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STATEMENT OF DR RJ M QUINN MB, FRCP, FRCPCH DCH Consultant Paediatrician

I am a Consultant Paediatrician at Altnagelvin Hospital, a post I have held since 1978. I qualified in medicine from Queen's University, Belfast in 1970 and passed my MRCP examinations in 1973. I am a Fellow of the Royal College of Paediatrics and Child Health, the Royal College of Physicians and Surgeons of Glasgow, the Royal College of Physicians of Edinburgh and the Royal College of Physicians of London. I am also an Examiner for the Royal College of Paediatrics and Child Health and an Examiner for the Royal College of Physicians and Surgeons of Glasgow.

In the days following the death of Lucy Crawford, I was contacted by telephone by Mr Hugh Mills, Chief Executive of the Sperrin Lakeland Trust to ask if I was willing to review the Hospital notes of the child and comment on certain aspects of the case. In the first instance I agreed only to look at the notes and records and consider whether I would be in a position to agree to discuss them. I was supplied with photocopies of the child's Erne Hospital Notes and Records on 21st April 2000 and was asked for my opinion on:-

1. - The significance of the type and volume of fluid administered;
2. - The likely cause of the cerebral oedema;
3. - The likely cause of the changes in the electrolyte balance, in other words was it likely to be caused by the type of fluids, the volume of fluids used the diarrhoea or other factors.

I reviewed the notes and records and made a hand written summary of them and questions that occurred to me as I was reading the records. I then telephoned Mr Hugh Mills and said that whilst I would review the records and discuss them with representatives of the Trust, I

was not willing to become involved in preparing a report for a complaints procedure, nor in preparing a report for medical/legal purposes. I made it clear to him that I would not interview the doctors involved, the nurses or the family and that if I accepted the papers it was only with a view to reviewing the records and discussing the issues which occurred to me as I read them. My recollection of events is that I recommended that they obtain an opinion from a Consultant Paediatrician, from outside the Western Board Area, for such purposes.

In June 2000 Dr J Kelly, Medical Director and Mr Eugene Fee, Director of Clinical Services at the Erne Hospital came to my office to discuss my review of the notes and records. We had a full discussion of the notes and records and I recollect advising both Dr Kelly and Mr Fee that I could not be sure, based on the limited information available to me, of the cause of the cerebral oedema in this case. There can be a number of causes of cerebral oedema. It was not possible to provide a conclusive opinion from the information contained within the notes and records. We did discuss the issue of fluid administration and I recollect pointing out, particularly to Mr Fee, that he needed to ascertain from staff involved in the care of the child the exact volumes of fluid given from admission to the possible "fit" before 3 a.m. and also during the subsequent resuscitation. I pointed out that there had been no prescription written for the fluids and that after 3 a.m. it appeared that normal saline had been allowed to "run freely" intravenously. Nowhere in the notes is it stated that the child gave the appearance of being "shocked" which would have required another fluid regime. We also

discussed inappropriate anti-diuretic hormone secretion which can occur in some sick children causing abnormal water retention.

At the conclusion of my meeting with Dr Kelly and Mr Fee I was asked to summarise on paper what we had talked about. The case note which I prepared is not a medical/legal report. It is a summary of my review of the case notes and records together with some of the questions which occurred to me whenever I was reviewing the records. When I prepare a medical/legal report I have an established format which would be to record the history, examination, provide a summary of the care and finally conclude with my opinion. The document which I produced in this case does not follow that format and this is for the simple reason that it was not intended to be used as a medical/legal report. I neither asked for, nor received, a fee for my review.

I was not called as a witness at the Coroner's inquest although I understand that aspects of my case note summary were discussed during the course of these proceedings. The document which I had prepared was not intended for this purpose. I understand that a copy of the document was not provided to the Coroner.

At lunchtime on Saturday, 25th September 2004, I was "doorstepped" by an Ulster Television Reporter, Trevor Burney. He had a copy of the document I produced in his hand and aggressively questioned me on aspects of its contents. During the course of this stressful confrontation with Mr Burney I said that, after discussions in my office, I was "sweet talked"

into writing down the case note summary. I did not intend this to mean that the content of my case note summary was in anyway influenced from anyone from the Sperrin and Lakeland Trust but rather that I had made it clear to Mr. Hugh Mills that I did not want to prepare a written report in this case. At the end of my meeting with Dr Kelly and Mr Fee I was asked to provide a written summary of our discussion and in this way I was "sweet talked" into writing the case note summary, rather than limiting my involvement to a discussion of the records. I was never asked to leave things out of the case note review nor to add anything to it. The case note review was a summary of the discussion and not a record of the totality of the issues which were discussed.

I understand that aspects of my case note review were subsequently criticised, particularly in relation to the paragraph headed "Fluids" on page 2. I wrote that "treating with Solution 18 (N/5 saline/dextrose)" was appropriate. This was the most commonly used intravenous solution used in the UK at that time as a maintenance fluid in a child with the perceived diagnosis of a "viral illness" and therefore I used the term "appropriate". I calculated the volumes of fluid over a 7 hour period, in other words from admission, for maintenance, 5% dehydration and 10% dehydration. I did indicate that I would be surprised if the volumes recorded in the notes could have produced gross cerebral oedema causing "coning", within that time-frame but during my discussion with Mr Fee had made it clear that he would need to check with the nursing staff exactly what fluids had been given.

Signed _____

Dr R J M Quinn

QSC Cross has asked me was I provided with a copy of Lucy Crawford's post mortem report. No I wasn't. QSC Cross has asked me who my report was sent to. Or was sent to Dr Lee, at the Royal Hospital. QSC Cross has asked me was I aware of any concerns raised by Dr Aiyegbusi in relation to Lucy. ~~No~~ Again No, I was not aware of any concern. Given the circumstances of Lucy's death, I feel that ~~[illegible]~~ from my experience that the coroner would have been involved. QSC Cross has asked me if any other significant issues were discussed during the meeting with Dr Kelly and Dr Lee that are not summarised in the report. I recall that Dr Kelly asked me should any member of medical staff be suspended on the basis of the information available to me. I answered that it was not a decision for me to take.

QSC Cross has asked me why I averaged Lucy's fluid intake over a 7 hr period rather than over the 4 hr period. I would