POLICE SERVICE OF NORTHERN IRELAND

Police Identification Mark WRC108

SUMMARY OF TAPE RECORDED INTERVIEW

TAPE REF NO:	PERSON INTERVIEWED:	TREVOR ANDERSON	
BDV 94/05	ADDRESS:	C/O ERNE HOSPITAL	
Master Tape Seal Number(s):	DOB:	[redacted]	
T17957A	PLACE OF INTERVIEW:	GROSVENOR ROAD PSNI	
	DATE OF INTERVIEW:	04/05/2005	
	TIME COMMENCED: 1029 HOURS	TIME TERMINATED:	1110 HOURS

INTERVIEWING OFFICERS:	OTHER PERSON(S) PRESENT:
1 D/SERGEANT CROSS, CARE UNIT, ENNISKILLEN PSNI	1 [redacted] SOLICITOR
2 D/CONSTABLE HALL, CARE UNIT, ENNISKILLEN PSNI	2
3	3

MADE BY: D/SERGEANT CROSS

Tape Number and Tape Times:

PACE 10 completed, rights of a voluntary attender explained, introductions made, reasons for the interview explained, caution given and explained.

Doctor Anderson was invited to read a prepared statement.

I, Doctor Trevor Anderson, Consultant Obstetrician at the Erne Hospital, employed by the Sperrin Lakeland Trust have made a statement of my own free will. I understand that I do not have to say anything, but if I do mention something, which I later rely on in court, it may harm my defence. I qualified in medicine in 1968 at Queen's University, Belfast. I specialised in Obstetrics and Gynaecology and obtained MRCOG in 1973. I worked in Rhodesia for one year, South Africa for one year, Canada for a year and over 20 years in South Africa at an Urban Mission Hospital in Durban. I worked in a hospital in Durban as Consultant in charge of Obstetrics and Gynaecology and the last seven of these years was working as the Medical Superintendent

Dr Anderson: as well as my Clinical role. I was then involved in private practice for five years in South Africa and completed voluntary sessions at the Mission Hospital. On the 1st of April 1998 I became Consultant obstetrician at the Erne Hospital and also became Clinical Director some twelve to eighteen months later. I resigned from the post of Clinical Director in March 2004 as I was almost 60 years of age and now continue as a Consultant in Obstetrics and Gynaecology at the Erne Hospital. At the time of Lucy Crawford's death I was Consultant Obstetrician and also held the position of Clinical Director of Woman and Children's Health. As Clinical Director I reported to Mr Fee, the Director of Acute Hospital Services in relation to management and administration issues and I reported to Doctor Kelly in relation to professional staff personnel matters. Myself, Mr Eugene Fee, Mrs Millar the Clinical Services Manager, and Doctor Halahakoon, the Consultant Paediatrician, she was actually the lead Consultant Paediatrician, met on a monthly basis to discuss the management of the two areas, i.e. Clinical issues and administrative issues, such as staffing, interviewing and protocols. Doctor Kelly was the Medical Director involving in overseeing medical performance where as Mr Fee was in charge of the administrative issues. They were both on the senior Hospital Management Team. Both reported to Mr Mills, the Chief Executive of the Trust, I did not report to Mr Mills directly. On the 14th of April Doctor O'Donohoe from the Erne reported to Doctor Kelly that there had been an incident involving a patient, Lucy Crawford. It is a small hospital and my recollection was that I heard informally and would have said to those involved to write up good notes. I cannot recall if this was have been before or after Doctor Kelly was notified. Mr Fee advised me that he was approached by Mr Mills the Chief Executive of the Sperrin Lakeland Trust and asked that he and I would carry out a review of Lucy Crawford's care in the Erne Hospital to

include looking at the notes to see if there had been any mistakes or lessons to be learned regarding the issues. This was in keeping with the arrangements coming into place for reviews of clinical incidents or untoward events. Mr Fee and I requested access to the notes and went through them. It became apparent straight away that there were some deficiencies in the notes, i.e. poor documentation. We had a meeting with the majority of those involved to say that a review was being carried out and that we would be seeking reports from each person involved to include Nurse McCaffrey, Nurse MacNeill, Doctor Malik, Nurse Swift, Doctor O'Donohoe, Sister Traynor, Nurse McManus, Doctor Auterson and Nurse Jones. To the best of my knowledge Mr Fee wrote out to each of these parties and we considered the reports, which we received. But upon looking at the fluids, drugs and dosages used we felt we would need an independent external opinion from a Paediatrician. I believe Mr Mills sourced Doctor Quinn. I was not involved or consulted in his choice. Mr Fee and Doctor Kelly met with Doctor Quinn. I was on holiday when this meeting took place. Doctor Quinn later provided a report to ourselves. I did not pen a letter to Doctor Quinn or discuss with him in advance of his compelling the report regard the ambit of his investigation. I have not met Mr Quinn, I was aware he was retained and got a copy of his report and I was content with that. On the basis of the reports from the staff and from Doctor Quinn, Mr Fee produced a draft report and sought my recommendations. I wrote a report on my findings to Mr Fee, he then wrote a report to Mr Mills, which incorporated my recommendations. When I was compiling information and considering matters for the purpose of my report I was in position of the preliminary autopsy report and not the final report. But I understand that Doctor Quinn was advised of the content of the final report by Doctor Kelly and Mr Fee. I

had no further role other than that I received informal feedback regarding what was going on at our monthly meetings thereafter. I had no contact whatsoever with the Royal Belfast Hospital for Sick Children or the Pathology Department regarding Lucy Crawford. Doctor Asghar was a Staff Paediatrician working in the Paediatric Department for a number of years. He was not involved directly in the Lucy Crawford case, but he was critical of Doctor O'Donohoe's Clinical management of the case. I cannot remember how and to whom he expressed this in the first instance. I discussed his criticism in relation to Doctor O'Donohoe's competence in the Lucy Crawford case with Doctor Halahakoon, who was the Senior Consultant in charge of the Department. She assured me that Doctor O'Donohoe in her opinion was not incompetent. He may have an unusual manner, but she thought he was not incompetent. Doctor Halahakoon was the most Senior Consultant in the Paediatric Department and Senior to Doctor O'Donohoe. There were personality clashes within the Department at a high level, none more so than between Doctor Asghar and Doctor O'Donohoe. There was an ongoing poor relationship between these two. When I heard of the criticism I felt it fair to take it to Doctor Halahakoon to see if the criticism was valid. I sought only an informal report from her on the Lucy Crawford case as it was felt that an in house report from her would not have been sufficient. Her comments would have been informal. Sometime later Doctor Asghar penned a letter to Mr Mills alleging medical incompetence against Doctor O'Donohoe. Actually he has written competent it should be incompetence, that's a typing error. I was also copied in on that later as were others such as Doctor Kelly. In this Lucy Crawford's case and three other patients were mentioned. I recalled discussing it with Doctor Kelly and he decided to call in the Royal College of Paediatrics and

Child Health and I agreed. They were brought in by Doctor Kelly. I got a copy of the report thereafter but was not present at any interviews with those concerned. I recall that Doctor Asghar then alleged incompetence and bullying by Doctor O'Donohoe against himself. Again the Royal College of Paediatrics and Child Health were involved and again they reported no evidence of incompetence or gross mismanagement. I was not called to the Lucy Crawford Inquest.

D/Sgt Cross: That's fine thank you very much. Could you just describe for me what the role of a Clinical Director is?

Dr Anderson: Ok. ... Very much sort of co-ordinating the administrative side of running the department. Now I'm an Obstetrician, I'm familiar with the obstetrics side, I'm not a Paediatrician.

D/Sgt Cross: Yes, right.

Dr Anderson: And I didn't volunteer for this post, I was appointed because nobody else would take it and so I very much relied on Doctor Halahakoon to run the Paediatric side and she reported to me what was going on.

D/Sgt Cross: So you were in charge of Paediatrics and the Obstetrics side and gynaecology.

Dr Anderson: They came under my.

D/Sgt Cross: They came under you ok. And...you've described that you would answer to Mr Fee re management and administration and to Doctor Kelly for staff and personnel.

Dr Anderson: As far as medical competence or otherwise.

D/Sgt Cross: Right. Could I ask had you any direct discussions with Doctor O'Donohoe in relation to Lucy's condition and decline?

Dr Anderson: I couldn't honestly remember what discussions I would have had, I have no doubt that we would have informal discussions, but you know if you were ask me what they were or when they were I honestly couldn't remember.

D/Sgt Cross: Yes. Right. Well, Doctor, the main concerns I suppose we had were around the review that Mr Fee and yourself did for Hugh Mills and I suppose Doctor Quinn's involvement in that too. And you have described broadly speaking that you had no part at all in the selection of, or discussions with, Doctor Quinn.

Dr Anderson: Correct.

D/Sgt Cross: That was for others.

Dr Anderson: I've never met the man, ever seen the man, I have had no contact with him at all.

D/Sgt Cross: Right. And you're there from 1998?

Dr Anderson: Yes.

D/Sgt Cross: So there has been, there have been questions raised about the independence of Murray Quinn, whether he was a proper choice or not. When you say you've never seen him then that's is corroborating to a degree what others have said, that actually while he did have a role in the Erne, he hasn't had a role in the Erne since Doctor O'Donohoe went there.

Dr Anderson: I understand I only found this out very recently that he used to come to do clinics but I've never met him and I think it was before I arrived.

D/Sgt Cross: Right.

Dr Anderson: Doctor O'Donohoe was there before me as well.

D/Sgt Cross: And could I ask doctor whenever your review with Mr Fee was being conceived you were going to interview, you listed Nurse McCaffrey and MacNeill etc. Malik and so forth, you were going to interview them.

Dr Anderson: We were asking for a report, we didn't actually interview them.

D/Sgt Cross: Sorry yes. What roles specifically did you envisage Doctor Quinn had?

Dr Anderson: I envisaged him giving us professional input into the actual management in terms of the drugs used, fluids used, volume of fluids used, Mr Fee is a background of a Mental Health Nurse, I am an Obstetrician. When we sat down to look at the notes it became very apparent to us that we had no idea whether the solution used was correct or incorrect, whether the dosage used was correct or incorrect, and so we felt we needed a professional independent expert to tell us.

D/Sgt Cross: Right and would you have felt it was part of Doctor Quinn's role to interview for instance, the nurses, the family or did you perceive that wasn't his.

Dr Anderson: I didn't perceive that to be his role, I perceived his role of that of commenting on the treatment that was given and whether the treatment was appropriate or inappropriate.

D/Sgt Cross: Right. Right and to summarise your view of Doctor Quinn's assessment did he say it was appropriate or was inappropriate how did you feel he assisted the review?

Dr Anderson: Right. As I said, I can't remember what I said or not, but we understood at the beginning that we were looking in to see if any mistakes had been made.

D/Sgt Cross: Yes.

Dr Anderson: And whether were there any lessons to be learned. I felt on reading his review and he had had access to the final post-mortem report at that stage, which I hadn't, but having read his review that he did not identify any obvious gross mismanagement, which to me was part of the remit we were looking at. Had we made any gross mistakes as far as my reading of his report was there had been no obvious gross mis-management.

D/Sgt Cross: Right, right. This is maybe jumping slightly sideways, but you have mentioned in your statement and again there that Doctor Quinn had sight of the full post-mortem report.

Dr Anderson: Yes.

D/Sgt Cross: How do you know that Doctor? ...I will tell you why I asked that, there are others of your colleagues are saying the exact same as you, but Doctor Quinn maintained he never saw the post-mortem report at any stage.

Dr Anderson: Right. Eh ... my information on that was that Doctor Kelly and Mr Fee when they met Doctor Quinn apprised him of the full post-mortem report, now whether they actually brought it in person or whether they told him about it verbally I don't know. I wasn't at the meeting.

D/Sgt Cross: Right ok.

Dr Anderson: And I think if I'm not mistaken he also quotes from the final post-mortem report, he quotes things like pneumonia, which was not in the initial report.

D/Sgt Cross: That's right. And do you recall, Doctor, that at any stage in I suppose considering the reports from the nurses or Malik or anyone, the issue of excess fluids being raised as a possible factor?

Dr Anderson: One of the things that Mr Fee and I, when we sat down to look at the notes, one of our concerns was - was the correct fluid used, and was the correct volume of fluid used? As I said there was deficiencies in the documentation and that was essentially our question to Doctor Quinn.

D/Sgt Cross: Right.

Dr Anderson: So we didn't know whether it was appropriate or whether it was excess or whether it was not. And his statement clearly said that he did not feel that the amount of fluid used would have been sufficient to have caused the death of the child.

D/Sgt Cross: Did any of the nurses raise concerns about the amount of fluid?

Dr Anderson: As I said there was a discrepancy between what Doctor O'Donohoe says he ordered and what the nursing staff heard him say. But the nursing staff at the same time said that the order which they understood was a, an order which was quite commonly used 100 mls an hour until the child passes urine. So they did not feel that was out of the normal.

D/Sgt Cross: Yeah. Maybe I pushing you beyond your memory you know, but do you recall, Doctor, which nurses said that?

Dr Anderson: I don't honestly. It's in one of their statements, in fact there is a statement I don't know if you would have it or not.

D/Sgt Cross: We would have yeah.

Dr Anderson: Ok. There was a statement ok, made by Sister Traynor the sister in charge of the ward that she understood that that was a commonly prescribed regime.

D/Sgt Cross: Yeah.

Dr Anderson: That was I think in an interview between herself and Doctor Kelly, when he interviewed her.

D/Sgt Cross: Yes.

Dr Anderson: I wasn't involved in that.

D/Sgt Cross: No. And, Doctor, what I want to do, there are quite a number of questions that really all relate to the review broadly speaking, you have covered the most of them, but for the sake of completeness I want to flick my way through them.

Dr Anderson: Sure.

D/Sgt Cross: ...There is a note where at one stage you discussed the suspension of Doctor O'Donohoe with Mr Fee, now suspension maybe is not the right word, because there would be the potential I suppose if there are medical reasons to restrict his access to patients without it being suspension, but do you recall a discussion of that nature?

Dr Anderson: I think it was part of the remit that we were given...I can't remember the exact wording, to see whether there should be any adjustment to the staffing of the unit. Again we did not feel that we were competent to comment on whether his management was such as warranted suspension or withdrawal from duty.

D/Sgt Cross: Yes.

Dr Anderson: That would be the responsibility of the Medical Director, Doctor Kelly. He would be ultimately responsible for medical competence and again after Doctor Quinn's report, we felt satisfied that there was no reason to suspend or to change the staffing.

D/Sgt Cross: Right and is that one of the reasons you discussed the issues with Doctor Halahakoon...

Dr Anderson: Yes...I relied very heavily on her as far as the management of the paediatric side was concerned, not being a Paediatrician. And in an informal discussion with her I would have said, Look, do you think Doctor O'Donohoe has done something grossly negligent, is he incompetent, is he safe? And her answer very clearly was he's a strange character, he's a difficult personality, but he's not incompetent.

D/Sgt Cross: Right. I think I provided you with a copy of the letter from Doctor O'Hara to the Coroner, Doctor O'Hara.

Solicitor: You did.

D/Sgt Cross: Doctor O'Hara was the Pathologist who did the post-mortem. Doctor, he says at the start that there was a difficulty at the time with Lucy's death that may lead to litigation, do you recall reading that?

Dr Anderson: I've heard that recently, I didn't have that at the time.

D/Sgt Cross: Well, we got that in the Coroner's file. Do you recall any discussion of that nature amongst the medical staff at the hospital?

Dr Anderson: Not specifically other than that we live in an era now where anything that goes wrong is potentially litigatious, if that is the right word.

Solicitor: Litigious even, I'll help you out; I think that's permitted.

Dr Anderson: You know we live in such an era now if somebody dies, it's a possibility.

D/Sgt Cross: Yes. Doctor, could I ask, you may not be able to be specific in this, do you recall when the Erne got the preliminary post-mortem report and when the final one arrived.

Dr Anderson: I can't remember when we got the preliminary one, I have seen the date stamped on the final one, it was stamped the 13th of, sorry dated by the Coroner the Pathologist, the 13th of June, I have also got a note from Doctor O'Donohoe that he received it, I think maybe it was the 21st of June and it was certainly available when Doctor Kelly and Mr Fee met with Doctor Quinn.

D/Sgt Cross: Yes. Right.

Dr Anderson: I wrote my report in July and I was actually unaware they had even received the final post-mortem report and I mentioned that in my report that I did not have sight of it.

D/Sgt Cross: Right. Yeah. The post-mortem report I would have to say confuses most people, not just the police, because it appears differently every where you see it, in what the Erne has is different to what we got from the Royal, not significantly, but page order etc. And what we have, this is a direct photocopy from the Erne and I think it is at the start of Lucy's notes. Here we have the final anatomical summary. It is dated the 13th and I assume that is Doctor O'Hara's signature on page 2.

Dr Anderson: Hm hm.

D/Sgt Cross: So when you talk about the final post-mortem report, is this what you're talking about?

Dr Anderson: That is the copy that I have subsequently received yes.

D/Sgt Cross: Right. Now whenever you go to page 9 of the Erne notes, we have a provisional anatomical summary.

Dr Anderson: Yes.

D/Sgt Cross: Is that?

Dr Anderson: I would have seen that initially.

D/Sgt Cross: You see what puzzles me is that that appears in the Royal notes on an additional page, but it's differently numbered with minor differences here.

Solicitor: I haven't discussed this was Doctor Anderson, but certainly there appears to have been a preliminary report which was obviously the first report numbered 1-5 I think it was and whether you're wondering did that get to.

D/Sgt Cross: Yes, am I right since you say you saw the provisional report is this what you saw then?

Dr Anderson: To the best of my recollection. I didn't take note of the numbers.

Solicitor: To be fair you couldn't assume comment about whether it is that particular page.

Dr Anderson: It looks similar if not exactly the same.

D/Sgt Cross: Now again for our information if you know, if a child dies in the Erne, sorry is sent from the Erne to Belfast and a post-mortem is conducted in Belfast, what is the normal form of communication between Pathology and yourself, do you normally get this provisional one first quickly and then a full one later?

Dr Anderson: Yeah, the again I am working from fairly sketchy experience of the situation here, thankfully in our department not too many people die, but yes they would normally do their post-mortem usually within the next day or so, they would write a preliminary report, then they would take slides and it would be some time before they would actually sit down and analyse the slides and come to their final, that would be normal.

Solicitor: May I intervene here, and suggest may you have received that verbally?

Dr Anderson: No.

Solicitor: You think you actually saw?

Dr Anderson: You mean the actual.

Solicitor: Well the preliminary results?

Dr Anderson: Now that I can't remember honestly.

Solicitor: You just wouldn't know.

Dr Anderson: In my report, in my letter which I wrote to Mr Fee I comment that I was aware of the preliminary, whether it was read to me or whether I actually saw it, I really couldn't.

D/Sgt Cross: That's grand... You have largely covered this, Doctor, but there were issues about the fluid therapy, but from investigation point of view there is a difficulty in that the nurses are saying 100 mls an hour every hour until urine is passed, whereas Doctor O'Donohoe is saying something different to that. But it is your recollection that some of the nurses said that was common enough practice, I think the review says standard practice and I can't really ask you when did you last see it used, because you're.

Dr Anderson: I've never seen it used.

D/Sgt Cross: You've never seen it used, that's fair enough. Can I ask, you have said that the nurses had one view and Doctor O'Donohoe's was different.

Dr Anderson: Yes.

D/Sgt Cross: How do you know what Doctor O'Donohoe's view was?

Dr Anderson: I can't remember exactly whether he had put it in his report or whether he said to me verbally, but I certainly am aware that his claim was that he stated, I think it was in his report, that he had ordered 100 mls in the first hour and then 30 mls thereafter. I think it was in the report written.

D/Sgt Cross: That's fair enough, he wrote that in the medical notes. Do you recall discussing that with him then?

Dr Anderson: I can't recall.

Solicitor: Is it right I think to say that you received a letter from Doctor O'Donohoe in the early stages of your preliminary investigation?

Dr Anderson: Yes, he wrote his letter to me, I don't know why he didn't write it to Mr Fee, I suppose he assumed that we were working together.

D/Sgt Cross: Right, well what I'm asking you is then I suppose, I can show you the note, you don't recall actually discussing personally with him how he worked out his prescription, the 100 mls and then the 30, why 100, why 30?

Dr Anderson: I honestly can't remember. My, whether he said it in his report or whether it was reported second hand, the impression I have was that 100 mls was to correct any backlog and then maintenance thereafter. But I, to be perfectly honest, I don't remember whether it was a face-to-face discussion or whether it was in one of his reports.

D/Sgt Cross: Yeah. Right I think yeah, I mean for your information, I think this is the entry here, Doctor Crean rang from the Royal showing the regime, was 100 mls over one hour.

Dr Anderson: One hour followed by 18 per cent sodium chloride, dextrose 4 per cent at 30 mls per hour, he said that he thought, that it had been employed 18 per cent dextrose 100 mls per hour. A bolus over one hour and 30 mls per hour as above.

D/Sgt Cross: Right and that's your recollection.

Dr Anderson: I was aware there was a conflict between what he claimed and what the nurses claimed.

D/Sgt Cross: And again for the purpose of the tape I'm reading there from page 23 of the Erne notes.

Solicitor: Would it be an important point to remind for the purposes of the tape that that was something that came out in your review, that you did see this as an area of?

Dr Anderson: Certainly an area of deficiency. To me and I have said this to him that his biggest mistake was not writing down what he ordered, having said that it was midnight and often would say to our junior ok this is what I want you to do and we maybe not check what the junior has written and I don't know, it wasn't clearly documented any way.

D/Sgt Cross: That I think is the root of the whole problem whoever's to blame obviously on the ward, the nurses didn't get a written.

Dr Anderson: They did not have anything to refer to.

Solicitor: And that was something.

Dr Anderson: And I highlighted, in my recommendations, I highlighted that they should be written down and definite protocols that people can follow.

D/Sgt Cross: Yeah but as far as the police are concerned you, those are serious issues, but you weren't part of that. So we accept that. There's one thing in Doctor Quinn's report and it does appear very surprising, to maybe a lay person, it's this issue about the 7½ hour period about average intake over 7 hours, 7½ hours as opposed to 4 hours. Doctor Quinn is of the view that the IV solution used and the total volume of fluid intake was spread over the 7½ hour period would be within the accepted range.

Dr Anderson: I think, I read that as being not just specifically intravenous, the total volume of fluid intake, which would have included what the child drank before the IV fluids were put up.

D/Sgt Cross: Right, so for that reason you were happy enough with that explanation from Doctor Quinn?

Dr Anderson: I know very little about paediatrics, as far as I was concerned, a senior experienced Paediatrician from a different Trust altogether, who tells me that was not inappropriate; I didn't see any reason to argue with him.

D/Sgt Cross: Right.

Dr Anderson: I was in no position, but my inexperience against his.

D/Sgt Cross: Right. Doctor did you discuss Murray Quinn's report with anyone in Belfast or in Pathology?

Mr Anderson: No. I had no contact with Belfast or Pathology at all.

D/Sgt Cross: Right. Again in the review.

Solicitor: For the sake of clarification is that Doctor Anderson's report or is that Mr Fee's report you are reading from?

D/Sgt Cross: This is what it's WRC3, is our, it's the review.

Solicitor: Penned by Mr Fee do we believe ...

D/Sgt Cross: Well it was conducted by Doctor Anderson and Mr Fee. Now I understand this was the first document, Doctor, that we received in relation to this. Now, indirectly, we obtained it from the family.

Dr Anderson: Right.

D/Sgt Cross: But having spoken to I suppose... Mr Mills I understand now that what you produced actually was not this, it was a far fuller document, this was the abbreviated form given to the family.

Dr Anderson: I didn't see what the family received.

D/Sgt Cross: Well this is it I think it's four pages... I'm not saying there was anything devious in that now, there was nothing left out of any great significance.

Dr Anderson: Right.

D/Sgt Cross: But the appendices are not attached here; say the report that you would have got from Nurse McManus, that was attached to yours as was all the other reports that you got, that wasn't handed out to the family.

Dr Anderson: Yes, I think we handed, what I saw as the final report was about four pages long, based on all the other information.

Solicitor: Are we talking about then the final report that we have termed as the Mr Eugene Fee report?

Dr Anderson: There was a report, there was a draft report that Mr Fee sent to me, which I read in conjunction with Doctor Quinn's report and the reports from the various nurses etc. and I wrote a letter, which is just over a page long, a page and a half long, back to Mr Fee and on the basis of that then he produced a report which incorporated the recommendations which I made.

Solicitor: Well I think then this is it. Yeah.

D/Sgt Cross: I think yeah, just so that we are a hundred per cent clear on all this. What I have here is what we call here as WRC11 and this came from the paperwork that the CSA provided to us from the Trust and it is entitled LC Case Review and it commences with a clinical incident report, I think Esther Millar prepared that.

Dr Anderson: Yes.

D/Sgt Cross: Two pages and then there is a letter to Doctor McConnell I think from Jim Kelly.

Dr Anderson: Which I didn't see.

D/Sgt Cross: Right eh there is a description then or sort of rough minutes of the meeting held between Murray Quinn and Doctor Kelly and Mr Fee.

Dr Anderson: Which I haven't seen.

D/Sgt Cross: Is that right. OK. That was on the 21st of June. And then there is the Murray Quinn report to Mr Fee.

Dr Anderson: Which I did see.

D/Sgt Cross: Yes and this is now the draft, this is what I have this is the actual report then.

Dr Anderson: Well that's the draft, if that draft does not include the recommendations, yes, that was sent to me, I then wrote my letter and then the final report incorporated my recommendations.

D/Sgt Cross: Yes right and on WRC11 then the letter you are referring to is page 17 and 18 then.

Dr Anderson: Yes.

D/Sgt Cross: This is your letter?

Dr Anderson: Yes.

D/Sgt Cross: And the very last page 19 that is the letter you are referring to Doctor O'Donohoe to Jim Kelly.

Dr Anderson: Eh.

D/Sgt Cross: Sorry you did not refer to that, that's just forwarding the post-mortem report. But you said as part of your review Doctor O'Donohoe submitted a report.

Dr Anderson: Yes.

D/Sgt Cross: That's fair enough. If we go back into the middle of this document then, broadly speaking then this is what we are classing as WRC3 what the family was given is prepared from this.

Dr Anderson: The document you have there does that contain the recommendations, because that was different to the draft?

D/Sgt Cross: I don't think so.

Dr Anderson: What I understood was the final report contained recommendations as well that were based on my letter to Mr Fee.

Solicitor: Yeah.

Dr Anderson: That is what I understand is a draft report what you have in your hand.

D/Sgt Cross: It seems to be. I mean I'm quite happy that we have the full report.

Dr Anderson: Essentially the same just with the recommendations added.

D/Sgt Cross: We have everything half a dozen of times, because everybody's file has one. That's what I brought up today because it had your letter in it.

Dr Anderson: Yeah.

Solicitor: Well just to help you I think we have a copy either, we didn't bring it either, the draft report, then Doctor Anderson's letter then it went back to Mr Fee and then he produced the final report.

D/Sgt Cross: The final report.

Solicitor: Which is really very similar to the draft report with recommendations at the end, which are really your recommendations.

Dr Anderson: Yes.

Solicitor: The four points you have covered.

Dr Anderson: See where it is.

Solicitor: I am quite sure you would have that.

D/Sgt Cross: I'm quite certain we would have yeah.

Dr Anderson: I can't remember.

D/Sgt Cross: Well I will accept that. Yes however what I wanted to draw your attention to is this page 124 of WRC3; the unexpected outcome of Lucy's condition, Doctor O'Donohoe proactively reported the unexpected outcome of Lucy's condition to Doctor Kelly. Now the reason for this whole police investigation is what happened on the ward that night, were there crimes there, and then afterwards was there a cover up that may amount to a criminal offence and what I am asking, I think, you could read that and say that is extremely misleading, because it wasn't Lucy's condition that produced her unexpected decline and the unexpected outcome, it was the treatment.

Dr Anderson: Except that we did not know that at the time.

D/Sgt Cross: Yeah.

Dr Anderson: We didn't know what caused, what Doctor O'Donohoe's statement was and they treated her as a gastroenteritis, they did not expect her to die.

D/Sgt Cross: That's what I'm saying, it wasn't her condition that killed her, it was something, according to the Inquest.

Dr Anderson: I think we know that.

D/Sgt Cross: We would.

Dr Anderson: We have a great instrument called the retrospectoscope, which is very rarely wrong ...

D/Sgt Cross: Well doctor what I'm asking you then is in respect to that phrase there was there a decision to put that in, to distance her death from the treatment to associate it with her condition.

Dr Anderson: There was not to my knowledge there was no deliberate decision to any way to try and influence, it was just purely a statement that we did not expect Lucy Crawford to die.

Tape Number and
Tape Times:

D/Sgt Cross:	Right and in relation because I know Doctor Quinn's explanation of his use of 7½ hours and I accept your explanation of that too, but were there discussions that that was a good thing to put in to stretch it over 7½ hours was that a decision taken.
Dr Anderson:	Not to my knowledge, I just read it as you know being the overall global figure.
D/Sgt Cross:	Right.
Dr Anderson:	And then I had no influence on Doctor Quinn's report.
D/Sgt Cross:	Yes I accept that.
Solicitor:	It's just the tape ending.
D/Sgt Cross:	It's defective this machine. It is 1110 and we'll change the tapes.