. I don't know if it's part  
8 of RQIA or the Department of Health, but every child and  
9 maternal death is reported in the same way as NCEPOD. I  
10 do not believe that was in place in 2000.  
11 Q. Does that mean that, so far as you can tell, because of  
12 the circumstances surrounding the treatment that Lucy is  
13 likely to have received at PICU, that there wasn't  
14 already a standard or benchmark by which her care would  
15 be measured at one of these clinical audit committees?  
16 A. No, but nowadays there is also an audit, if you like, or  
17 a review, which is presented at the monthly audit  
18 committee, usually every three to six months, of adverse  
19 incidents. So the adverse incidents are all collated  
20 and they are, in a way, audited to make sure that the  
21 standard is continually improved, that action is taken  
22 about, for instance, pharmacy errors, dispensing errors,  
23 prescription errors and that, through the audit cycle,  
24 there is an attempt made to eliminate all pharmaceutical  
25 errors in the same way as there might be to eliminate

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1 we were all following the correct audit procedure,  
2 supporting the audit department, and returning our audit  
3 monthly reports.  
4 Q. And if we come closer, in fact, actually to Lucy's  
5 admission, in terms of the care that she was receiving,  
6 were there actually any standards that you would be  
7 benchmarking that against?  
8 A. Um ...  
9 Q. Well, Lucy had come in in effectively a moribund state.  
10 A. Yes.  
11 Q. She had been stabilised.  
12 A. Yes.  
13 Q. She had had a CT scan, which showed the position was  
14 irretrievable, she had had two brainstem death tests  
15 which were both negative, and as a result of that she  
16 passed away on the 14th, and then there was a report to  
17 the coroner, and ultimately a hospital post-mortem was  
18 carried out and a death certificate issued. In all of  
19 that, are there any standards that would have been  
20 looked at by the clinical audit committee?  
21 A. At that time and with the time pressure, I can't think  
22 of any. Now, all perioperative deaths are captured  
23 under NCEPOD. She wasn't a perioperative death, but  
24 there's now CEMACH, which is the Confidential Enquiry  
25 into Maternal and Child Deaths. And every --

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1 other errors in the practice that's highlighted by the  
2 adverse incident reporting.  
3 Q. So far as you're aware, when Lucy died on 14 April 2000,  
4 even though the adverse incident reporting was in its  
5 infancy and maybe not even formally instigated, was  
6 there any way of achieving something like that?  
7 A. Not to my recollection at the moment. If I think of  
8 something, I will inform the inquiry --  
9 Q. Thank you very much.  
10 A. -- but I can't picture it now.  
11 Q. So then if that wasn't going to happen because that  
12 system wasn't up and running, if I can put it that way,  
13 the other way in which her death would be looked at is  
14 the mortality meeting.  
15 A. Yes.  
16 Q. And when there is a mortality meeting into a child's  
17 death, I think I understood you to say that there  
18 weren't really minutes of the mortality meeting.  
19 A. No. As I said, I asked Professor Shields this recently  
20 because he handed over to me, and he was given  
21 instructions not to keep minutes of mortality cases that  
22 were discussed.  
23 Q. Who gave him those instructions?  
24 A. Professor Mike Shields gave those instructions to me  
25 when I took over as audit facilitator.

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1 Q. What we can see, though, is, if we pull up  
2 319-023-004 --  
3 MR UBEROI: I think there may be a misunderstanding in the  
4 question and answer there. I believe the question my  
5 learned friend asked was:  
6 "Who gave the instructions to Professor Shields?"  
7 And the answer that came back was,  
8 "Professor Shields", because I think the question was  
9 misheard.  
10 MS ANYADIKE-DANES: Ah. Who would have given the  
11 instructions not to maintain minutes?  
12 A. I think you should ask Professor Shields that question.  
13 Q. Thank you very much.  
14 If we're not keeping minutes, this is the best that  
15 one receives, which is you know that five cases were  
16 presented and discussed, and then anything outside the  
17 five cases, the presentations there listed, and there  
18 will be a record somewhere of those cases, is that  
19 right, of the actual five cases?  
20 A. Yes, the PICU secretary, Mona Riley, was delegated the  
21 responsibility of the mostly administrative task of  
22 running the mortality, and I again remember discussing  
23 whether I should take over the audit facilitator or not,  
24 because I was a very busy person and Professor Shields  
25 was keen to give it up, and one of the selling points

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1 a traumatic death with a car accident or whatever, then  
2 there would not be an awful lot of items to discuss  
3 regarding that death. Perhaps about encouraging the  
4 public safety campaigns and whatever, but really some  
5 deaths were unavoidable. But deaths of a child in  
6 intensive care for a long time or who was known well to  
7 the hospital with heart disease or chronic disability,  
8 the story and the narrative leading up to the child's  
9 death would obviously be important to tell to those who  
10 would attend that meeting.  
11 THE CHAIRMAN: We'll get directly to the point, doctor: in  
12 Lucy's case would there be something substantial to  
13 discuss?  
14 A. I can't remember Lucy's case.  
15 THE CHAIRMAN: I understand that you don't remember, and  
16 we're not helped by the fact that there's no record of  
17 the meeting, but from what you know of it now, which may  
18 be different to what you knew of it in August 2000,  
19 would there be something substantial to discuss about  
20 Lucy?  
21 A. Yes, I think any death where there was concern about the  
22 death certificate or concern about the cause of death --  
23 as I have already said, these meetings were not passive,  
24 people sitting, drinking coffee, they were very active  
25 meetings and, from that, serious matters were discussed

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1 that he told me was that -- the ways not to sell me the  
2 thing was he said the mortality was a major  
3 administrative task and he found it very difficult to  
4 keep it going. So I discussed it with the PICU  
5 secretary. I said that I would like her to take on the  
6 role of recording every death that came, mostly through  
7 PICU, so she was recording -- or she had access to those  
8 deaths anyway, and that would she please take on the  
9 role of administering that task, contacting the relevant  
10 consultants, picking a date when they would all be  
11 present for the presentation and doing all the necessary  
12 arrangements, which was a lot of telephoning and  
13 organising, and leaving me free then to concentrate on  
14 what I thought I would prefer to do and be skilled to do  
15 and be trained to do, which was actually encourage my  
16 colleagues to undertake the clinical audit process.  
17 Q. Yes. When these cases were being presented, can you  
18 help us with roughly how long would be available for  
19 a discussion? It may turn out to be as long as a piece  
20 of string as it might have something to do with the  
21 complexity of the case, but can you give us an idea?  
22 A. You're absolutely right, there's a variation. Some  
23 children unfortunately will be brought in to the A&E  
24 department without a heartbeat, and obviously one's  
25 interested in knowing why they died, but if it was

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1 and -- a recent meeting, for instance, very shortly  
2 after the start of the presentation, the clinicians  
3 present asked the presenter to please stop the  
4 presentation and take the case for a serious adverse  
5 incident and the person presenting then said, "That's  
6 what I was concerned about. It seemed a bit of a grey  
7 area for me to bring it here", and that case is  
8 currently, I believe, undergoing a serious adverse  
9 incident investigation within the Trust. So this was an  
10 opportunity for people, and is now an opportunity for  
11 people, to say, "Stop, get an adverse incident going".  
12 MS ANYADIKE-DANES: Let's think about 2000 though, when  
13 you have just said that didn't really exist at that  
14 time.  
15 MR UBEROI: To be accurate, we've seen the note earlier,  
16 which shows it was coming in at exactly at that time,  
17 preceding the mortality meeting, which you're just about  
18 to go on to ask about. So there's the gap there, but  
19 we've seen it was propagated by May 2000.  
20 THE CHAIRMAN: The Royal Trust policy came in in May 2000  
21 and this meeting takes place in August.  
22 MS ANYADIKE-DANES: You're quite right, thank you very much  
23 indeed. I'm so sorry.  
24 So there was a way in which to do that. So if there  
25 is a robust exchange and there is a concern about the

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1 death certificate in the way that you may have heard the  
2 clinicians say they were still unsure really,  
3 nonetheless the death certificate was issued, but if you  
4 had asked them clinically to be able to say exactly how  
5 Lucy had died, there may have been some difficulty about  
6 doing that, and if that kind of thing emerges during the  
7 meeting, what would you have done in 2000? I know that  
8 you can't remember actually, but what would you have  
9 done?

10 A. I was the chairman, so I ensured that debate took place,  
11 that it was orderly, that we did keep to time because  
12 without a time limit this could go on endlessly and that  
13 would leave less time for another death to be discussed  
14 or another element of the agenda to be ... So there was  
15 a need for a summary, a review, but remember they only  
16 were bringing cases that already had undergone  
17 a coroner's inquest or a hospital post-mortem or the  
18 death was certifiable. So this was of the end of the  
19 investigative process.

20 Q. Lucy's death had, by this time, undergone a hospital  
21 post-mortem. There was a report in June.

22 A. I believe so.

23 Q. So if that's the case -- and some of the clinicians have  
24 expressed the view that they're not entirely sure that  
25 that had advanced matters terribly from the concerns

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1 Q. Could you have done it yourself in 2000? Because the  
2 culture may have changed more. This has been in  
3 existence for longer, maybe in 2013 people may be more  
4 predisposed to see it as a friendly act to guide them.  
5 In 2000, when it was in its infancy, people may not have  
6 regarded it in that light. If you got the feeling that  
7 there might be a resistance, did you have the ability to  
8 refer something yourself?

9 A. I would. I don't know if I would have the credibility  
10 because a bunch of paediatricians and highly-trained  
11 specialists in paediatric neurology or paediatric  
12 cardiology would say, "How is an anaesthetist telling me  
13 how to treat a patient with complex heart disease?". So  
14 I think there might have been a credibility issue with  
15 someone like me telling somebody else how the child  
16 died -- or a pathologist --

17 THE CHAIRMAN: Doctor, let me ask you this: there aren't any  
18 minutes beyond what is on the screen in front of us; can  
19 you remember or point to anything of substance which  
20 emerged from the mortality meeting in Lucy's case?

21 A. Not in Lucy's case.

22 THE CHAIRMAN: Can you help me understand why nothing  
23 emerged of substance from a discussion of Lucy's case?

24 A. I can't understand why a serious incident didn't happen.  
25 I do have experience around this time of a consultant

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1 that they had when they referred the matter to the  
2 pathologist. So let us say that that is what's still --  
3 there is still a concern about exactly how Lucy came to  
4 deteriorate and die. If that emerges in a meeting, what  
5 do you do or what do you think you would have done as  
6 chairman?

7 A. I'm an anaesthetist like Dr Crean, I'm not  
8 a paediatrician, a surgeon, a cardiologist,  
9 a neurologist. I don't have the diagnostic training and  
10 skills to work out, "Was this a death from meningitis  
11 versus brain tumour?", or whatever. So I would rely on  
12 those other attendees to say, "I know about paediatric  
13 medicine, I'm interested in this disease process,  
14 I think there was poor management of this case", and  
15 I would encourage them to get the message to the person  
16 presenting. I can tell you that when the person  
17 presenting the case which we stopped, she, the  
18 consultant, there, in that case said, "Thank you very  
19 much for giving me the confidence and the encouragement  
20 to take this to ...", so it wasn't seen as a slap on the  
21 wrist, "How dare you bring a case, you naughty person?",  
22 it was seen as a way of giving the paediatric community,  
23 the paediatric consultant and trainees support for that  
24 doctor to go ahead and make it a serious adverse  
25 incident.

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1 who did present a case and that led to an investigation  
2 of that consultant's competence through the medical  
3 director process. So this was a group of doctors and  
4 nurses who were not shy of not only encouraging that  
5 person to report it as an incident themselves, but if  
6 that person was deemed to have not reported that  
7 incident themselves, to go above that person to the  
8 clinical director or, in the case I do recall, to  
9 actually the medical director, and that led to, as  
10 I say, an investigation of that consultant's competence.

11 THE CHAIRMAN: Okay. Without going through all the details  
12 that we've been discussing for the last week, do you  
13 accept that on the information which would have been  
14 available at that time there should have been serious  
15 concerns registered about the treatment which Lucy  
16 received in the Erne and the cause of her death?

17 A. Well, yes. I wasn't there for her treatment, I wasn't  
18 there at the time of her death, I don't recall her  
19 presentation. I don't even know if her presentation was  
20 on 10 August as stated because the people presenting it  
21 were not on the attendance register and I would not have  
22 allowed, as the chairman of that session, a case to be  
23 presented without at least two of the three major people  
24 involved. So I fail -- it defies logic to conclude that  
25 her case was discussed at that meeting.

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1 THE CHAIRMAN: Okay. Then let's put it this way: Lucy's  
2 case should have been discussed at a mortality review;  
3 is that right?  
4 A. Correct. The secretary was very good and very tenacious  
5 at making sure that every case was presented.  
6 THE CHAIRMAN: Whether it was July, August, September,  
7 whenever it was, does that change the answers that you  
8 gave to me a few moments ago that nothing of substance  
9 emerged and you can't understand how there was no  
10 serious incident review on foot of the sort of analysis  
11 and exchange which would have taken place at such  
12 a meeting?  
13 A. I should caveat that by saying it was early days in the  
14 adverse incident reporting. There may have been not the  
15 full generalisation of the usefulness and the need to  
16 use that system. Certainly today, to give you  
17 confidence, there is no fear or shyness about telling  
18 a consultant that this case needs to be incidented.  
19 THE CHAIRMAN: But you remembered -- you told me a few  
20 moments ago about an incident from around that time, of  
21 issues being raised about the competence of  
22 a consultant.  
23 A. Yes.  
24 THE CHAIRMAN: So it looks as if this review system kicked  
25 in pretty quickly?

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1 paediatric department. At the same time, I contacted  
2 the consultant paediatrician involved and let him know  
3 that I felt his management of the patient should have  
4 required hypertonic saline as per the protocol, and  
5 after a discussion he agreed with me that it was fair to  
6 fill out the adverse incident form and it was fair to  
7 criticise his management, but he had been under the  
8 thinking that the child had a febrile convulsion, not  
9 a hyponatraemic convulsion.  
10 THE CHAIRMAN: Dr Crean said earlier this afternoon that the  
11 outcome of any mortality meeting in Lucy's case would  
12 have been that people would have been jumping up and  
13 down at the content of the death certificate. Does that  
14 ring true with you, his --  
15 A. I presume he means metaphorically jumping up and down.  
16 I don't think the consultants and the trainees I know  
17 would jump up and down. But I think what he's trying to  
18 express is what I've explained when this other case was  
19 presented, that a body of consultants made it very clear  
20 that this case should be stopped now and reported as  
21 a serious incident. So that would be metaphorically  
22 jumping up and down.  
23 THE CHAIRMAN: But that didn't happen and you can't help me  
24 to understand why that didn't happen?  
25 A. No, I'm sorry.

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1 A. Well, I can't remember the date of the case I quoted.  
2 THE CHAIRMAN: It was from around that time generally?  
3 A. In my memory, it seems to be from around that time.  
4 THE CHAIRMAN: Would it --  
5 A. There are other issues involved, but it was triggered by  
6 a mortality presentation, I believe.  
7 THE CHAIRMAN: Would it have mattered that, to the extent  
8 that there were concerns about the treatment which Lucy  
9 had received, that that treatment was given to her  
10 in the Erne rather than the Royal? Would that have been  
11 relevant?  
12 A. I can't truly answer for the time, but I can give you an  
13 example of a case that happened two years ago with me.  
14 A child came into another hospital -- it wasn't  
15 Altnagelvin and it wasn't the Erne, but I'm not going to  
16 name the hospital -- and the child presented with  
17 hyponatraemia. It wasn't dilutional hyponatraemia. The  
18 child was having a seizure, which was thought to be  
19 a febrile seizure. The child was intubated and treated  
20 and transferred to us, and when the child got to us  
21 I completed an adverse incident report, even though the  
22 child was no longer seizing in my department. I now  
23 know that that adverse incident report goes to my  
24 medical director, who shares it with the other  
25 hospital's medical director and it's fed down to that

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1 MS ANYADIKE-DANES: It's right, Dr Taylor, that you have an  
2 opportunity to respond to some of the points which are  
3 critical points that the inquiry's expert Dr MacFaul has  
4 made. They're all in his report, 250-003, and they're  
5 essentially three points he makes. The first is that  
6 you did not ensure that the cause of Lucy's death was  
7 adequately scrutinised at a mortality or audit meeting  
8 in August 2000. I suppose he might add to that, if it  
9 wasn't going to be August 2000, at some other point you  
10 didn't ensure that that happened.  
11 You failed to identify that Lucy had received an  
12 excessive volume of fluids at the Erne Hospital before  
13 her admission to the Children's Hospital and that her  
14 hyponatraemia was likely to play a role in that. He  
15 goes on to say:  
16 "... and that the autopsy had not disclosed the  
17 cause of the cerebral oedema from which she died and  
18 that the death certificate was illogical in its  
19 description of the sequence of pathogenesis."  
20 That is one, which may be all rolled up by saying  
21 you failed to make sure there was proper scrutiny  
22 in that way of Lucy's death.  
23 A. Well, I think Dr MacFaul is very unfair to me because,  
24 as I've said earlier, I am not a pathologist,  
25 a neurologist, a paediatrician. I do not have the

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1 skills and training to understand what the different  
2 diagnostic paediatric conditions might be that can lead  
3 to the death of a child, and it would be unfair to put  
4 an anaesthetist in charge of scrutinising the death when  
5 it would be the members of the meeting who would be  
6 better placed to scrutinise the death of that child.  
7 Q. If we conclude that bit by this question to you. If it  
8 had emerged that what had been put forward and indeed  
9 recorded as the cause of her death was what's set out or  
10 was, until it was corrected, in her death certificate,  
11 even as a paediatric anaesthetist would that not have  
12 concerned you?  
13 A. I have never seen a death certificate included in the  
14 medical records. The death certificate goes to -- so  
15 I can't comment on what the death certificate says.  
16 Q. Sorry, I beg your pardon, Dr Taylor, that's not the  
17 point I meant.  
18 MR UBEROI: [inaudible: no microphone] relevant to the  
19 question you're asking.  
20 THE CHAIRMAN: Sorry, Ms Anyadike-Danes, give me a moment.  
21 Are you saying that the death certificate would not  
22 have been at the mortality meeting?  
23 A. I have never seen a death certificate included in the  
24 medical notes. The death certificate goes with the  
25 funeral director to the Register of Deaths after the

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1 Q. Thank you. So that is one criticism he makes. The  
2 other he makes is that you failed to identify the fact  
3 that Lucy's death remains unexplained or that it had  
4 occurred as a result of treatment and failed to take  
5 steps to ensure that her death was formally investigated  
6 by the Trust and its cause the subject of an accurate  
7 explanation. Just for referencing purposes to tell you  
8 where that comes, it's 250-003-134 at paragraphs 715 and  
9 716. Can you comment on that criticism?  
10 A. Well, it's quite a long statement. I can't remember  
11 every point he made, but again I think he is unfair.  
12 I think he's confusing the audit -- sorry, I beg your  
13 pardon -- the mortality presentation with an  
14 investigation of death. And to try and suggest that  
15 I was in some way the convenor or the investigating  
16 officer of a mortality investigation is not my  
17 understanding of my role as the audit facilitator and  
18 chairman of that meeting.  
19 THE CHAIRMAN: Okay. Well, is it fair to describe it in  
20 this way, that the mortality meeting which should have  
21 raised issues about how Lucy died failed to do so?  
22 Is that fair?  
23 A. Can I give you a little bit of extra information about  
24 the mortality?  
25 THE CHAIRMAN: I was going to ask you a two-part question.

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1 body is released.  
2 THE CHAIRMAN: Are you saying then that the content of the  
3 death certificate would not have been outlined or  
4 referred to at the mortality meeting?  
5 A. Yes. There is often a note of what is included on the  
6 death certificate in the medical records. That would be  
7 the normal -- but I was asked did I see the death  
8 certificate.  
9 MS ANYADIKE-DANES: No, sorry, I didn't ask you if you saw  
10 the death certificate. I said if you were told that the  
11 cause of death was as recorded on the death certificate.  
12 That's why I corrected it because I realised that's what  
13 you had thought. That's what I want to know. If you're  
14 given that sequence, as a paediatric anaesthetist, if  
15 you heard that sequence, would that have concerned you?  
16 A. I understand, I'm sorry.  
17 Q. That's all right.  
18 A. Yes, that would not make sense, that death certificate.  
19 If I recall, it was cerebral oedema due to dehydration.  
20 That is not a correct cause of death.  
21 Q. So if that had emerged in the presentation of Lucy's  
22 death at that meeting, that is something that would have  
23 concerned you and you'd presumably want to know a little  
24 bit more about what the explanation for that was?  
25 A. That's correct.

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1 Let me tell you what the two parts are, which might help  
2 your explanation. The first is, is it fair to say that  
3 the mortality meeting should have raised concerns and  
4 issues about Lucy's treatment and death? And secondly,  
5 if it did not do so, is that a failure on the part of  
6 that meeting? Rather than perhaps a personal failure to  
7 you, is that a failure on the part of that meeting  
8 because it failed to achieve what it should have  
9 achieved?  
10 A. Yes. The extra information -- you can decide if it's  
11 relevant or not -- is that the pathologist is the trump  
12 card. When a pathologist presents the pathological  
13 organs, the cause of death, he or she is the person who  
14 gives the final answer. I have never been at  
15 a mortality review where the pathologist's cause of  
16 death has been not taken as the gold standard. In fact,  
17 in Toronto it was very often very dramatically portrayed  
18 that the clinicians would present the clinical course of  
19 the patient, the investigations, the presumptive  
20 diagnosis, and then it would be all revealed by the  
21 pathologist.  
22 Now, that wasn't quite as dramatic in Belfast, but  
23 certainly when the pathologist stood up and showed how  
24 the patient's organs looked after the time of death,  
25 that was seen to me as the gold standard of the

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1 mechanism, the cause of death, and it was never to my  
2 memory disputed by the clinicians.  
3 MS ANYADIKE-DANES: Is that because, Dr Taylor, by the time  
4 you got to this mortality meeting and the pathologists  
5 would be presenting together with the clinician, if you  
6 like, that the clinicopathological correlation had  
7 already taken place? So if there was an impact of what  
8 the clinicians had seen during treatment with what the  
9 pathologist was finding on autopsy, that reconciliation  
10 or correlation had already occurred?  
11 A. I couldn't put it better myself. Correct.  
12 Q. I have only two more questions to ask you, Dr Taylor,  
13 subject to what anybody else may say. One is, when  
14 Dr Crean was giving evidence, he said, and it was  
15 particularly in relation to the difference, if I can put  
16 it that way, between the paediatric understanding of  
17 appropriate fluid regimes, particularly in relation to  
18 the use of low sodium, and maybe the paediatricians, so  
19 between the anaesthetists and the paediatricians, if I  
20 can put it that way, and he said that they were forever  
21 going back to their colleagues in the district hospitals  
22 if they saw that some inappropriate regime had been  
23 used.  
24 I think he referred to always telephoning colleagues  
25 in the district hospitals about using hypotonic

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1 A. I recall offering this document. I do not recall the  
2 circulation list, but it's likely that I would have sent  
3 it to various hospitals.  
4 Q. It's likely you would have sent it?  
5 A. Yes, or I would have given it to a colleague who was  
6 from that hospital.  
7 Q. And if you were doing that to the Erne, then can you  
8 recall why you would have been doing it, what would have  
9 been prompting you to do that?  
10 A. I think this was following the death of  
11 Raychel Ferguson.  
12 Q. Then I think we'll leave it for investigation later on  
13 to perhaps investigate better the circumstances of it.  
14 I recognise you have only seen it latterly.  
15 A. Thank you.  
16 MS ANYADIKE-DANES: Mr Chairman, I have no more questions.  
17 THE CHAIRMAN: Thank you very much.  
18 Mr Quinn, have you anything for the doctor before  
19 I come to Mr Uberoi? Any questions from the floor?  
20 Mr Uberoi?  
21 MR UBEROI: No, thank you, sir.  
22 THE CHAIRMAN: Doctor, thank you again. Thank you for  
23 coming back.  
24 (The witness withdrew)  
25 Ladies and gentlemen, that concludes today. We've

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1 solutions for replacement as well as maintenance or if  
2 they became concerned in some other way about the fluid  
3 regime that had been used in the referring hospital.  
4 Did you yourself engage in that in phoning the referring  
5 hospital and speaking to the paediatrician and  
6 explaining your thoughts on the fluid regime?  
7 A. Well, I've given an example of when that happened to me  
8 recently, yes.  
9 Q. But in 2000 did you do that?  
10 A. I have no recollection of doing that in 2000.  
11 Q. Do you believe you were engaging in that practice that  
12 far back?  
13 A. I don't think I ever commented on somebody's fluid  
14 practice, but I would probably have commented on  
15 somebody's drug practice, on what drugs they used to  
16 resuscitate a child with meningococcal disease, for  
17 instance.  
18 Q. Then the final question is -- and if we can pull up  
19 043-101-223 and then 224 alongside it. This is  
20 a document that I appreciate you haven't had very long  
21 to look at and, in any event, it's likely to be the  
22 subject of another part of this investigation, but it  
23 might help if you can address this with me. Do you  
24 recall whether you sent this document out to the  
25 Erne Hospital or Sperrin Lakeland Trust?

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1 got Dr Hanrahan tomorrow at 10 o'clock. Thank you very  
2 much.  
3 (5.08 pm)  
4 (The hearing adjourned until 10.00 am the following day)  
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I N D E X

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3 DR PETER CREAN (called) .....4  
4 Questions from MS ANYADIKE-DANES .....4  
5 DR ROBERT TAYLOR (called) .....161  
6 Questions from MS ANYADIKE-DANES .....161  
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