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*JARLATH MICHAEL O'DONOHOE, sworn

THE CHAIRMAN: Thank you, doctor. Please take a seat. I shall spare you my usual introductions, you have heard it enough times by now. I will pass you straight to Ms Foster.

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Examined by MS FOSTER

Q Thank you, doctor. Would you be kind enough, for the record, to give your full name and the address where you live, please?
A My full name is Dr Jarlath Michael O'Donohoe. I live at [redacted] Northern Ireland.

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Q We know that you are MB, BCh, MRCP, MSc, FRCP, CMN and you were qualified in Dublin in 1978. Would you be kind enough to tell us what those qualifications reveal?
A The MB, BCh is the standard medical degree in University College, Dublin where I qualified. MRCP is Member of the Royal College of Physicians. FRCPCH, if I may correct that, is Fellow of the Royal College of Paediatrics and Child Health. MSc is Master of Science, in this particular case in biochemistry.

D

Q Where was your Master of Science in biochemistry from?
A Kings College, London.

Q Could you tell us from your qualification then in Dublin in 1978 where you went and what your career path was from there, please?

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A I worked in the Republic of Ireland for the first year after qualification. I first went to London in 1980 to work in casualty in St Mary's in Paddington and subsequently started working in paediatrics in the same hospital in 1981. I have worked pretty much continuously in paediatrics since that time.

Q At what stage was your MSc in biochemistry obtained?

F

A That was in 1978.

Q You were saying that you had been in paediatrics since 1981. Did you stay at St Mary's or did you go elsewhere?
A I worked in neonatology in Birmingham. I have also worked in paediatric nephrology in the Children's Hospital in Glasgow. I have worked in Brompton Hospital in London; St Bartholomew's Hospital in London and subsequently Westminster Children's Hospital in London.

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Q We know that you came as a consultant in paediatrics to the Erne in July 1997. Were you at consultant level at that time?
A I was, yes.

Q How long had you been a consultant?

H

A About five years.

Q Which hospital were you a consultant at previously to Erne?
A That was Queen Mary's Hospital, Roehampton, South London.

Q Were you there for the whole of the five years before 1997?
A I was, yes.

Q Was there any particular reason for your return to Ireland at that stage?
A There were changes afoot in the structure of services in that part of the world and it started conversations at home as to where we would like to be in the future. My maternal family come from [redacted] from the hospital I am working at at the moment and I guess that was probably the reason, the precipitating factor.

Q Is your wife connected with the medical profession?
A She is a nurse.

Q When you arrived at the Erne Hospital, what was it like, describe in terms of beds and the nature of the hospital briefly, please?
A It is a relatively small hospital, something of the order of 200 to 300 beds, I think, and there were approximately 25 beds on the children's ward at that at this stage and a neonatal unit with approximately six ventilator spaces. There was a second sister hospital, if I can put it like that, about 30 miles away, where children admitted to the hospital were, at the time I arrived, under the care of adults, the adult physicians, I should say.

Q That, as I understand it, is not at the Erne, but that was at the sister hospital?
A That is right, yes.

Q Is that sister hospital still in existence?
A The hospital is still in existence, the paediatric -- there is no paediatric service there now, shortly after my arrival, as a result of discussions between colleagues, responsibility for that hospital was moved to consultant paediatricians based at the Erne Hospital?

Q When you arrived what was the complement of paediatrician consultants?
A There were two paediatricians in post at the time I arrived, I was to be the third one. There were four SHOs at that time.

Q When you arrived what was your responsibility as between the two hospitals?
A The initial arrangement that I arrived to was that I would be responsible for inpatient and outpatient work at the Erne Hospital, and would provide telephone cover out-of-hours for the sister hospital and do outpatients on a nine to five basis at the sister hospital, two days a week in my case.

Q At the time that we are talking about here, which is in April of 2000, what was the system for consultant paediatricians with the Erne and the other hospital, if it was still relevant?

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A At that stage the other hospital had ceased to have inpatients shortly before that and it had become an ambulatory paediatric unit working predominantly nine to five but on some occasions with some extended hours of service into the evening.

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Q Where did the paediatric inpatients go?
A The ones who had been there, predominantly I think came to the Erne.

Q There were how many paediatric consultants available?
A At the time that I arrived there were three, I was the third consultant paediatrician. One of the three decided to retire approximately six months I arrived and it was not possible to get a substantive replacement in post for approximately five years.

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Q That would take it, by my calculation to 2002, is that accurate?
A That sounds right, yes, that sounds right to me.

Q Who was the other consultant paediatrician at that time, working with you?
A Her name was Chrishanthi Halahakoon, if that helps. Do you want me to spell the name?

D

Q I think that might be an idea?
A Chrishanthi, C-h-r-i-s-h-a-n-t-h-i, that is the first name. The surname is Halahakoon, H-a-l-a-h-a-k-o-o-n.

Q Were her responsibilities similar or different from yours?
A Broadly similar, she took a particular interest in the neonatal unit, for example, that is something she spent a lot of time when she was working as a senior registrar in Belfast doing.

E

Q What were your obligations for call-out at night?
A At that point, it was what would be called a one in two; in other words you worked nine to five five days a week and then available every second evening and every second weekend thereafter, to be called in as and when necessary.

F

Q When you arrived can you say anything about the materials that were available to the working paediatrician at the hospital?
A Paediatrics had been established as a speciality within that hospital a relatively small number of years before the colleague who retired shortly after I arrived was the first paediatrician appointed on site. There was still a substantial amount of paediatric unit construction to be done, I do not mean in the physical sense of having a ward but in terms of the apparatus one would need in order to deliver the sort of service that we would all like to see.

G

Q When you say the apparatus, are you talking there about paper materials or something else?
A Both. Just in the present context if I may refer to the case in question, one of the features of transferring Patient A to Belfast was, I believe, I had to hand ventilate the patient all the way there. The reason for that is that the Trust had refused repeated

H

requests to have a paediatric ventilator made available, particularly for that sort of purpose.

You also mentioned paper materials, the colleague who had started there and who retired had started putting together guidelines and protocols and so on, to try and, what shall we say, organise, let us say, the nature of the work. He had maybe produced something like four or five -- had dealt with four or five topics but he retired. In terms of attitude to training junior staff, it was something of a shock to arrive and attend my first cardiac or cardio-respiratory arrest, I should say, resuscitation on the children's ward to find an SHO who had been there when I arrived who clearly had very little idea as to how to proceed and to find that no effort had been made to ensure that some sort of training was available to her before she started

Q Now, you have spoken about when you arrived, we obviously are dealing with an incident in 2000, was there anything that you were able to do or advise or change in the course of those three years that you were there?
A I started the changes which were beginning to come into effect, so that, for example, when new doctors started, there was an arrangement that some sort of resuscitation training would be given. In general the change-over of junior doctors in Northern Ireland is traditionally February and August, and at those points there was an arrangement that new people starting would have some training, formal training, before they started working. I started to put together a collection of written guidelines, with a view to trying to ensure that there was more consistency in what we were doing with a view to ensuring that the wheel did not have to be reinvented (if I can put it like that) every day of the week.

Q I wonder if you would pause there. You have spoken about guidelines, I do not believe this is a matter in issue between us, sir, but there are some paediatric guidelines that were drafted, which we understand for which you are responsible. I think formally I ought to hand this and ask if you would acknowledge it, it should be headed "Paediatric Medical Guidelines Version 4, February 2000"?
A Yes, that is mine.

MS FOSTER: Could you keep it in front of you for the moment and then we will have it prepared for the Panel. I do not need it in detail at the minute, sir, and it is quite a lengthy document I would propose an extract of it is copied for you at a later date.

THE CHAIRMAN: Or could it perhaps just be available for us to peruse in its original form when we are in *camera*, we could not, just simply because of the vast amount of photocopying that we do generate in these proceedings, and I can see it is a very lengthy document.

MS FOSTER: It is.

THE CHAIRMAN: Frankly, I would have thought, what you are inviting us to do is each of us spend a few minutes looking through it to get a sense of the content and the flavour and its got no further purpose, is that correct?

MS FOSTER: That is very helpful, sir. There is a page that I ought to take you to, but

A that need not be done immediately.

THE CHAIRMAN: Mr Grundy?

MR GRUNDY: I cannot recall whether I have actually ever seen it before and therefore, at an appropriate moment, perhaps before cross-examination, simply I will have the
B opportunity to look through it. It may be in the large bundles of unused material and that I have seen it but not looked at it recently, but I would welcome the opportunity just to fresh my memory from it.

THE CHAIRMAN: Yes. It certainly will not go near the Panel other perhaps than the page you want to specifically refer us to until Mr Grundy has had a chance to refresh his memory.

C

MS FOSTER: I was not aware of that and, of course, I intended no discourtesy or inconvenience to him.

(To the witness) Could you just tell us, perhaps, in broad terms, what that is and what you did to create it or develop it?

D A In broad terms it was an attempt to make available in one place a set of guidelines, as it says on the cover, and that would be agreed by as many people as possible, with a view to facilitating everybody's work. For the first number of years I used to produce it twice a year to try to correspond with the arrival of new junior doctors, I sent copies to both of my consultant colleagues whenever I made any changes, asking for their input, their opinions on the changes that I had made.

Q When was the first one of these that you produced?

E A I cannot be entirely sure but the earliest one I could find a copy of was 1999, but because of the nature of what I'd seen in it I know I did one earlier, possibly 1998, but I could not find the first version, what is definitely the first version of it.

Q Were you instigator of this?
A I was, yes.

Q We have heard about the APLS guidelines?

F A Yes.

Q Is that something you are familiar with?
A I am, yes.

G Q Was that something that the Trust provided to the hospital?
A The Trust did not provide copies of it to the hospital. The copy that was on the ward when I arrived was my senior colleague's, his personal copy. When I acquired a second edition I brought that to the ward as the ward copy of the second edition of that book.

Q Did you invite the Trust to provide it or any other documentation?

H A Yes, repeatedly.

Q What was their response?
A No, they refused me.

Q We have looked at a number of documents in this case, and I wonder if you would be kind enough to turn to the Panel bundle which should be on your desk, I think maybe under the grey cover?
A The Panel bundle, yes, I have it, yes.

Q As you know we have been looking at medical records and I wonder if you would be kind enough to start once they become legible, if I can put it that way, about page 186, Doctor.
A Yes, I have that.

Q Yes, if you were to just flick through those documents and the ones that are following, for example, 188, 189 and so forth. Are there any documents there into whose format you had any input or whose format you recognise?
A If you look at the document on page 186, that looks to me like an admission note probably from November 1998. If you look at the one related to the time in question (page 188) that is a format that I put together with a view to trying to increase the reliability with which we collected particular types of information which tended to get forgotten.

Q Could you explain that in a little more detail? We see, for example, at 186 the '98 document that there appears to be effectively a sheet with writing upon it?
A Yes.

Q It is called a continuation sheet and I am just wondering whether or not would there have been an admission sheet on the front of that at the time?
A No, you a look at the top of that page it says "P/C" which would be a shorthand for presenting complaint.

Q If you look back, for example, at 185 where it says "best available copy", which sadly means it is difficult to read nonetheless, that is a paediatric medical admissions document, although we cannot see exactly when it was dated, is that similar in form to anything that you recall?
A If you look at the top left hand corner you see the words "problem/diagnosis", I think.

Q Yes.
A This would be what will be referred to as a problem list, and again it is something I put together.

Q Then we see at 188, "paediatric admission", and the format of that, did you design the whole of that format, or were you adapting something else?
A It was adapted, I think, from something else but I do not quite remember where we got the initial structure from.

Q What was it on here that you felt had not been included before, and was necessary?

A Well, if you look, for example, at the section where it talks about previous hospital admissions, it was not uncommon at that stage for a child to be admitted with no reference to the fact that there had been previous admissions. The hospital in question had not worked out a system by which previous notes could be made available at reasonable speed. There is a section you can see on the second page, for example, which is about immunisation, trying to encourage uptake of immunisation, for example. Then things like developmental history, which were an attempt to try to ensure that which each acute admission some copies would be taken of the background circumstances. On the bottom of page 189, there is a section that says "examination" and you will see it has headings of "height", "weight", and "head circumference" and the hope was that by having those as specific headings it would encourage the recording of those pieces of information which were not well or commonly recorded up to that point.

Q Do you recall what date these changes were instigated by you?
A I do not, I cannot say, no.

Q Did you have any input into obligations upon doctors to make notes in general?
A One of the things I instituted was an audit of note-keeping in general. The idea was to have a discussion with everybody working in the department at the time, and to ask people what they thought should be recorded and then to try for all of us to look at what we were recording on a monthly basis to try and identify what we were doing well and what we were doing badly.

Q Do you recall when that was set up?
A Approximately 1998.

Q You say on a monthly basis, was that something that continued through time and including through the time of this incident?
A Yes.

Q Turning now to the staff that we have heard from, and some we have not at the moment. We have heard from Nurses McManus, Jones and Swift. Are they all nurses with whom you had worked previously before this incident?
A Yes.

Q I am sure it is no issue but Nurse Swift would have been there before you arrived?
A Yes.

Q Nurse McManus, in fact, would have arrived less than a year before the incident in question, is that right?
A That sounds right, yes.

Q How about Nurse Jones, do you know how long she had been there?
A She had been, if I can put it like this, around the hospital for quite a number of years, I think she preceded me on the children's ward, to the best of my recollection.

Q And Dr Malik. What was your knowledge and experience of Dr Malik?
A I worked with him as an SHO for probably I think something like six or seven months before this episode. I had no particular reason to be concerned about the

nature of his work. I do not believe any other colleague had drawn any concerns to my notice.

Q What was his provenance? Do you know where he came from?
A He was from Pakistan originally. He came to work in the Erne Hospital via a programme run, I believe, by the College of Physicians in Edinburgh. My senior colleague who had retired had originally qualified in Edinburgh and, by various connections, had made available a place for Dr Malik to work with a view to having overseas experience at the request, as I understood it, of the hospital at which he was working in Pakistan.

Q How many years' experience did you understand him to have?
A I thought that he had been working in paediatrics for something like two or three years before he came to us.

Q In paediatrics?
A Yes.

Q Did you have a good working relationship with him?
A To the best of my knowledge, yes, we did.

Q Had you seen anything to suggest that he was not a good doctor?
A There was nothing that I recall drawing attention to him.

Q We heard evidence given by Nurse McManus earlier about the system, as she understood it, of fluid management and nursing and she told us that it would be a matter for, as she understood it, and her words were these, "A junior doctor generally prescribes/ decides and writes in the fluid chart and a nurse signs when she has put the fluid up". Is there anything in that description of nurses' responsibility that you disagree with?
A No.

Q In terms of your experience of what happened at this hospital and your experience to date before the incident in question, does what she describe accord with what you had seen and heard in practice?
A You mean in terms of the fluid being written up and being put up by nursing staff?

Q No, the junior doctor prescribing it and it being put up by nursing staff.
A Yes. That was a daily activity.

Q That anticipates my next question. You describe it as a daily activity. How common or frequent is putting up a fluid for a child who is admitted to the paediatric ward?
A It would happen a number of times every day.

Q Would that take place in the treatment room or a similar treatment room to the one we have heard about?
A Commonly. It would depend to some extent I suppose on the time of day or night. If it was late in the evening, it was more likely to be in the treatment room to ensure that anybody who was sleeping was not woken up. It might be in the bed spaces during the

daytime.

Q I think there is no issue between us that the figures suggest that 80 to 90 per cent of the time it is the junior doctor who does that without any involvement from somebody at your level.
A That would be correct, yes.

Q If you would turn with me in the bundle where we were looking, please, and look at page 188, the paediatric admission. Again, I think there is no issue but does that look to you like Dr Malik's writing?
A It does, yes.

Q We see the admission and the timing. You see also, if you look down with me, the description of the conditions of the child and we will go into that in slightly more detail later. If you would turn with me now to page 190, you will see below the first hole punch:

"Plan

- Admit & observe & encourage feeding
- Check urine for leukocyte and nitrate
- Bloods"

and a list of blood tests

"- I/V fluid after I/V cannulation".

Is there anything there that is striking or different to you from what you might understand to be a normal fluid regime?
A No, that would be normal note-keeping in that hospital at the time.

Q Do you have any reason to doubt that Dr Malik would have written down appropriately on the entry under "Plan" what he understood was a proper plan for a child with the symptoms that were noted?
A I am sure that that is what he was trying to do; that is what he was wanting to do.

Q If it says "Admit & observe & encourage feeding", did you have any reason to doubt that regular observations would have been carried out?
A I had no reason. To my mind, it actually specifies that it should happen. It would be common practice in any case even without saying "observe" that temperature, pulse and respiratory rate would be recorded a number of times every day.

Q Is there anything unusual at all in what is being said there in respect of what you would expect a nurse to be looking for and doing in the course of treatment with the patient with this presentation?
A No. That would be the sort of information that I would expect a nurse to be looking for.

Q You were sitting here when Nurse Swift gave her evidence about what happened

on that night. Do you, seeing that evidence of what she did and what she says she understood, have any comment about what you saw?
A I am sorry ...

Q It was a long question. Nurse Swift's evidence. She has given us evidence about what she did or did not do on that night and what observations were and were not taken during the course of the evening. Do you have any observations on what you saw and heard from her about what went on?
A There are a quite of number of things that I can refer to. I can only refer directly to what happened once I was called in. I was called in on the basis that Dr Malik had made a number of attempts to insert an IV cannula and he had been unsuccessful at that. I was called in to insert an IV cannula. One of the first things I did was to put on Emla cream, as has been mentioned, with a view to making the insertion of the IV cannula as painless as possible.

Q Would you pause there. Do you recall getting a telephone call or do you recall how you came in? Were you there?
A I was called. No, I was not in the hospital; I was called from home.

Q Do you recall any discussion that you had with him at that time?
A Not particularly at that time. I think it was to the effect of, "There is a child with gastroenteritis; the child needs an IV cannula. I have had difficulty. Can you come in and try to put one in yourself" or something to that effect.

Q I stopped you and you were telling us about putting the Emla cream on.
A Putting that cream on takes approximately 45 minutes to have its effect. Maybe if I can go back to the next step. If you look at the plan, Dr Malik had said to encourage feeding and, by the time I came in, there had been no sign of a great encouragement of any oral intake. I think that there had been 50 mls of juice given at that stage. Juice is not a particularly good thing to be giving in somebody who has been vomiting. Once I had the Emla cream on, the next step was to make up some Dioralyte which is the combination of glucose and sodium solution for use in dehydration. I went to an area called the milk kitchen which is where the materials are, I brought it back and the patient took 100 mls fairly enthusiastically is my recollection.

Q Can I stop you there. If you do not have a recollection, of course, please, say so, but do you have any recollection of when you first walked into the room as to who was there?
A My recollection is that the patient's mother was there and Nurse Swift. I do not remember if Dr Malik was there when I first entered the room.

Q Did the time come when he came into the room?
A Yes. He was in the room later.

Q How much later was that?
A At the time, I was putting the intravenous cannula in.

Q What was he doing?
A When I was putting the cannula in, he was I suppose observing for want of

a better word. He had made an effort to put the cannula in and had been unsuccessful. So, in one sense, there was no specific role for him at that stage.

Q Did he have any notes with him or paperwork?
A As I was securing the cannula, Nurse Swift asked a question about fluids to be started. When I spoke, I glanced over my shoulder and I saw him what I believed to be writing in the patient record.

Q You say that you saw him writing in; did you see him writing something?
A Yes.

Q You said you looked over your shoulder.
A Maybe I should have said out of the corner of my eye rather than over my shoulder.

Q Did you have any doubt about that?
A I had no doubt, no.

Q Why did you think that it was the patient record he was writing in?
A I suppose only on the grounds that he was there, Nurse Swift had asked some question about fluids – I do not remember the words – I had responded and then he was writing something. It may have been a presumption on my part.

Q What words do you recall saying to Nurse Swift in answer to her request about fluids?
A The words that I recall were … I am sorry about fluids or intravenous fluids?

Q About intravenous fluids at the time when you were fitting the cannula.
A The words I remember were "100 mls a day bolus to be followed by 0.18% at 30 mls per hour".

Q At the time when you spoke those words, did you see Dr Malik writing?
A Yes, within one or two seconds. I was aware that he was in the room and I looked, as I said, out of the corner of my eye to see him, what I thought, recording as would be not uncommon if he was there and was not hands-on, as it were, helping with the IV line.

Q Would you expect him to be noting it down or not?
A That would be quite a common occurrence.

Q Did you look in order to see if he was writing it down?
A That is the reason why I looked in his direction.

Q Did he say anything after you had said the words that you have told us here?
A No, I do not recall him saying anything.

Q Did Nurse Swift say anything immediately after you had said those words?
A I do not recall. There may have been some words but I do not recall any.

Q Did either of them give you any indication that they had either not heard or not understood what you had said?
A No.

Q I want to take you back, just a moment after we have dealt with that important passage, to when you come into the room to start off with. It is no longer alleged against you that you did not perform an adequate assessment, but can you tell us what you did in respect of this child when you walked into the room and saw her there with her mother.
A The first thing inevitably one does is pause at least for a few minutes to talk to the mother and to the child herself. It is making a rod for one's back in any case to try to insert an IV cannula in the child when you have just walked through the door. I am sorry, I have lost my thread now.

Q I was asking you exactly this. You are talking us through what you did when you first came in to see the child.
A There was some discussion with mum in terms of what had been going on in terms of the history, vomiting and so on. Dr Malik relayed to me some of the information. I think that we had the urea level available at that stage. He had recorded a prolonged capillary refill time. The decision that one has to make in somebody who may be dehydrated who has gastroenteritis is to divide the seriousness of the disorder into one of three categories, by and large: mild dehydration, moderate dehydration or severe dehydration. If there is severe dehydration, that is what would usually be referred to as shock. If there are no physical signs or no abnormality with that history of vomiting, it would generally be referred to as mild dehydration. So, the assessment was that the child had a urea of 9.9 and intravenous fluids were entirely appropriate.

Q We will deal, if we may, a little later on with the particularity and, if you like, the chemistry of that. You say that Dr Malik told you some of the history. Do you have a recollection of what he said to you or what he described to you?
A Something to suggest gastroenteritis, vomiting for some time. I do not remember further details. It was in many respects a very ordinary day-to-day history, if I can put it like that, the kind of thing one would hear a number of times a day even at times.

Q Did he volunteer that history to you?
A Yes.

Q When you came in, was he still trying to site the cannula or had he effectively given up by that stage?
A He had given up at that stage.

Q Did you have any idea how many times he may have attempted it?
A I did not. I do not. I have heard a number of numbers suggested.

Q If you do not have evidence of it directly, then ...
A I do not. I did not stop to. I was looking for veins, not counting any other marks that might be on the hands, as it were.

Q Did you see anything to suggest to you any amount of times he may have tried or not?

A I could only identify two possible sites for cannulation on this child. My guess was that there probably had been a number of attempts but what that number was I did not pause to try to estimate.

Q So, you are presented with a child and you have told us the types of dehydration. What would you have done in order to determine for yourself the condition of this child?
A Partly it is down to things like the history, what mum says has happened, and it is partly the general demeanour of the child and their response to the very fact of just appearing in the room and talking to them, for example. If a child does not notice you entering the room, for example, something as simple as that, and just lies there in a rather lethargic fashion, clearly the child is very seriously ill. You do not necessarily even have to go any further than that. There are various other physical signs that one tries to elicit which we have had a lot of discussion about, capillary refill time, skin turgor and so on. There are other things like dry mucous membranes, the membranes in the mouth. If you see a child's tongue and it may very obviously be dry, you would not necessarily have to put a spatula into the child's mouth for example to notice that. There are a variety of physical signs one could elicit.

Q What did you do in this case?
A Having the capillary refill time available and the urea, my recollection is of looking at skin turgor.

Q How did you do that?
A A pinch of the skin on the chest, if I remember rightly, while looking at the abdomen.

Q Why did you look at the abdomen?
A Anybody with vomiting I think you automatically look at the abdomen, particularly someone who is vomiting without diarrhoea because if the abdomen was swollen then you would wonder if there was a blockage to the intestines, for example.

Q You spoke about a child who is obviously lethargic and may be seriously ill. How would you describe this baby at this time that you saw her?
A I would describe the baby as tired rather than lethargic. Lethargy has the implication that the child is not able to understand clearly who is who, if I can put it like that, or what is what around them. This child clearly knew who the mother was, clearly knew that I had entered the room and, in fact, I felt the need to put on Emla cream which would only be worthwhile doing if there was a child that could feel pain clear enough to make it an important issue.

Q I think the word used in the notes is that she had been sleepy?
A Yes.

Q Might that be a suggestion to you that it was possible this child had some inhibition or problem with her, well, the potential for hypovolaemia?
A That possibility is always there but it was late in the evening so the fact that somebody is sleepy of itself would not be particularly remarkable in a child of that age at that stage in the evening, probably past normal bed time, if I can put it like that. Being sleepy but rousable and recognising what is going on around you, I mean, things that you

would be expected to recognise like mother's face and the presence of a stranger are the concerning issue rather than somebody being slight sleepy. If somebody falls asleep but can respond that is different, that is tiredness and being unwell it would not be surprising to be tired under the circumstances.

Q You described mild, moderate and sever dehydration?
A Yes.

Q Where did you place this child?
A Moderate.

Q If you were to express it in terms of a percentage, whereabouts in terms of percentage? Do you disagree with Dr Evans and 7.5?
A No, no. 7.5 is a figure arrived at by looking at the highest value it could be and since Dr Evans had said the child was not shocked, and I agree with that, the highest value it could be was ten per cent. You then look at the lowest figure it could be and since there were physical signs of dehydration and since the urea was raised the child has to be at least five per cent dehydrated. In truth, what one normally does is plump for half way between the two, a fairly standard approximation, or a basis for identifying a percentage. One cannot identify with any greater precision than that. When he says 7.5 per cent and somebody else says seven or eight there would not be any difference. It cannot be a precise measurement.

Q How common is it for a child to be admitted following vomiting with an assessment of about 7.5 per cent or moderate dehydration?
A I would not be hugely rare. I could not give you a number but, again, it would not be the kind of thing that would attract a great deal of attention as being out of the ordinary.

Q Would you expect an SHO to be able to deal with something like that?
A Dr Malik undoubtedly would have dealt with many cases both before coming to work with us and during his time with us.

Q How about the nurses? Would they have dealt with many cases like that?
A I am sure they would have dealt with hundreds, possibly thousands in the case of the more experienced members of staff.

Q You have told us that you put on the Emla cream and you have also mentioned fluids. Did you take any steps yourself in terms of oral rehydration?
A I went to the milk kitchen, as I mentioned, and I made up the oral rehydration fluid myself.

Q How often do you, as a consultant, go and make up oral rehydration fluid?
A Not very often.

Q Why did you do it yourself?
A The instructions was "Encourage feeding." There had been a lot of concentration on trying to get an IV line *in situ* and I suppose times when that happens part of what you had intended to be doing gets put to one side or ignored. I was trying to re-establish it on

A the agenda, I suppose.

Q What of your views about the role of oral rehydration for a child who has a potential gastroenteritis and has been vomiting?
A If I can talk about this particular patient most specifically. First of all, maybe in general at that time and I think still it would be regarded as the first line of treatment for
B gastroenteritis with mild or moderate dehydration. It can be used even in severe dehydration but most people would not do so and certainly not as a preference. The child in question had had a number of efforts at intravenous cannulation being undertaken. I had put on Emla on two sites and I had been successful on the second of those. One of the reasons why oral rehydration was particularly important in that particular situation is that some hours hence the intravenous line had tissued, in other words, stopped working, then potentially there could have been a problem. From what I saw at the time I would
C not necessarily be able to say that could have sited a further intravenous line later on that evening.

Q Could you just pause there and explain that? You say that one of the reasons was if the line had tissued there could have been a problem. What do you mean by problem?
A Supposing, for example, the line had tissued and you were not able to get further intravenous fluid in and the child then had a large amount of vomiting or diarrhoea, you
D would have a child whose condition was deteriorating with difficulty in responding in terms of treatment. If you have started oral rehydration therapy and if you are able to show that the child is able to take oral rehydration therapy, even if the line tissues then you might feel the need to do no more. If a child became very unwell and the line had tissued the next step at that point would probably have been to have a central line inserted, by which I mean an intravenous line going into one of the large vessels in the neck or the upper chest which is potentially certainly a very difficult procedure and
E potentially a dangerous procedure. It is not something that I personally would have undertaken.
I would not claim to be able to do so. It would have involved at least getting our local anaesthetic colleagues to look at the situation. So partly what you are trying to do is take that possibility into account.

Q If I just understand you. This is a comment you make in respect of this particular child because of the difficulties?
F A Yes. On some occasions when I have been called to put in a ---

Q Sorry to stop you. You are speaking quite fast there actually, doctor, and I am sure that the typist will keep up but for those who are relying on a note for this time if I could ask you to slow down a tiny bit in your answers?
G A Yes.

Q I am very grateful. I stopped you in mid-flow. You were saying about what you need to take into account?
A On many occasions when I am called in to put up an intravenous line in a child that somebody else has not been able to put an intravenous line in, I see a number of possible alternative sites leading me to think, well, if I do get called back at two o'clock
H in the morning to put another line in because the first one has stopped working I will have no difficulty doing so. That was not the case here.

Q Was it a possibility or real possibility in your mind that this child's line might not last for long?
A Intravenous lines in children, particularly small children, are very variable in how long they will last. Sometimes they will last for days, sometimes a few hours is all that you are able to achieve. So it was a real possibility that the line would tissue before the child had recovered from the presenting illness.

Q You say when you came in that nobody had given Dioralyte therapy. Why would Dioralyte be the relevant fluid in this case?
A Dioralyte is the standard oral rehydration fluid in use. I possibly should not use the name Dioralyte, which is a trade name, but it just happens to be the one that we have used on that ward fairly consistently. It is made to a standard recipe and there are a number of manufacturers.

Q What is it about it that is particularly suitable in a case of this sort?
A It is a combination of sodium and glucose, salt and sugar, and the way it works is that the last part of the intestinal function to stop working is the mechanism that absorbs sodium and glucose together so that even when you are vomiting, even when you have got diarrhoea your intestines can still often absorb the salt as long as it is with the sugar. There is a particular mechanism in the intestine that salt and sugar are absorbed together and if the salt is absorbed the water is dragged in after it, as it were. It has now a long, long history of highly successful use. It is one of those very simple ideas that has made an enormous difference in many places.

Q You have heard there have been a number of suggestions as to why it is wrong to have a programme for the child which involves in a large part oral rehydration as opposed to IV hydration. I wonder if you would first of all, please, look at what is our paper record of your recollection which is page 192 in order to orientate you. I will ask you some further questions about this a little later. Big black 192 and little 13 which is part of the paediatric record there is no dispute and at the time we have is "14/4/00". Can I first of all take you, please, to the last two lines on that page because turning over the page has a note of a calculation. Could you read out your note, please, from those last two lines?
A

> "[Patient A] had had 50 mls of fluid PO...

which is by mouth:

> "...before I saw her. I gave her 100 mls while waiting for the EMLA cream to take effect..."

That is 100 mls of Dioralyte. Then I went on to do calculations to show what I thought we might be able to do under these circumstances.

Q Can you talk us through "Maintenance [equal to]..."?
A If I start and explain my thought process as I was going through it. The dehydration is something like 750 mls or thereabouts. The patient had been given 100 mls Dioralyte and when the IV line was started another 100 mls intravenously was to

be given. In terms of a step in the direction of sorting out the dehydration aspect of it that was 100 mls of 750 mls dehydration. So that is how I started on that particular calculation.

Q Can I stop you there. You were saying that 100 mls was going to be given IV?
A Yes.

Q Part of the dehydration. What fluid did that mean?
A No. Normal saline IV. There are two things you are thinking about at the same time, one is maintenance fluid, as has been mentioned before, and the second is replacement. The two 100 mls, if I can put it like that, the suggestion previously was that 100 mls was actually a rather small volume of fluid to be using for any purpose. The standard maintenance fluid for a child in the first ten kilos of weight wise is 4 mls per kilo per hour. The 100 mls I was giving intravenously was intended to be roughly two and a half hours' worth, so the amount of time that been passed while the child was in hospital not having any fluid at all given. The 100 mls Dioralyte was roughly 100 mls of 750 mls dehydration, so a significant step in the direction of tackling the dehydration. It would not be fair to say that you could extract from that that the dehydration would have been treated within eight hours because there is no way of knowing what would come next, what diarrhoea or vomiting would happen. In terms of the volume given it was a significant step in terms of treating dehydration and was not a trivial amount, as I think was suggested at one point by Dr Evans.

Q I think the way he phrased it towards the end was "...neither here nor there...". He did not think it had done much good but he did not think it had done much harm?
A I would not accept that about either of the 100 mls, if I can put it like that. There is agreement broadly as to the degree of dehydration which is approximately 750 mls short. One person might say 500, another might say 750, even in those terms it does not matter very much. If you look at 100 mls oral rehydration therapy that is probably something likely 13 or 14 per cent of the dehydration. If you persist with oral dehydration and if it is successful that would mean you are looking at a substantial improvement in the dehydration situation over the course of a number of hours. Many people would recommend that you do not try to replace dehydration fluid over a shorter period than 24 hours but other people would try do it differently. The idea that they were trivial amounts I do not think really adds up in the scheme of things.

Q You said to us just now 100 mls, I think the words you used was "normal saline"?
A Yes.

Q We know that elsewhere the word "bolus" has been used. You say you said the word "bolus" to Nurse Swift in the presence of Dr Malik?
A Yes.

Q Do you recall whether or not you used the word "normal saline" after "bolus"?
A I do not recall. I would see the two as pretty much synonymous, if I can put it like that, but I do not recall and I do not think I said "bolus normal saline". I was writing, as I remember it.

Q You say the words are synonymous. If you ask for a bolus to be given to a child what would it be given in?
A Normal saline would be the bolus.

Q You appear to say that with confidence. Why do you say that with confidence?
A Nothing else, well, there was reference to the use of plasma and other blood products the past but there has not been any occasion on that ward that I can remember using anything other than normal saline as a bolus.

Q Have you ordered a bolus before on that ward?
A Yes, it would not be an uncommon thing to do, particularly in a child who is shocked or very markedly dehydrated.

Q Do you recall you would have ordered in that way as ordering a bolus? Would you have described it any further?
A I think I have used that word on many occasions. It is one of those words that almost comes to be part of what you say on a daily basis. Sometimes maybe it becomes a reflex word that is used reflexly and maybe it should be elaborated.

Q Do you accept it would have been clearer if you had said, "A bolus of..."?
A It would have been clearer, yes.

Q Did anything lead you to suggest that the words that you used were not clear to those who were apparently listening?
A There was no comment made by either, not at the time, nor was there any follow up phone call to say, "Are you sure you have got this right?" or whatever.

Q Would you expect a comment or a follow up if something unusual, extraordinary had been ordered?
A Very much so. I think it may not be the spirit in most or in other places, but I think that the spirit everyone, certainly from the medical point of view, tries to engender, that is to say that everybody should feel free to speak up if there were causes for concern. It was not the sort of unit where people were trying to say, "I am the boss and you'll do what you are told", kind of thing, if I can put it like that.

Q We were looking at 193 when we were involved in this latter discussion. Could you back, please, to that page, and you were talking us through, explaining about maintenance and replacement and your views on the oral rehydration. You have mentioned, as we saw, at the bottom of 192, in writing, that [Patient A] had had 5 mls of fluid and you gave her 100 mls and you explain when you did it, and the maintenance. Then you say afterwards, "immediately pre-transfer". Now, taking you, if I may, back on to 192, could you read for us, please, where it is 14/4/00: "Yesterday Dr Peter..."?
A

> "Yesterday Dr Peter Crean rang from PICU RBHSC" - PICU being Paediatric Intense Care Unit, and RBHSC being the Royal Belfast Hospital For Sick Children - "to inquire what fluid regime Patient A had been on. I told him a bolus of 100 mls over one hour followed

by 0.18% NaCL" - which is sodium chloride - "/dextrose 4% at 30 mls per hour. He said he thought it had been NaCL 0.18% dextrose 4% at 100 mls per hour. My recollection was of having said a bolus over one hour and 30 mls/hour as above".

Q Thank you. Can you tell us the circumstances in which that note came to be made?
A Dr Crean rang, this was a patient who had deteriorated unexpectedly during the course of an illness that one would not expect to see such an outcome from. He had raised a query about fluid under the circumstances of the deterioration for which I do not think I was entirely clear in my own mind as to what had happened.

Q Can I just stop you there. It is dated on the 14th and it says "yesterday" so that necessarily means it would have been the 13th that you spoke, is that right?
A Yes, that would be right.

Q We know there is no dispute that this child had to be taken to Belfast. Were you yourself involved in taking her to Belfast?
A Yes.

Q Did you have any input into her care in the course of that journey?
A One continues the same lines of treatment broadly speaking. I think there is a reference in one point to the fact that her blood pressure fell during the course of the journey and a form of treatment called dopamine was started to try and maintain the blood pressure.

Q Was she still on a hand ventilator at that time?
A Yes.

Q On the 13th, which is, as it were, the early morning after the events in question on the 12th, what time did you get back from Belfast about, do you recall?
A Eight or nine o'clock in the morning.

Q What would you have done as soon as you got back?
A Started the day's work, the following day's work, outpatients or whatever. I think it was outpatients on that particular day, I think it was a Thursday.

Q Did you go straight into your outpatients clinic on your return?
A Yes, I mean, I cannot say that I did not go home to change my shirt, if I can put it like that, but if I did that then that is as much as I did before starting the next day's work.

Q Yes. Do you have any recollection of when it was on the 13th that Dr Peter Crean rang?
A I have a recollection of mid-morning but I did not write it down and I could not really be sure about that.

Q When he did ring did you have in front of you any of the records that refer to this patient or would they have been at the hospital or on their way to the hospital?

A I did not have them. They are normally brought to the hospital to which you are transferring the child, they are normally brought back and I am sure I brought them back. They are then processed, if I can put it like that, from an administrative point of view, so they would not necessarily still be on the ward, for example.

B Q At the time when you phoned you, did you have access to those notes?
A I did not have the notes, no.

Q What is his speciality, Dr Peter Crean?
A He is a paediatric anaesthetist, I think, but working in the intensive care environment, as well.

C Q To the best of your recollection what did you say when he, as you put it, inquired what fluid regime [Patient A] had been on?
A I think he said something to the effect -- either my transfer note or when I had talked to the people when I arrived in Belfast, that I had said something like 30 mls per hour and he said it looked to him as if it had been 100 mls per hour. That was the start of the conversation.

D Q What did you say to him at that point?
A I said something like, "I do not think that is correct but I will look for whatever information we have here".

Q You have then written down a note on the following day. Is there any reason why you did not make a note on this record at the time of the telephone call? Was that record to hand?
E A I did not have the notes at the time, they are tracked by a computerised system. I would not be able to retrieve them independently; someone else would have to get the notes.

Q Is that because you do not have access to them unless you ask somebody for them?
A They are tracked by a computer system. I do not have access to that tracking
F system, I am not allowed to pull them, as it were, because that would mean booking them out, is the phrase that is used, and only designated people are allowed to book them out and to track them on the computer system.

Q I see. So when did you actually come to to put pen to paper in making this note?
A It was the following day.

G Q How were you able to have them in front of you at that point?
A I cannot say that I remember, but normal procedure would be I would ask one of the paediatric secretaries can they retrieve the notes.

Q Had you been able to look at any other notes by the time you came to make this note?
H A With regard to this patient, no. This was the only note. These were the only notes available for this patient.

Q Did you have a chance, when you made this note, to have a look at the fluid chart, for example?
A I did look at the fluid chart, yes.

Q When did you do that?
A That was when I got the notes, they were in the body of the notes.

Q At the same time as you were able to get this continuation sheet, you had the others to hand them?
A They are in the same place, they are filed together.

Q Let us have a look at page 222 which is 43, and 44. Would you, for example, have seen those?
A Before making this note?

Q By the time you had got to the piece of paper on which you could write, "Yesterday Dr Peter Crean", you would have had that in there, too?
A I would have had the notes, yes.

Q What did you think when you saw what is written there, particularly under the fluid column
A I saw what I understood to be 100 mls of fluid to be given per hour, as he had suggested.

Q What did you think?
A I was very surprised, I was shocked to see those numbers there. Partly because it was not what I recalled happening and partly because I could not imagine that if I had seen them at three o'clock in the morning they would not have registered with me.

Q We will deal with three o'clock in the morning in a moment, in fact, Doctor. I want to check that I have got your answer. You say partly because it was not what you recalled saying?
A Yes.

Q What effect did reading those notes have on your note-making on the 14th?
A I was very surprised and it precipitated the note recording. I cannot necessarily say it was the calmest, most collected and thoughtful note I have ever made. If I was to say that it was an upsetting and even distressing thing to think that, in a child who had deteriorated so markedly from although what was a potentially dangerous illness, was the sort of thing we would expect to deal with normally, and to have something like that pointed out to me was, it would not be unreasonable to say, a distressing experience.

Q You have used the words here, "I told him" - and by him, if may I lead on this, that is Dr Peter Crean, you are speaking of there?
A Yes.

Q
"... a bolus of 100 mls over an hour followed by 0.18&% NaCL".

Were those to the best of your ability the words that you recalled speaking?
A To Dr Crean?

Q To Dr Crean?
A Yes.

Q Were they, as best as you could remember at that time, the words that you had spoken in front of Dr Malik and Nurse Swift?
A Yes.

Q Then you have noted down, as we have read, that he said that he thought it had been that. You then say, "my recollection". Why did you use the phrase "my recollection"?
A It was the following day, I did not want to, I suppose, give the impression that it was purporting to be anything other than what it was, what it is, an account of a conversation after the event.

Q Why did you make a note there with reference to a telephone call that you had had on the 13th, the time after?
A When I had that telephone call, and subsequently was able to identify that the fluid balance sheet suggested 100 mls per hour, my intention was to hand the notes to the Medical Director with a view to ensuring that the issue would be examined. I did not, I suppose, want to hand a set of notes that did not have some reference to the precipitating factor in that, which was the phone call from Dr Crean.

Q Did you realise or recollect at that point that you yourself had not made a note in her records of what you had ordered?
A Yes, I did.

Q What did you think at that stage?
A I very much regretted not having done that. I suppose not having done it one just had to accept it and in anything written subsequently, which is this note in question, make sure that there is no effort to try for things to be anything other than what they were.

Q Did you in any way, when you were making this note, seek to change or suggest anything different from what you honestly recollected had taken place?
A No.

Q Did you, when making this note, try, in any way, to bolster what you might think was your own interest or protect your own position, Doctor?
A This is not a way, this note is not a way of protecting myself; it could not protect me in the sense that I handed these notes to the Medical Director saying, "I have had a phone call from this particular individual about this particular topic". That left it - and I honestly cannot say and I do not know if the Medical Director ever did contact him or not - but it left it open for him to contact the individual in question to say, "Did you have this conversation? What was the conversation about", and so on and so forth. If I was trying to bolster my position or hide something I could have put down, even if I was handing the notes to the Medical Director, something like, "I reviewed the notes with

a view to doing a further discharge summary and I noticed the following", and there would have been no way of verifying that that was not the case. But the name is there very, very consciously and it is partly because he made the phone call, but partly if somebody is going to examine the issue, that is a possible starting place.

Q Were you intending to be completely open about your role in this?
A Yes, I am not trying to make anything of what I did, other than what I have done. It would not be terribly difficult, possibly, if one had been so inclined, to have written other things at that point that might suit my purposes better, if I can put it like that.

Q You have spoken about handing the materials to Dr Kelly. How soon after did you do that?
A I think it was on the 14th, I did not record it.

Q Did you believe it appropriate to speak to Dr Malik?
A I told him that I had had this phone call, I did speak to him and I told him I was going to hand the notes to Dr Kelly.

Q Did he say anything about this to you?
A Anything about...?

Q About the fact that this had happened to you?
A We did not have a long conversation on the topic. The only part of the issue that I raised with him was the fact that as I understood, although I was not entirely clear about it at 3 o'clock in the morning, as I understood when I was reading through the notes, he had given 500 mls of normal saline, running freely or very freely I think is the phrase used, and I did ask him what was that for and he said something about diarrhoea. I did not like to pursue the issue in too much detail in case it might seem to be trying to persuade him of something or convince him of something.

Q You say you did not like to pursue the issue. Did you say to him anything like, "Well, what happened? What did you give this child? What was your prescription?" Did you say any words like that to him?
A I do not recall doing so, and I do not think I would have because if I was asking the Medical Director, if I was handing the notes over to the Medical Director with a view to him looking at them, it would not be appropriate to have, as it were, started examining the situation myself.

MS FOSTER: Did he say anything to you, like, "What on earth do you mean ---

MR GRUNDY: I hesitate to interrupt. These are very leading questions. I am sure my learned friend can ask, "Do you recall what he said", rather than leading.

MS FOSTER: My friend is entirely right, and I apologise. *(To the witness)* Did Dr Malik say anything to you about these events?
A Other than the comments about the diarrhoea and the normal saline, nothing else. We did not have a long conversation on the topic. It might be fair to say that Dr Malik was clearly upset by the turn of events, as I guess everybody was under the circumstances, and maybe one of the reasons why I did not pursue it was that degree of

upset.

Q Did you have occasion to go and talk to the nurses after this about what had happened then?
A I did not because the nurses tend to work shifts, so there would not have been any opportunity to identify each individual nurse, so I did not seek them out.

Q Did you think it was appropriate to go to speak to them about what happened on this evening?
A There might have been a case to do so if I was the one who was examining the issue, if I can put it like that. But if I had handed over to the Medical Director with a view to him examining it, it would seem inappropriate for me to have pursued the nurses. If I had, as it were, a chance to cross somebody I am sure we would have discussed the issue in a human sense but I certainly did not make any effort to try to investigate it, if I can put it like that.

MS FOSTER: I wonder, sir, given the time, whether this might be an appropriate moment for your break?

THE CHAIRMAN: Yes, Doctor, you have been on the stand, as it were, for over an hour now. Ms Foster, do
Do you have a sense of how much longer you are likely to be?

MS FOSTER: Whether this might be a moment perhaps to take our luncheon adjournment?

THE CHAIRMAN: Yes, I was wondering.

MS FOSTER: Yes, I wonder, sir, if that were convenient to you, do you mind if I ask my client?

MS FOSTER: If we were to take our lunch break now and resume at one o'clock, would that be suitable for you, Doctor?
A Yes.

THE CHAIRMAN: Very well, that is what we will do. One o'clock, then ladies and gentlemen.

MS FOSTER: *(To the witness)* You realise of course, Doctor, that you will have to have lunch in purdah and please do not discuss the case with anyone at all.

THE CHAIRMAN: Thank you, Ms Foster.

(*The Panel adjourned for lunch*)

MS FOSTER: *(To the witness)* We were talking just before lunch about what happened afterwards and any questions you might have raised with others or discussions you had, and the words I have noted down for you are that you made no effort to investigate

yourself. When we look at the note, as we looked before lunch and it is page 192, you described that as being that you were careful not to suggest anything that you did not or could not recollect or words to that effect at the time. This question arises. Doctor, why did you not seek to defend yourself further as to what you had done at the time?
A I suppose the only thing I could have done to defend myself further would have been to have put yet more details in at that point. I am not sure that any details written in at that point would have any great value to somebody looking into the issue.

Q Did you yourself recall giving greater details at the time of your instructions for fluid?
A Yes. My recollection at the time was, if I can put it like this, if asked, I could have provided further details and quite likely could have provided supporting or corroborating information.

Q What would that have been?
A A lot of, I suppose, details of a conversation that one might have had for example with the mother about the use of oral rehydration fluids for example, and I suppose that if one were trying to find some way of identifying what had happened, some of those recollections might be hooks to which various other pieces of information could be connected.

Q Why did you not think it appropriate to defend yourself further in that way, then?
A I gave the notes to the Medical Director with a view to him investigating is probably the best word. I felt that there was enough information there to be a starting point and that that would just be a starting point.

Q Did he ever come back to you and ask you for an account based upon the notes that you had handed him?
A No, he did not.

Q We know that the time came when you wrote a letter to the Trust and, if you look in the bundle that is the bundle of documents for this case, you will see that, under tab 9, and I hope that you have a tab 9 ...?
A I have a tab 9.

Q It should say 137 in big black letters.
A I have that, yes.

Q There was a letter written bearing no date of composition but, if we look at the top, do you see in the top left-hand corner of the copy that I have "07/01/04"? I do not think that there is any difficulty about this. There is also an 01 date and then there is one underneath which has an 0959 fax and I cannot read the date there. Can you help us at all as to when that would have been written?
A I cannot. I did not date it. I must have typed it myself.

Q Do you recall how long after the events in question that would have been written?
A I do not. I believe some years later.

Q Do you recall what stimulated that letter to the Trust?

A I think it was at the Trust's request. I think it was during the course of civil litigation by the family.

Q Did you have any assistance from the Trust or their lawyers at the time when you were writing this letter?
A No.

B

Q Did the Trust ever offer you independent legal advice in the course of an investigation?
A No.

C Q Looking at this letter on page 137, you see that it says that you were called to see Patient A on the date of admission because Dr Malik was unable to site a drip, that she had been admitted with a history of vomiting and drowsiness and, on examination, that she was sleepy but rousable. Perhaps you would be kind enough, if you are able to read that copy, to read on. If you have difficulty with that, it is a matter of agreement that the same statement appears in a Coroners Act form on the next pages.
A I can read it.

D Q That would be fine. If you have difficulty, you may look under the next tab because you will find that the same material is included in another statement.
A

> "Since blood had been sent for urea and electrolyte measurements, I applied local anaesthetic cream to the areas where I thought I was most likely to be able to insert an IV cannula. In the meantime I gave her a bottle of fluid which she took well.
>
> E When the local anaesthetic cream had had time to take effect I inserted a cannula. Whilst strapping the cannula in situ I saw Dr Malik writing as I was describing the fluid regime i.e. 100 mls as a bolus over the first hour and then 30 mls per hour. The 100 mls was approximately 10 ml/kg and to cover the possibility that the cannula might not last very long and the succeeding rate was relatively slow since I had seen her taking oral fluid well and presumed the rate of fluid need was relatively small. The intravenous fluid used was saline 0.18% saline".

F Would you stop there, please. You have just said 100 mls as a bolus but you have not in any way qualified what the bolus was to be made up from. Was there a reason for that?
G A There was no specific reason. It is presumption that the bolus is always saline, normal saline.

Q You say "... as a bolus over the first hour and then 30 mls per hour" and you do not there describe what the fluid should be.
A No.

H Q Was there any reason for that?
A No. I went on to write in "saline 0.18%". No, there is no particular reason why I

A wrote it that way.

Q When you say, "The intravenous fluid used was saline 0.18% ..." that describes what happened but what does it say about your intention at that time?
A I do not think I was writing anything about my intention in terms of which type of fluid. I was describing fluid as given, I think.

B

Q You do not in any of that go on to explain or defend yourself as to what was ordered or offered. Is there any reason for that?
A I cannot think of any particular reason. As far as I remember, I had no particular information or questions. I think it was a request for a report or words to that effect. So, this was not written in response to a series of specific questions.

C

Q Going on to the next paragraph, perhaps you would be kind enough to read again, doctor.
A

> "I looked into the treatment room a few minutes later and [Patient A] was standing on the couch in front of her mother and looking better.
>
> D I was next called at approximately 03.00 because [Patient A] had had what sounded like a convulsion. My initial presumption was that this was a febrile convulsion. However since she showed no signs of recovering by the time I arrived and since there was a history of profuse diarrhoea I took a specimen for repeat urea and electrolytes. My recollection is that Dr Malik had started the intravenous normal saline before calling me and that the 500 mls given was virtually completed before I arrived. Her repeat urea and electrolytes
> E measurement showed the sodium had fallen to 127. When I took over bagging from Dr Malik it was clear that there was no respiratory effort and her pupils were fixed and dilated. I continued bagging until Dr Auterson (anaesthetist) arrived and he intubated her and she was transferred to ICU"

and that refers to ICU in the Erne Hospital.

> F "I arranged transfer to the Paediatric Intensive Care Unit in the Royal Belfast Hospital for Sick Children and since there was no anaesthetist to travel with her I accompanied. I was unable to make a diagnosis for her deterioration prior to transfer. She was hand bagged until arrival in Belfast, either by myself or the accompanying nurse from ICU. The only problem in transit was a fall in her blood pressure towards the end of the journey at which I started a dopamine
> G infusion".

Q If we turn over into the next tab – and again I believe there is no dispute between us on this – we see the Coroners Act statement was the gist of what you had said to the Trust previously.
A Is this 1619?

H MS FOSTER: It is 87a in my bundle.

THE CHAIRMAN: It is under the same tab.
A I only have one sheet.

MR GRUNDY: It may not have been inserted in that bundle. My recollection is that it was inserted at the defence request at the outset and may not have made its way into the witness bundles. The witness has it now.

THE WITNESS: I have it.

MS FOSTER: Would you glance through it, please, doctor. That was, as I understand it, a deposition made on your behalf for the purposes of the Coroner's hearing and was put in as written evidence.
A That is right.

Q Again, it is common ground that an inquest took place. Did you give oral evidence at that inquest?
A I did not, no.

Q Can you tell us at what stage you were asked to give oral evidence at the inquest.
A I attended all three days of the inquest. On the second day, the Coroner advised me that I should get independent legal advice.

Q May I stop you there. Until that point, who had been representing you?
A I had gone of my own volition. I had been called – I do not know if the word "summonsed" or "subpoenaed" is the right word but I had been called to go – and I had gone under my own steam.

Q Had the Trust been representing you and the nurses until that point?
A The Trust had a barrister who was representing the Trust. I was not particularly aware of him representing me in the sense that I had no great dealings with him. There had been one meeting which he had held which I had attended, but that was everybody who was going to the inquest type of thing.

Q You say everybody who was going, is that everybody who was going from the Trust employees?
A Yes, from the Trust employees.

Q Had you been present at that meeting? Did you take part in that meeting?
A I attended that meeting.

Q Did the Trust suggest at that meeting that you got independent representation?
A No. There was very little discussion about the issues. I attended on the grounds that it was the first and indeed the only inquest I had ever attended in Northern Ireland and it was more or less in terms of this is how it works type of thing rather than any considering of individual accounts for example.

Q Do you know what it was that prompted the Coroner to suggest, on the second day in the middle, that you should have independent representation?
A No.

Q Was it ever explained to you by anybody there what it was that underlay his suggestion?
A I have no recollection of any explanation being given.

Q Did you take steps to secure representation?
A I did, yes.

Q At what stage did that representation arrive?
A At midday on the following day.

Q Had you had an opportunity to show any of the papers or any of the underlying materials to the person who showed up?
A No. I was not even sure that I knew what all of the underlying materials were at that stage, so I could not even give her an estimate of what would be involved.

Q What did she do when she arrived at midday?
A She requested time from the Coroner to make some preparation and review of the materials in question.

Q What did he say?
A The Coroner said she or I – I am not sure what the right person to refer to in this context is – or maybe I should say "we" could have I think it was an hour but it may have been less than an hour; it was a very short amount of time.

Q Did she ask for more time?
A She did, yes.

Q What was the result?
A That time was refused.

MS FOSTER: For the purposes of this, would you care to tell the Tribunal what you were told by your Legal Adviser at that stage.

MR GRUNDY: One has to be a little careful. If my learned friend wants to waive legal privilege, you cannot just waive it in part. If you are waiving it there, then there is a risk – and I simply say this – that you waive it in general and therefore I could ask for other materials to look at in respect that. It is a matter entirely for my learned friend. If she wants to waive legal professional privilege, so be it, but it strikes me that it cannot be waived in section. If it is waived, it is waived in total.

MS FOSTER: This is not the place to have a detailed argument about that. I can elicit the information in another way, if you will allow me this, sir. *(To the witness)* Was the result of your consultation with your legal adviser at that stage that it would be inappropriate for you to give evidence?
A Yes.

Q I wonder if I can take you back, since you have in your letter referred us to events at three o'clock, to page 191 and indeed back to page 190 to orientate ourselves in the

notes.
A Which tab is that, please?

Q It is the first tab which contains the hospital notes.
A Page 190?

Q Yes, please. It should say "continuation sheet" and it should start with Dr Malik's writing. We have looked at it before. It is his plan and the admission.
A Yes, I have that page.

Q If we look down under where he says "Plan" we have an Hb result of WBC. Is that your writing, doctor?
A That is my writing, yes.

Q We then see further writing, a sodium result and urine analysis. Is that your writing?
A I think that is Dr Malik's writing. It is not my writing.

Q Then you see under that approximately 1100. Is that your writing?
A That is my writing, yes.

Q It says, "IV line inserted." There is then a telephone number for a Dr McKeague. We will come across that in just a moment, if we may. We then see a note:

"13/4/00, 3:15 Called Dr O'Donohoe to assess the condition..."

with Dr Malik's signature, as I understand?
A That is right, yes.

Q What do you recall of what happened at about 3.15 on that morning?
A Dr Malik rang to say that Patient A had deteriorated and had had what colloquially one might refer as to as a funny turn. I could not get enough details to be entirely clear what he was talking about and I was not entirely sure whether it was something he had seen himself or whether this was a second hand account.

Q Did he invite you to come in or did you...?
A I cannot remember if he said, "Please, come in", or I said, "Well, it sounds like I need to come in." My initial thought was this was a febrile convulsion which would be a relatively straightforward matter but there should usually be a fairly clear description of such an episode, so it sounded, although my initial thought was febrile convulsion it did not sound cut and dried.

Q Tell us briefly, if you can, and fairly simply what is a febrile convulsion?
A It is a convulsion that a young child gets when there is a raised temperature.

Q What effect, in brief, does it have on the physiognomy of a child or its mental state?
A A child would become unconscious, often would become rigid and quite commonly have jerking movements.

Q Where were you when you received the call for that?
A At home.

Q About how long did it take you to get in?
A I would guess about 15 minutes.

Q Do you have a recollection of your arrival at the hospital and at the side of the patient?
A I do, yes.

Q Could you describe what you found as you went there?
A When I arrived Dr Malik was using a bag and mask to support her breathing. The patient was clearly unconscious and there was a number of nurses present, although I do not remember exactly which nurses were present.

Q Did you say anything as you came in to anybody?
A I suppose trying find out, I cannot remember exactly what the opening remark would be but, you know, "Who has been here?" "What is going on?" type of thing.

Q Would that be standard in a situation like this or was there something particular you would have asked here?
A Well, if you have not been there you wanted to figure out who would have the information and get as much information as you can. At the same time when somebody is very unwell there is an element of ongoing resuscitation, so you are trying to do, I suppose, two things at the same time; trying to continue resuscitation efforts, bagging, masking if somebody is not breathing well and at the same time trying to find out what had changed since I was last there.

Q Did you get physically involved in the resuscitation yourself?
A I did, yes. I think Dr Malik was not entirely sure that he was doing the bagging and masking entirely appropriately. I think I made one, possibly two efforts to intubate the patient, in other words put a tube into her bronchus, her breathing tube, which is an easier way to sustain breathing. I did not find that particularly easy and I knew that the anaesthetist would be available fairly shortly, so I did not persist with that.

Q What did Dr Malik, do you recall, say to you at that time as you arrived?
A I did not get a great deal of information beyond what he had relayed on the phone. There was a history of some diarrhoea, there was history of this sudden collapse episode but I was trying to find out who had first hand details of it and that was not immediately apparent. So I suppose he was trying to tell me something that I was not entirely sure that he had seen himself.

Q Did you ask any questions of the nurses?
A Again, it was the same approach, "Who knows what is going on?" "Who is in charge here?", as it were, "Who is dealing with the patient?" "What information is there available?"

Q Did you ask that question specifically of one person or in general in the room?
A There were a number of nurses there, so I asked in general.

Q What response was there?
A I did not get a clear response from any of the nurses.

Q Do you recall any response that was made to you about what had happened previous to your arrival?
A There were some features that - diarrhoea kept being mentioned, the funny turn, if I can use that phrase, the collapse episode maybe is a better way to put it but I could not elicit any detail of information.

Q How about the mother? Was she there at that time?
A I think she was still in the room at that time when I came.

Q Did you have any specific conversation with her?
A I do not recall having any conversation with her, no.

Q Do you recall her telling you anything at that time?
A No.

Q Do you recall seeing any patient's notes? Did you look at any patient's notes?
A I would normally look for notes under those circumstances. I do not recall seeing them at that time.

Q Do you remember whether you looked and did not find them? Or is it that you just do not remember?
A I looked and did not find. I did not possibly persist very long in the sense that since there was an ongoing resuscitation effort I suppose my attention was diverted fairly quickly to that aspect of the situation.

Q Would you have considered yourself in charge of the resuscitation effort? Or would that have been someone else?
A No, I would consider myself in charge, at least until the anaesthetist arrived.

Q Did somebody call for the anaesthetist?
A Yes.

Q Who was that?
A One of the nurses but I do not remember.

Q Did everybody stay in the room where the child was whilst the resuscitation effort was taking place?
A There was certainly a number of people. I cannot say that everybody stayed all of the time. The focus is inevitably on the patient under those circumstances and if there are two or three people and one leaves I would not necessarily have noticed that.

Q You have told us in circumstances here obviously of collectedness and calm. What was the situation, so far as you recall, when the resuscitation attempt was taking

place?
A I would describe it as being very high drama. I suppose I am trying to find a good word. It was not a calm situation.

Q Do you remember what happens to the mother, whether she stayed there or whether she left at that time?
A I think she left but I cannot remember the circumstances, whether she left herself or whether one of the nurses asked her. I think the father had driven in as well, had been called at the same time.

Q The anaesthetist you explained was called for. Do you recall his attendance?
A Yes.

Q Can you describe when he did when he arrived?
A He intubated Patient A.

Q What were you doing at this time?
A I do not remember in detail but normally if there is a possibility of a difficult intubation and the anaesthetist had been called under the circumstances I would have probably made myself available as a second pair of hands in case there was assistance required with what is called a cricoid pressure, for example---

Q Would you mind saying that a little more clearly?
A I would normally have deferred to him, would be the best way to put it, because he would need to do what I could not do. I would try to make myself available in this case there was assistance he might need. There was a particular manoeuvre called cricoid pressure sometimes with anaesthetists.

Q What is that?
A It is pressing on the font of the neck to try and make it easier to intubate.

Q Do you recall whether you were called on to do that or not?
A I was not called on to do that, no.

Q Would you look, please, with us on page 190 again. Do we see your handwriting, "13/04/00 0515"?
A Yes.

Q Would you please read the notes that you have written there under that time?
A The first symbol means approximately 0300, three o'clock:

> "Mother noticed [Patient A] rigid. [Approximately] 5 mins later
> rectal diazepam 2.5 mgs [rectally]. There had been diarrhoea before
> this episode and subsequently.
> [Reduced respiratory] effort
> Bag & mask.."

was started. I cannot read some of the words at the end there. The third word is "throughout" and the next words are "O_2 sats" which are O_2 saturations.

Q Yes.
A I think the next is the oxygen saturations 85 to 100. 95 to 100 would be normal, so they had been low at one point but had varied between 85 and 100.

"[About] 03.30 capillary refill [less than] 2 secs. Pulse easily filled. Pupils dilated and unresponsive."

Q Would you have been responsible for asking for tests to have been undertaken at that point?
A I think, in fact, I took the blood myself for the urea electrolytes which is recorded there.

Q How about the capillary refill test?
A That looks very much like I did that.

Q The pulse and the check of the pupils, who would have done that?
A I did those.

Q We then have a U+E result?
A Yes.

Q Do you have any recollection of when you got that result?
A Probably about half an hour after the specimen was sent but I cannot remember what time in the morning that would have been.

Q Would you continue reading, please?
A

"Dextrostix [approximately] 12 [therefore] normal saline."

Q Could you just tell us what "Dextrostix" mean?
A It is a measurement undertaken on the ward of the blood sugar level and 12 is high so there was no grounds for using a solution which contains extra dextrose.

Q Pausing there. You said that your recollection is that the written notes were not available. Do you recall seeing any fluid up when you walked into the room?
A There was normal saline, there was a bag of normal saline when I walked into the room.

Q Did you have any conversations about that?
A I think it was something to the effect of, "How long has that been running for?" It was pretty much finished by the time I got there. Dr Malik had mentioned normal saline when he had called me but I do not recall at that point having any discussions about the rate or the time it was started. I think it may still have been running freely, in other words not controlled by the pump, and that is something that would inevitably draw attention and I suspect my comment if that was the case would have been something like, "Maybe we can get a pump to be sure what we are doing with that."

Q Do you recall the anaesthetist have input into fluids or any other matters whilst you were there?
A We did not have a lot of discussion about it but I recorded that and as we were about to leave he suggested 40 mls per hour and I thought it just as well to leave it where I at least thought it had been rate wise.

Q When you say leave it where you thought it had been?
A Thirty mls.

Q Can I take you back. You said before we leave, I stopped you as you were reading your note on 191. I wonder if you would go through, please, after the normal saline?
A Yes, the next two letters are "D/W" which is discussed with:

"...Dr McKeague at RVH..."

which is the Royal Victoria which is the Royal Belfast Hospital for Sick Children for transfer:

"...? cause of respiratory arrest...",

in other words, I was not sure at that time what caused the respiratory arrest and I must have discussed with him the possibility that this was some sort of post convulsion episode.

Q Then it is the arrow ICU?
A Yes, to ICU, about five o'clock, I think leaving at five o'clock for ICU, "Claforan 1 gm IV stat", Claforan is a broad spectrum antibiotic. There was no reason to think it was likely to be of relevance but it is something that is often done under the circumstances. Mannitol 5 grams intravenously over half an hour and that is used for cerebral oedema.

Q Why did you use something for cerebral oedema at that point, doctor?
A I do not remember exactly what precipitated the thought of cerebral oedema. It may very well have been during the course of my discussions with Dr McKeague.

Q How did you initiate your discussion with him?
A I rang with a view to transferring the patient for further ventilation.

Q Who is he?
A He is a consultant paediatric anaesthetist working in the paediatric intensive care unit.

Q That is the paediatric incentive care unit?
A In Belfast.

Q Would you look, please, I think to your left on the desk and the Panel also have it and my friend, there is letter there with Patient A's reference at the top?

A Yes.

Q Perhaps you would be kind enough to read it, doctor?
A

"Dear Dr McKeague,

Thank you for accepting [Patient A] for transfer. She presented at approximately 19.30 with a history of fever, vomiting and drowsiness, capillary refill > 2 seconds [therefore] intravenous line [started at[approximately 1100.

Initial investigations

[haemoglobin] = 12.1 [white cell count] = 15.0 platelets = 397 [sodium] = 137 [potassium] = 4.1 [chloride] = 105 [carbon dioxide] = 16 urea = 9.9 glucose 4.5 creatinine = 45

At approx 03.00 her mother noticed her very rigid. She was given diazepam 2.5 mgs (But it is not likely much was absorbed because of diarrhoea shortly afterwards). There were a number of episodes of diarrhoea - watery 0 blood 0 mucus.

She responded (O_2 sats) to bagging and was intubated at [about] 04.00.

Here pulse was palpable throughout this time. Her pupils were fixed and dilated from 0330 when I first looked at them.
[Chest x-ray normal]
[Abdominal x-ray] distended loops of intestine ? colon.

She had 1 gm of Claforan [about] 0500 and 5 gms of mannatol at [about] 0530 (with a brisk diuresis)..."

Q Turning back to 190, the beginning of the note that starts about two inches up from the bottom of the page, you have written 0515. Would that have been the time that you wrote the note or did you write it at any other time?
A I think that is time I wrote the note.

THE CHAIRMAN: Ms Foster, I am sorry to interrupt. Can we go back to the letter to which we have just been referred? First of all, where is it that you would wish us to put this now? Or is it to be assigned an exhibit number?

MS FOSTER: I suspect that the best place would be if it became 237A and 237B. That is at the end of my tab 1 and I think yours, sir.

THE CHAIRMAN: Secondly, have we established the date on which this was written?

MS FOSTER: I was going to take the doctor to the note actually in the records just before asking him that question.

THE CHAIRMAN: We will be establishing that?

MS FOSTER: Yes, sir.

THE CHAIRMAN: As it stands it is rather out in the open.

MS FOSTER: I understand entirely, sir. I was going to take the doctor back to 190 and the 0515 note, which I think we have done. Then I want to take him up, please, above that, there is a telephone number written in there, "[redacted]Dr McKeague". Do you know when that note was written? I think you said Dr Malik's writing?
A That looks like Dr Malik's writing, yes.

Q Did you have occasion to contact Dr McKeague in writing as well as by telephone?
A I think this was a handwritten note which I brought with me when we went to Belfast, and I left there.

Q Where would you have been when you wrote that?
A I believe that was at the Erne Hospital.

Q I was going to ask you, at 5.15 in the morning where would you have been when you wrote the note that we see dated at that time. Would you have been up on the ward or where you have been elsewhere, do you think?
A Probably in intensive care.

Q Did you go down to intensive care or along to intensive care with Patient A?
A Yes.

Q Where did you go after that?
A I think I left from intensive care to travel to Belfast.

Q Why was it that you went with this patient particularly, Dr O'Donohoe?
A There was no anaesthetist available to go and I was the more senior of the two people working in the paediatric department. I thought it would be unfair, unduly onerous to ask Dr Malik to do it.

Q Who would one normally expect to accompany a child in this condition to another hospital?
A It would depend very much on who was available in the hospital at the time. Technically, if I can put it like that, it was an anaesthetist's job, but there was normally one anaesthetist on-call and the practicality of the situation was that if somebody needed to be transferred it was matter of ringing round to try and find if somebody was available.

Q You say that the letter which we have put in at 237A and B you wrote, and did you take it with you?
A Yes.

Q Is that normal practice in a situation of this kind?

A It would be normal practice to have some form of written communication.

Q In your letter at 237A you have said, "IV at approximately 11". You have not given any further details there with the IV, would that have been normal or was that unusual?
A It is a very brief letter but bearing in mind that there was an ongoing resuscitation situation and I was going to have to do the transfer, it was less than I should have written, less than I might have written on other occasions, but it was a very pressurised situation.

Q Did you have the fluid charts available to you at that time with which to write this?
A I do not think I did, no.

Q Do you remember seeing any nurses writing in fluid charts at the time, at three o'clock in the morning?
A No.

Q I need to ask you some questions now on a slightly different theme. We know, from having listened to Dr Evans, that he has some points of disagreement as to how the child was managed in the initial stages?
A Yes.

Q I want to ask you first why it is that you gave this child Dioralyte, bearing in mind that he has characterised this as Dioralyte because you could not get a line in. Was that your reason for starting with Dioralyte?
A No, that was not the reason. The plan, brief though it was, did specifically include a reference to ongoing oral feeding. One of the traditions in treating for gastroenteritis in the past has been nil by mouth, in other words, stop feeding, the idea in the past being that that helps the intestine to rest, as it were, and that might be a useful thing to do. That idea had gone out by the time in question and it seemed very clear to me that that was not what was intended. The intention from the beginning, from the word go, was that there should be oral fluid used.

Q Some seven objections are taken to that particular treatment and a number of points were raised in answer to points that I put, suggesting that this treatment was acceptable. Dr Evans says this was a child who showed signs of the risk of getting worse and for that reason it was unacceptable to have a regime which was, in some ways, effectively half oral and half IV. What would you say to that?
A As far as I am aware, and I think all of the publications on the question of gastroenteritis do accept that there is no way of predicting who is going to get worse. Moderate dehydration starts at five per cent, severe dehydration starts at ten per cent. Moderate dehydration is halfway to severe dehydration. There is no way of predicting who is going to go from one step to another and certainly at that stage there was no basis for suggesting that you could predict who was going to deteriorate.

Q He has supported his suggestion that intravenous therapy alone was the only appropriate way of dealing with the situation, on the basis of her drowsiness, her vomiting over the past 36 hours, and the fever. Now, he supports it with those symptoms,

what do you say to that?
A None of those symptoms are reasons for using exclusively intravenous fluids. Fever will increase your fluid requirements, although not hugely, but there is no particular reason why fever should have anything to do with using intravenous versus oral rehydration therapy. You will have to forgive me, I have forgotten the other two.

Q Drowsiness?
A If somebody is unable to respond then I can understand the logic in that, if you offer somebody oral fluid by a bottle or a cup and they are unable to take it because they are so drowsy or have a decreased level of consciousness, it is a pointless activity. But I had seen her taking fluids very well. There is no reason, from that point of view, why she could not take fluids as she had done before I arrived in actual fact already. There was a third reason, you have to forgive me, I have forgotten.

Q Not at all, the vomiting.
A Vomiting is not a reason for using exclusively intravenous fluids. Oral rehydration therapy can be a useful part of the treatment of gastroenteritis whether it starts with vomiting or with diarrhoea and whether it contains both or not.

Q If we look under what I hope is your last tab of the bundle ... Sir, it is tab 11, advanced paediatric life support. It begins I trust little 89; I have no big black number for it. *(To the witness)* Doctor, do you have that?
A I do, yes.

Q I am grateful. I think you have already told us THAT it is a publication that you are familiar with.
A Yes.

Q We have looked at it in part with Dr Evans. Would you just glance through there and do you recognise that as being the document or something similar to it that you had spoken of earlier as something that you bought yourself for use?
A Yes.

Q Looking at table B we see, on the fourth page, a setting out of the fluids, their types and their characteristics?
A Degrees of dehydration in Table B.6, is it?

Q Yes indeed. In fact, just at the bottom of the previous page there is an indication there that:

> "The major causes of dehydration in children are gastrointestinal disorders and diabetic ketoacidosis."

Then, as you say, on the next page there is the fluid and electrolyte management section. We see under management of dehydration:

> "*Mild dehydration* (*<5%*) can usually be managed with oral rehydration if vomiting is not a major problem. Oral rehydration fluids are better absorbed if they contain a small amount of sodium

A

> and glucose in addition to water. Commercial preparations contain, for example, [35-50 mmol of sodium per litre when made up as instructed].
>
> *"Moderate and severe dehydration* will require more accurate replacement of fluid loss and although oral rehydration may sometimes be possible, intravenous therapy may be needed."

B

Is there anything in that that you would disagree with?
A No.

Q Now, Dr Evans, as I understand it, when looking at that, says: Ah, yes, but in this particular patient it is different. He points to what he regards as particular dangers. He has said firstly, and I put it to you earlier, this was a child who was at risk of getting worse and for that reason there ought not to be half of one and half of another. You said that you cannot predict. What was it about what you saw particularly here that made you choose the plan that you chose?

C

A Dr Malik had, in actual fact, put an outline of a plan which included both intravenous and oral fluids and I had no reason to change that in the first place. But, as I mentioned previously, the intravenous fluid access was not secure in this particular child. It was not reliable in the sense that I was not entirely sure that I could continue it if there had been a problem with it. If there had been a problem then the hope in using oral rehydration therapy is that you are able to establish good oral rehydration therapy and that if there is a problem with the intravenous line the child will not need central venous access with all the risks associated with it.

D

Q One of the other things that Dr Evans said, dealing with this point, was if the child is well enough for half oral fluids then it is well enough for all of them. In other words, it is an all or nothing; you either have to have wholly intravenous fluids or you have to have wholly oral?

E

A I do not see any basis for that at all and I do not think he offered any particular basis for it. In one sense possibly I would agree in that if this child was taking oral rehydration fluid well, for example, and the intravenous line had tissued then my inclination would be to try to increase the amount of oral rehydration fluid and not bother looking for more intravenous access, particularly the more dangerous central venous access. But there is no reason why you cannot use both at the same time and it indeed would be very commonplace to do so.

F

Q Another reason that he put up against your programme of treatment was he said that there were problems with the fluid lying in the stomach, that is to say the oral fluid lying in the stomach and you not knowing how much had been absorbed and used. What would you say to that criticism?

G

A That is true, you do not have any way of measuring it directly but, if that was a strong reason, you would never use oral rehydration therapy because you never know when it has been absorbed. In some respects, if you have got gastroenteritis, fluid does not necessarily lie in the stomach for very long. If you put a lot of fluid in and if it is not going to be tolerated generally speaking you would expect it to come back reasonably quickly. That had not happened with any of the two doses given so there was no reason to think that this child's intestines were not capable of dealing with oral rehydration fluid.

H

A It is not a guarantee and if, as happened, the child started vomiting again then the issue needs to be reconsidered, as was done later on that night, as I understand.

Q My next question was how do you police a programme which invites oral fluid as well as intravenous fluid as the rehydration?

A You cannot, with oral rehydration fluid, use it in the same way as you do intravenous fluids that you set up a machine which will run at 'x' mls per hour. You do require the child to take the fluids and the question then becomes well why would a child take oral fluid? The bottom line is that drinking is nature's response to dehydration and provided a child has a clear enough conscious level so that the child is able to take fluids then a child will respond to dehydration by drinking fluid. The corollary is that if a child does not need fluid, a child is very unlikely to continue drinking a fluid, particularly something like oral rehydration therapy which does not taste terribly pleasant; it is not something people will take for fun, they will take it because they need it.

Q Would you expect a nurse to know about oral rehydration as part of a programme needing to be taken by the child and needing to be offered?

A It is a daily activity on a children's ward. In fact it is something that you would anticipate most parents being able to do and a standard part of the nursing staff job to teach parents how to use it and how to be able to deal with their children at home.

Q Would you expect a nurse to understand and know to offer fluid or to educate a parent into offering fluid to a child who is in fact on a drip as well?

A Yes, that would be again a very common occurrence. It would be universal after some hours, in the sense that you would want to try and establish when a child is able to feed by themselves. The only way you are going to know is by offering them something to eat or drink.

Q You see one of the things that Dr Evans said, and one of the reasons he castigated what you were doing, was to say it would only be when the child was getting better that you would contemplate having an IV line and offering oral fluids?

A No, there is no reason why that should be the case.

Q Another thing that was said against your particular plan, we have heard discussion about paralytic ileus, and Dr Evans said at one point, although he did not necessarily maintain the line as hard as this, he said: I have no doubt it was a factor in this case. Do you agree?

A I do not see what the basis for him making that assertion was. It may have been, and certainly at 3 o'clock in the morning when I did the abdominal X-ray - and you will see from my cartoon - that there were dilated intestines and I would guess that there was a paralytic ileus at that stage.

Q When the decision was taken to offer oral fluids and set up an IV line, what part did the potential for paralytic ileus play in deciding to offer what was offered?

A It is a consideration but the frequency with which paralytic ileus is a problem in oral rehydration therapy is very small. In one respect, I think one of the articles put it very well, if you see that problem then just use intravenous therapy. The child did have an intravenous line in, and if it had been working and there was paralytic ileus then you would identify the paralytic ileus by bulging and the tummy becoming distended and so

on and then would you need to change to full intravenous therapy at that point.

Q The way in which you would identify paralytic ileus is ...?
A There is usually an increasing amount of vomiting or the abdomen becomes swollen as the fluid and air and so on accumulates within the intestine.

Q In terms of the observations which we see noted in the plan by Dr Malik, what sort of frequency of observation would a nurse understand in the case of gastroenteritis with an IV line in?

A Once you have an IV line inside you, observations and measurements are an hourly occurrence. You go once an hour to check the fluid, that is the whole basis for the way the fluid sheets are constructed. There is a section for each hour, observations to be made in parallel.

Q If the child vomited, would that be a relevant consideration and why?
A It would. Both in terms of the amount of fluid you wish to give and potentially the route you would want to use to give it. If the child had a large volume of vomit then you would need to reconsider at that time your approach and you might end up saying, "We have an intravenous line inside you, let us stop the oral rehydration therapy and move completely to intravenous drip."

Q By the same token, diarrhoea, would that be relevant?
A Exactly the same consideration. Although I suppose you would not -- if somebody had diarrhoea you would not necessarily stop feeding by mouth. That would be less likely under those circumstances.

Q You have heard Dr Evans himself would not have used oral rehydration therapy and we know that you preferred that in part with the intravenous treatment. Was his regime acceptable to have intravenous only?
A I cannot say that it would be wrong. There are reasons to think that children who are treated with oral rehydration therapy, all else being equal, will recover more quickly and will be able to get home more quickly. So I think there are reasons to think that it is a better of way of doing it, but I would not necessarily say that it would be outside the range of what people would do on a day-to-day basis.

Q I want to ask you one or two more questions, if I may, about after the event, that is to say after the tragic events that followed on from her admission to Belfast or perhaps I should say that took place on that evening. You indicated that, on the day you made the note, the 14th, you spoke at once to Mr Kelly. Who is Mr Kelly and what is his title?
A Dr Kelly is the Medical Director of the Trust.

Q You said earlier that he did not come back to you and ask for your input on a statement.
A He did not ask any further questions. He did tell me some time later that they had sent the notes to a paediatric colleague in an adjacent Trust, but that colleague did not contact me either to seek any further details.

Q We have heard the nurses describing a meeting with Mr Fee or meetings with

Mr Fee. Who is Mr Fee?
A He had two titles: I think one was Director of Acute Services and the second was Head of Nursing within the Trust.

Q Head of Nursing? Is he a nurse himself?
A He is, yes.

Q Did he speak to you at any time?
A Not about this matter. I have no recollection of him ever talking to me, no.

Q Did you say ever?
A About this matter, no, he did not. I have spoken to him on many occasions about other matters.

Q Was there any interest in the local community after the events that had happened here?
A There was a very intense local interest, very strong feeling.

Q Was that feeling made plain to you directly or to your family?
A It was certainly made plain to my family, particularly my daughter who had what one can only refer to as anonymous and abusive phone calls.

Q About this event?
A Yes.

Q And your supposed part in it?
A Yes.

Q Do you have any knowledge of other staff at the Trust being involved in anything similar?
A In terms of publicity?

Q In terms of publicity and unwanted attention?
A I think that there were a number of people working on the children's ward who felt a lot of pressure, if I can put it like that. I cannot say that I heard of any specific episodes.

Q In terms of your own involvement and these proceedings, have you ever been called before the GMC before in your career?
A No.

Q Have you been working at the Trust since this happened?
A I have, yes.

Q Have you been doing effectively the same job that you were doing up to these events in question?
A Yes. There have been some changes in recent times in that there are new contractual arrangements so that hours are significantly shorter and posts have now been filled which were not filled. So, there are differences but not in the core nature of the job.

Q That brings me neatly on to this question. Since the events in question, have any changes been made, as far as you are aware, to the manner in which the nursing is carried out?
A There has been the introduction of what is referred to as a named patient nursing system. In other words, when a patient is now admitted, a named nurse is allocated to look after that patient.

Q In terms of the document upon which notes may be taken, have any changes taken place in those?

A There have been a large number of changes in terms of sheets on which intravenous fluids are prescribed and recorded. Both have been substantially changed.

Q Were you questioned by the police about these matters?
A Yes, I was.

Q Do you recall when abouts in the chronology of events, that is to say the events, the inquiries and the inquest that that would have been?
A It was after the inquest.

Q Do you recall, was it a short or long time after that inquest?
A I think about a year.

Q Do you recall your interview with the police?
A I do, yes.

Q Do you recall how you were feeling at the time you gave the interview to the local police force?
A I was unable to work for a significant period of time, approximately a year.

Q Why was that?
A I suppose the total consequences of this episode and their impact on me and my family; I suppose in truth on me, to be honest about it.

Q How did you react emotionally to the fact that there had been this death within the paediatric ward?
A It was a very intense and distressing experience and one that I suppose in many respects I and others will never recover from. I do not say that in any sense to minimise the tragedy of the family nor indeed even to try and suggest that there is any comparison between the loss of a child and anything others of us may have experienced.

Q You have been accused by your professional regulator of dishonesty in relation to this matter. Have you at any times been dishonest about what you recall went on during that night at the material times?
A No, I have not.

Q Have you intended to mislead anybody about anything that you did or said on that night?

A I have not and I believe that I have actually tried to do the opposite in drawing the attention of the senior medical person within the Trust to this tragic occurrence. I have not attempted during the course of my time to protect myself from the consequences of whatever investigation would have been put in place at that stage.

Q Have you sought at any time to blame anyone else for something that you think is your responsibility?
A I have not, no.

MS FOSTER: I do not believe that I wish to ask the doctor anything else, thank you, sir.

THE CHAIRMAN: Thank you, Ms Foster. We will take a break now and return at 2.30.

MS FOSTER: *(To the witness)* Doctor, you are still in purdah until the questions have finished.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Mr Grundy?

Cross-examined by MR GRUNDY

Q Doctor, what I am going to try and do is deal with some general points to start with and then we will deal with the specifics of 12 April. Some of the general points. As far as the transfer note is concerned, just to help, is the purpose of a transfer note, which has now been produced, so that you can provide the relevant information for the receiving doctor? Is that correct?
A It is probably what you might call an introduction of the patient. The point of transferring from one unit to another is invariably to transfer to somebody who knows more or better, or at least you would hope they know more or better, than you do yourself. It is therefore not always the case that I would produce the information that the receiving unit would wish me to give.

Q In general terms, leaving aside that one for the moment, if you are transferring, the purpose of you providing is, at least from your perspective, to provide them with relevant information.
A Yes. Broadly speaking, that would be true.

Q In order that we can understand this transfer note, am I right in thinking that you had spoken to Dr McKeague before you wrote it?
A Yes, I believe so.

Q That was the reference and, it was following the discussion with ... Is it a him or a her?
A Him.

Q ... him, that there had been some talk about cerebral oedema. Is that right?
A Yes. If mannitol was given, there has to have been consideration of cerebral oedema.

A

Q I think that we had been looking at page 191 behind tab 1 when you were referred to that earlier in the questions.
A That is correct.

Q I would like to explore that a little further. Is it your recollection that it was
B Dr McKeague's thought that there might be cerebral oedema here or your thought because that is what you had given Patient A prior to speaking to Mr McKeague?
A My recollection is that the idea came from him.

Q Presumably, if cerebral oedema was being thought about, that logically meant fluid overload.
C A No, that is not necessarily the case. You can get cerebral oedema from many causes. You can get cerebral oedema with fluid overload if you have a head injury or if you have a brain tumour for example. There are quite a number of different causes of cerebral oedema.

Q I am sure that there are many different causes but, in this particular case, would the most obvious cause of cerebral oedema be fluid overload?
D A If you remember, there were questions asked about whether this child had had a head injury, whether this child could have got her hands on poisons and so on and so forth. While in retrospect it is a very obvious explanation for the cerebral oedema, at the time, there were other issues that were being thought about, some of these other issues which could also produce vomiting, for example. If you had a head injury and you were getting raised pressure in your brain, that would produce vomiting. If you had taken poisons, for example, that could produce vomiting and could produce cerebral oedema as
E well.

Q There was no history of either head injury or taking of poisons in this case, was there?
A No. Questions were asked at three or four o'clock in the morning. The fact that you do not have a history of a head injury or of poisons does not mean that there has not been a head injury and that there have not been poisons.

F

Q That was something that you did not in fact put in your transfer note, no history of head injury or poisons, did you?
A No, I did not. The situation was that I was trying to resuscitate a child with a view to transfer with facilities which, to be blunt about it, were completely inadequate for the purpose in hand and, at the same time, trying to write a letter of transfer. The letter of
G transfer that you have there is not the only documentation that accompanied the child or would normally accompany the child. The normal procedure there was that all the hospital notes would be taken with the child on transfer as would whatever nursing notes there were available and, if the receiving hospital had a photocopier, then they were welcome to photocopy them or let us photocopy them if they wish. We did not have access to a photocopier at the time, for example.

H Q Cutting through quickly, is that what happened on this occasion, that you took the notes and they were photocopied and then you took them back?

A I took the notes back. I do not remember whether they were photocopied or not. I could not say. I have no recollection as to whether they were photocopied or not.

Q Cutting to the point of what is obviously missing from this transfer note once we have it, why did you not provide information to Dr McKeague firstly as to what IV fluid plan you had prescribed?

B A I think what I said was that this was not the only information that would normally travel. All of the nursing information would traditionally travel, so that normally one would expect to actually have the account of the fluid in and the fluid out available as well. This was part of the information, the part that I wrote, but it was not all of the information that would normally travel.

Q We know that, for example, the biochemistry results would be in the records, would they not?

C A They might be in the records. Do you mean the printout?

Q The haemoglobin level at 12.1 would be in the records.
A Yes.

Q You wrote it in the records, doctor.

D A Well, if I wrote it, it was in the records, yes.

Q The question I am asking you is, why did you not tell Dr McKeague what IV plan you had prescribed?
A Because the IV fluid as administered would normally be on the nursing information which travelled as well. That is as far as I can go to explain it.

E Q That is fine. If that is your explanation, so be it. Why did you not tell Dr McKeague what IV fluid had actually been administered?
A Again, that information is the sort of information that is recorded in a particular place in the charts. At 5.00 in the morning when you are trying to do a number of things at the same time, the letter you have in your hand is a very brief summary of the situation. It is very clear to me that I did not understand what was going on and, in the absence of that orientating sort of information, I suppose I did not pull the rest of the information

F together as well as I might have done. That information went with the child. Otherwise, Dr Crean, who rang the following day, would have had no basis for ringing. He would not have known what had been given.

Q He certainly would not have known what had been given from your transfer note, would he?

G A No and that was not the intention. There is certainly no effort there to contradict anything that was contained in the nursing prescription recording sheet that went.

Q Why did you not even include in the transfer note that 500 mls of normal saline had been left running freely?
A I honestly cannot say why I did not. I do not know if, at the time of transfer, I was entirely clear whether that had happened or not.

H Q You were not entirely sure whether it had happened or not?

A I did not know at what time the IV normal saline had been put up. There is no record of it in the notes that I am aware of. There is no prescription to say that it should be started. All I can say is that, when I arrived in, it was finished or very nearly finished is maybe a better way to put it. So, I did not actually know at the time. I indicated earlier that, when looking for information, I was not getting clear information.

B Q Doctor, was the position at the time that you knew there had been a cock-up on the IV fluid plan and you decided not to mention it?
A That is not true.

Q And all you put down was, "[Therefore] IV at approx 1100". Why did you not say what the IV was and the regime?
C A Fluids are normally recorded on a fluid recording sheet which is a separate and specific piece of paper which was brought and which was available. When you arrive at intensive care, their way of recording that sort of information is somewhat different from normal wards. They tend to have a much larger sheet, an A3 sheet, and the information that is brought is transcribed from one set of notes to their notes. The information was brought and was made available to them.

D Q Unless I have missed it, are you saying that in any other note it was ever written down that your regime was - apart from what you wrote on 14 April - 100 mls bolus followed by one-fifth in 30 mls per hour?
A Not that I am aware of.

Q I will perhaps return to that. I wanted to deal with it as it has just been produced. As far as the medical notes were concerned at Erne Hospital for Patient A, am I right in
E thinking that at the relevant time on 12 April it was either you or Dr Malik who made the entries?
A Yes. As far as I can see. That is pages 188, 189, 190?

Q Yes, and 191?
A Yes.

F Q Running on to 192, I think. That may be the next day?
A That is the following day.

Q The 12th is?
A Up to page 190.

G Q Yes.
A Yes.

Q Are we to understand, just looking at page 190, the entries of some of the biochemistry which follows the plan and the "[approximately eleven o'clock] IV line inserted", that you made those entries before you left the hospital that night to go back home?
H A I have not put any time on them so I cannot say at this stage.

Q If you had written them in subsequently would you not, in accordance with normal practice, have stated that?
A I expect I would but, again, I do not remember at what time or at what stage I wrote those numbers in.

Q Whether you remember it specifically or not, what is your normal practice? Is your normal practice to write it in at the time?
A At the time that I receive it, that I have the information.

Q Yes.
A That would be my normal practice, yes, at the time I get it and I can get my hands on the notes.

Q From where we can see how it appears in these notes on page 190 it would appear that you made, for example, the entry for the haemoglobin levels and the like, white blood count, before Dr Malik put in the biochemistry results for the sodium, the urea and the like. Is that correct?
A That could be. They certainly look like I have put them in the line above and normally that would indicate before.

Q On the face of the records it certainly looks as though you had access to and wrote in those records before you left to go home again that night?
A That could easily have been the case. I do not particularly - I do not know whether that is the case. For example, if you could imagine, if, for example, Dr Malik had left two lines blank for the full blood count it is possible I could have written it in another time. There is no way I can remember.

Q Surely you would remember, would you not, if you were adding things back into the notes at a later time?
A The bloods are listed there as full blood count, urea, electrolytes, glucose, et cetera, and that looks to me like an effort to accumulate the results of the test close to the place where the tests were requested or suggested in the notes. There is no timing on it so there is no suggestion that anybody was very conscious of writing them at a particular time. They were the results of the preceding paragraph. One can make too much of small things but if you look at that Dr Malik has five dashes on the last line, there is nothing after the dash.

Q Let us deal with the other entry, the "[approximately] 2300 IV line inserted". Are you saying that you did not make that entry at the time it is stated, namely at approximately 2300 hours? Or did you make it retrospectively?
A I am not stating in that that was as a time at which I was doing something. If you look at the symbol in front of it, approximately 2300, that indicates that it is a recollection. That is not a timing.

Q When did you write that in?
A I have not recorded the time at which I wrote it. If you look at the numbers for Dr McKeague, who looks most likely to me that around the time that we were contacting

with a view to transferring to intensive care and, therefore, it may have been an attempt on my part to make sure that I had some of sort of chronology to refer to.

Q That is what I was going to ask you. You certainly made an entry later on at 05.15 hours. Yes?
A Yes.

Q Are you saying that you made that entry above approximately "...2300 IV line inserted" at 05.15?
A No, I am not saying that because I did not write 05.15, so I cannot actually tell you.

Q Why were you retrospectively trying to put information into the medical records as to when you inserted the IV line?
A I think that was in an attempt to ensure that there was some framework for a chronology. I do not know that there is any particular importance in terms of anything I have heard so far about the timing of the IV line. If there is some issue about what time it was inserted then I can understand why putting a time in might be a problem.

Q Dr O'Donohoe, it is not a question of being a problem. This is your note. What I am asking you is why retrospectively you felt it necessary to write it in?
A What I think I have said was that I do not remember. That is the first time that question has been asked of me and that was nine and a half years ago but if I look at it above the telephone number of Dr McKeague it may very well be just as a reminder of chronology if that should be asked.

Q If you were thinking of putting reminders in the notes in case it was asked, why did you not write in then what your IV management plan had been?
A If you remember, I have tried to describe a situation in which there was an ongoing resuscitation activity. At the same time I did not have a clear-cut diagnosis. Possibly
I should have but I did not have a clear-cut diagnosis. I took over the bagging from Dr Malik. I described some physical findings such as fixed dilated pupils which would lead one to believe that something disastrous either had happened or was happening at the time. I did not probably have time, I would guess, nor did I think it appropriate to then start writing it in when it was becoming apparent that there was something disastrous had happened or was happening.

Q You clearly made a very detailed note at 05.15, did you not?
A I would not describe it as terribly detailed but it has more information than the previous ones.

Q The question I was asking you, why not even at that point do you not make a record of what your IV management plan and prescription had been?
A If the question is why would I have been in a position to write a note at 05.15 that I might not have been earlier, I suspect that at that stage, Dr Auterson, the anaesthetist, had intubated the patient and I had hands free, if I can put it like that, to write the notes.

Q The question was, clearly you had time to do it. When you had time to make that

note why did you not, if you were at the same time writing in "[Approximately] 2300 IV line inserted" say what prescription you had given?
A Are you talking about the note at 05.15?

Q Yes.
A That starts clearly at the top 0300, sorry approximately 0300, that is a chronology starting at 0300 and the event precipitating transfer. As far as I can see there is no effort in that to harking back to what happened before.

Q Let us move on. Just so we can understand your case in general terms, is it right that you are saying to this Panel that you did at the time make an assessment of the degree of dehydration of Patient A?
A Yes.

Q That you assessed it as at or about 7.5 per cent?
A Yes. It being an approximate estimation.

Q That is why I said "at or about". That you put it in the category of moderate?
A Yes.

Q When you put it in the category of moderate that is in the terms set out in the document APLS?
A Broadly, yes.

Q You were not putting it in the category of mild?
A No. If I used the word mild that would not be a reflection of what I saw at the time, nor, indeed, of the insertion of an intravenous cannula. The very fact of having an intravenous cannula means that almost by definition, although not quite by definition, there is enough dehydration to warrant that. The urea was 9.9. If I used the word mild that would be mistaken.

Q You would not describe Patient A as being mildly dehydrated?
A That would not be what on the basis of the information available. I do not recall saying that she was mildly dehydrated but if I did so then that was a mistake.

Q As best as you can recollect have you ever thought to yourself Patient A was only mildly dehydrated?
A If you look at the urea, 9.9, then that by itself without anything else would say this is not mild dehydration. So if I did say - I am not entirely sure I understand the question. If the question is did I say - and I do not believe I did - but if I did based on the information there I should not have said it.

Q Obviously a lot of water has passed under the bridge - apologies, that is a dreadful pun - from the year 2000. Obviously you have reflected on matters. At any point did you think to yourself, well, in fact, what I thought about Patient A at the time was she was only mildly dehydrated?
A I do not remember ever thinking that. The urea of 9.9 would not lead me to reach such a conclusion. If there was question, for example, was the patient severely dehydrated I would quite likely have answered no, the patient was not severely

dehydrated. Whether that left me or someone else saying mildly I am not aware of but I do not recall saying.

Q I will help you with your recall in a moment. Do you remember preparing a statement for the police investigation?
A I do, yes.

Q Did you prepare that statement yourself?
A To the best of my recollection I did, yes.

Q If I perhaps provide a copy for you and the Panel of it. (*Same handed*) C5. Just take our time to identify it at the moment, doctor, and then we will look at it. If you turn to the third page, is that your signature?
A It is, yes.

Q Dated 20 or 26 April 2005?
A 26 April, I think.

Q We see that:

> "This statement is a true and accurate reflection of my dealings with [Patient A] to the best of my knowledge and belief"?

A That is what I said, yes.

Q As we have already identified, this was a statement which was prepared specifically for the police investigation. Yes?
A I presume so. I do not see anything to say that. It does not look like a police statement form is all I am saying.

Q Just to explain to you, it was one of the police exhibits which was disclosed by the police.
A I am happy to accept that but it is not the usual statement form I am used to, that is all I am saying.

Q If we go to the first page, the bit that I wanted to take you to at the moment in relation to what you have just been saying is the third paragraph:

> "I attended and saw the child who appeared sleepy but could be roused. Dr Malik and Nurse Swift were present in the room when I saw her. Dr Malik had already carried out a full examination and noted it in her medical notes and from my observations I agreed with his assessment that she was dehydrated (though only mildly)..."

Is that correct, that you thought she was only mildly dehydrated?
A Again, I do not remember the full details of this but if this was for the police then it was not written as a technical medical document. It was an attempt to explain what had

gone on rather than to be a technical medical document. When I say "...only mildly" that would be very unusual to use that as a way of classifying dehydration. Again, I do not remember what I was thinking at that stage but I went on to talk about fluids orally, so I would guess what I was referring to was the lack of a need for other interventions such as intraosseous infusions and so on but I do not remember beyond that. It would technically be incorrect, I would have to accept that.

Q Just so we understand. You accept that those were your words?
A Yes, yes, yes.

Q "Although only mildly"?
A Yes.

Q What you are telling the Panel is that you used those words certainly not in a medical sense. Is that right?
A I think that that is what it looks like to me, yes.

Q From that sentence I have read out:

> "Dr Malik had already carried a full examination and noted it in her medical notes and from my observations I agreed with his assessment..."

Do we take it from that, doctor, that you had looked at the medical notes and seen what he had written in it?
A Maybe the difficulty with this is that if somebody is mildly dehydrated they do not have any physical signs of dehydration.

Q Just listen to the question. I am leaving aside mild dehydration, you have dealt with that point. This is a separate point. What I am asking you is whether you looked at the medical notes yourself when you came in before you did your observations of Patient A. The question I asked was, do we take it from this statement that what you did on that night was when you came in at some point you looked at the medical records and that which Dr Malik had entered?
A What I have said was:

> "Dr Malik had already carried out a full examination and noted it in her medical notes and from my observations I agreed with his assessment..."

I did not say that I read the notes. I may have done but I do not see myself as having said that in that sentence.

Q Doing the best you can, perhaps refreshing your memory if needs be from this statement, I appreciate, in 2005, do you think it is correct that if you were agreeing with his assessment you must have looked at the notes?
A No. If he had talked to me that would be another way of him telling me what he thought.

Q Let us return to a few more general points, if I could. I think am I right in thinking that you accept that when you came into the hospital that night you became directly responsible for the treatment of Patient A?
A The way the system is organised, in actual fact, I am responsible for the patient whether I am in the hospital or not.

Q I appreciate that but I was making the distinction here. It goes beyond that in this case, does it not? When you came in you became directly responsible for the treatment of Patient A?
A I became involved in the treatment of Patient A and what I did when I was directly involved I am responsible for what I did, if that is what I understand you to be asking.

Q You were the person who was responsible for assessing the degree of dehydration, were you not?
A Yes.

Q You did not discuss that with Dr Malik?
A Did not discuss the ...?

Q The degree of dehydration with Dr Malik?
A As far as I remember, he told me about the capillary refill was prolonged and the urea was 9.9. There does not actually need to be any more detailed assessment than that to realise that the child is dehydrated. There may have been a lot more discussion or other physical signs referred to.

Q Well, from your evidence that you have given thus far for the Panel, and certainly it was not put to Nurse Swift that there was any discussion between you and Dr Malik in the treatment room about the degree of dehydration of Patient A. Now, is that right or wrong?
A Is it right that there was or ---

Q Yes, that there was or there was not?
A I do not remember. What I have said in this police statement is that I agreed with his assessment. Whether he told me in the treatment room or whether he told me when he phoned me at home, for example, I have no way of knowing. If he had rung me at home and said, "I need an IV cannula, have not been able to do it myself", and if he said, "Well she is really not dehydrated at all", I probably would have said to him, "Well I hardly need to do it do I?" If he had said, "She looks severely dehydrated", well I would be saying something like, "Well, we really need to be moving very quickly and if necessary we need a central line and osseous access.

Q That is all pure speculation on your part now, you have no recollection of any of that, have you?
A No, I do not because, as has been said on a number of occasions, it was nine years ago. What I wrote in 2005 was that I agreed with his assessment.

Q Leave aside the police statement for the time being, Doctor, do not trouble yourself with that now. I just want to deal with who is responsible. Do you accept that

you were the person responsible for determining the degree of dehydration of Patient A?
A Dr Malik had determined -- had recorded a capillary refill time greater than two seconds and urea 9.9, that determines dehydration.

Q Right.
A As I mentioned, as I said, not serious dehydration but dehydration therefore it falls into the moderate group. There are no physical signs in the presence of mild dehydration.

Q That was a decision, that was an assessment which you made, as the consultant, was that right or wrong?
A I agreed with that, with what Dr Malik -- I have said I agreed with what Dr Malik said.

Q Well, Dr Malik had not put down, had he, in the records whether this was mild, moderate or severe dehydration, had he?
A I do not know, it is not written there, but an assessment where you have a urea of 9.9, and a capillary refill, that means dehydration in the context.

Q Well, I am not quite sure why you are concerned about this, Doctor, I am simply putting to you, is it not the case that you, as the consultant, were making the decision as to the degree of dehydration of Patient A and that, therefore, what treatment she required?
A Yes, I made a decision, yes. As I think I have said, I was asked by Nurse Swift a question about fluid and in order to give any response to that you have to have made an assessment. You cannot just pick figures out of the air, if I can put it like that, it has to be based on something.

Q Yes. You were determining also what fluids should be given to Patient A?
A I was encouraging by giving, by making up the Dioralyte, for example, oral rehydration therapy, so yes.

Q Sorry, it was not a very well phrased question. You were responsible for determining what type of IV fluid should be administered to Patient A?
A I do not think I have said anything different, I think I have said that Nurse Swift asked me a question and I gave a response.

Q So the answer is yes?
A That is the answer I gave. I am trying to understand if the question is something different to what I have answered.

Q Doctor, I am not asking you what response you gave at the moment, I just want to deal with who is responsible for deciding what treatment is being given to Patient A. It is a very simple question, Doctor, it was your decision, as the consultant, as to what type of IV fluid should be administered to Patient A, was it not?
A Yes.

Q It was your prescription, was it not?
A No, it was not my prescription.

Q Well, you were the consultant who was deciding what fluid should be prescribed,

yes?
A I do not want to appear to be trying to be technical about it, but the word prescription refers to a written prescription, that is what the word means.

Q Well, who prescribed the fluid?
A Dr Malik wrote something in the notes -- I beg your pardon in the fluid chart.

Q Put aside written prescription, who decided what fluid should be decided for that child?
A I responded to Nurse Swift.

Q Leave aside who you responded to ---
A I responded, and when responding I believe that Dr Malik was writing a prescription

Q On your behalf?
A On my behalf, yes.

Q So whose prescription was it?
A It was a prescription recorded on my behalf by Dr Malik.

MR GRUNDY: Right. What was ---

MS FOSTER: I am sorry to interrupt my friend. I do think that there may be just a misunderstanding because to this doctor the word "prescription" means the document you have with your own hand or someone with their hand has written and there is a distinction in my friend's mind between decision and a piece of paper, prescription, and there have been several questions based on that.

THE CHAIRMAN: I think you are right, I think that resolved itself in the exchange of just a moment or so ago.

MS FOSTER: I hope so, yes, I hope so.

MR GRUNDY: (*To the witness*): You were deciding also the rate of administration of the fluid to Patient A?
A Yes.

Q It was your decision, not Dr Malik's was it?
A No, no, I did not say it was Dr Malik's.

Q Did you ever check what had been written down on your behalf?
A No, I did not.

Q As you were the person who was responsible for the prescription, would that not have been the proper and appropriate thing to do?
A The prescription, just so we can be clear, is the written document. The fluid is

attached to the drip which I had inserted. The prescription is put into force by connecting the bag to the drip which I had inserted. There is a set procedure for checking the administration of all medication and fluids. You check with the prescription, with the written document, you check the fluid, you check what guide has been put on the drip stand, you look at the expiry date and so on and so forth. You look at the rate on the drip counter and you compare that with what is on the document. That is the process.

Q Did you do any of that?
A No, I did not, no?

Q You were the person who was saying what should go on there, you did not do any of that, is that right?

A No, the fact that I said that that should be done, does not necessarily carry an obligation to see it through to all of those steps. There are at least three steps in the procedure that I can think of, one is inserting the cannula.

Q Yes.
A I think, as one of the nurses said, that is often blocked off with a sterile bung. The second step then is to find a bag of fluid and run it through a plastic tube which will, in time, be connected to the patient and the third step then is to connect it to the patient. The prescription ---

Q I am hesitant to interrupt but you were present throughout all that process, were you not, in the treatment room?
A Not that I am aware of. I was ---

Q You are not aware of that?
A No. I do not know that I was aware of when it was connected, for example. I certainly was not invited to take part in a checking procedure which would be the normal occurrence when you connect fluids to a cannula or when you administer any medication.
Q It was never suggested to Nurse Swift, either by my learned friend Miss O'Rourke or by Ms Foster when they cross-examined Nurse Swift, that you were not present in the room when that was done, was it? Now, are you saying that you just ---
A Pardon me interrupting, but when *it* was done, which?

Q Well, when any of that was done, because now you are saying you cannot remember being there at all for any of those matters?
A No, no, no, I have said I connected the drip ... Sorry, I beg your pardon, I have said I inserted the drip. The second step then ---

Q Hold on a minute, inverted the drip or inserted the Venflon?
A Inserted the Venflon, yes, I beg your pardon, I am sorry. It is a different use of -- different words.

Q Calm down, Doctor.
A I am sorry.

Q Just take things slowly. I am not meaning to catch you out. Let us just take it slowly.
A Okay. My apologies.

Q You were clearly there to insert the Venflon, because that is what you did, yes?
A Yes.

Q Were you there when the bag was put up?
A By put up, you mean put up on the drip stand or attached to the patient?

Q Yes?
A I do not recall whether I was or not. I may have been there and would not necessarily pay any great deal of attention to it, to tell the truth. Physically somebody can be attaching a bag to a plastic tube and without me necessarily seeing what they are doing or indeed regarding it as part of any inspection on my part. The verification step is when you decide to actually give the fluid to the patient, which is when you attach it to the cannula.

Q Leaving aside formal verification, are you saying to this Panel that when the bag was put up you could not see what was in it?
A If you consider that the shape of the bag, it is something like a large paperback in size and shape. If I could see the front cover, as it were, I could see - if I was looking and if I focused on it, by which I mean if I paid attention to it - I could certainly see what was in it. If I was looking at it from the back because it is transparent, and if I saw it and I focused on it in the sense of paying attention to it I could see what it was. If my eye line hit the bag on its side, then I would not have anyway of seeing it, even if I am reading it, even if I tried to focus on it. So the fact that somebody is putting a bag up in the same room does not necessarily mean that I am going to be paying a great deal of attention to it, particularly, if I may say so, when I have just put in a cannula, which I have already acknowledged might be the last one I could see doing. The cannula is then generally wrapped up. Over the next little while one of the things you are trying to do is make sure that the child does not interfere or dislodge it in some way. So I do not think I would necessarily anticipate paying a great deal of attention to a bag of fluid being put together, if I can put it like that, in that room. I cannot remember the geography really enough now to know where it would have been put together. But one of the steps in constructing the bag, in putting the bag together, is that you have to flush the tube through. You have to let the fluid run through to the end of it in order to make sure there are no air bubbles. That will have to be done somewhere where the fluid, as it comes through, does not fall on the floor. So, for example, you would normally expect somebody to go to the sink to do that. Now, we have had a significant refurbishment in the ward since then, and I cannot tell you where the sink was, for example, with respect to the child. Those details I just cannot remember.

Q Do you disagree with Nurse Swift's evidence when she said that you would have been in a position to see the bag that was put up?
A I do not in the sense that if my head was turned in the right direction and if I looked I might very well see the bag. Whether I could read it or not - which is really I think the point at issue - would depend on what its orientation was towards my line of sight and it may have been appropriately orientated so that I could have seen it or it may

not have been, it would depend on which part of the room it was in.

Q Well, let us just go back. Nurse Swift said, and I think this was accepted, she said to you, "What shall I put up?" Yes?
A Yes.

Q You did not tell her, did you?
A I did tell her.

Q You did not say, "Put up normal saline", did you?
A I think I was very clear in what I said. I recorded two days later, or whenever it was when I wrote that note, that I said a bolus. I did not say that I could say, even at that stage, with 100 per cent certainty that I had said normal saline.

Q "What do I put up?" She is not actually asking you how much to give at what rate, she is simply asking what do you want up on the drip? Now, either you say in response to that, normal saline or you say one-fifth saline or whatever else is appropriate. You did not tell her, did you, normal saline?
A No, your question is based on the assumption that this is exactly the question as asked. At the time that the question was asked, I was still in the process of securing the cannula. So I do not remember exactly what the question is, therefore I do not or cannot tell you exactly the format of my answer.

Q What you said was, according to you - and it certainly put in cross-examination - 100 mls bolus and then 30 ml per hour.
A Yes.

Q You did not even then mention the type of fluid, did you?
A Where is this? When? I mean ---

Q Even on what you told her, and what you say you told her, you simply said, did you not, on your case, 100 mls bolus and then 30 mls per hour?
A My recollection is that the 30 mls was 0.18 per cent.

Q Let us just have a look at tab 9, page 137. This is the letter you wrote to Mr Doherty.
A Yes, I see it.

Q We have looked at it a number of times. The second paragraph, second sentence:

> "While strapping the cannula *in situ* I saw Dr Malik writing as I was describing the fluid regime, i.e. 100 mls as a bolus over the first hour, and then 30 mls/hour."

Now, is that how you described the fluid regime?
A The first time in which I described the fluid regime was the one or two days after when I got the phone call from Dr Crean. That recording of it was open to scrutiny at the time in the sense that I drew that to the attention of the Medical Director. I did not notice

A that I had written then 30 mls per hour and did not put in 0.18 per cent at that stage. That was a letter that I must have typed myself because I do not have a date on it, and that is my inadequacy as a typist, if I can put it like that. So if the letter is less than entirely satisfactory, it may be partly for that reason.

Q This was a letter, as I understand it, which was then subsequently used, if you turn over the page, for the purposes of your deposition for the Coroner?
B A Yes.

Q You knew that your role was to assist the Coroner in what had occurred?
A Yes.

C Q No doubt you were trying to be as accurate as possible?
A I allowed this to go forward as part of the deposition, I think at the Coroner's request or during the course of the inquest. I did turn up at the inquest, with a view to answering any questions the Coroner wished to put to me. I am not so familiar with the procedure involved in that context that I can say I necessarily handled the situation correctly by not having independent legal advice right from the word go, but I have described the sequence of events that led to me not being able to answer questions
D directly from the Coroner.

Q I am not asking you about that, I am asking you about what the deposition which was prepared where you were trying to be accurate. What you said was that when you described the fluid regime which Dr Malik was writing down, were you ---
A Sorry, which page are you on?

E Q Exactly what I have asked you before. But let us go back to 137?
A Yes. The second paragraph, second sentence.

Q Yes.

"I saw Dr Malik writing as I was describing the fluid regime".

F Just pause there. You are setting out there what Dr Malik was going to write down in the records, is that right?
A Yes.

Q What he was going to write down in the records was, "i.e., 100 mls as a bolus over the first hour and then 30 mls per hour", that is what is you expected to see in the record
G A Yes, that is right, that is what I expected to see in the record.

Q You did not expect to see in the record reference to the type of fluid, did you, because you had not said it?
A You mean in the record of fluid as administered?

H Q Yes. You were not expecting Dr Malik to write down either one-fifth saline or normal saline because you did not tell him, did you, according to this?

A Can I answer the first question?

Q Yes.
A Which was that I would always expect to see the fluid in the fluid prescription and the recording sheet, if that is what you were referring to.

B Q I was not referring to that. What I am suggesting is that, according to this, your record, all you told Dr Malik was the rate?
A What I have written there ---

Q Do you agree with that or not?
A I have told him the rate. I did not say that is all I told him, but I told him the rate. You are correct in saying that I, in that sentence, I do not include the nature of the fluids. I accept that. But that is not the same thing as me saying I did not tell him anything about what type of fluids to use. Or did not talk about the fluids when Nurse Swift raised the issue.

C

Q The intravenous fluids used was saline 0.18 per cent saline, yes?
A Yes.

D Q Again you allowed that to go forward in the form of a sworn deposition to the Coroner, yes?
A Yes.

Q Why did you not record, in your deposition or in your letter, that that fluid should not have been used as the bolus?
A I wrote this letter originally to Mr Doherty at the request of the Coroner, as I remember it, it was included as a deposition. I attended the inquest with the belief that I was going to be asked further questions on that. I was not asked to do a further more detailed one, there was no indication that there was any concern with what I had written. It was written and there is nothing wrong about it. I made myself available for questions.

E

Q But to coin a phrase it is economical with the truth, is it not because ---
A No ---

F Q Just let me finish. Because it is simply saying intravenous fluid used was one-fifth saline, it is not indicating anywhere, is it, that in fact you always intended that normal saline would be given as a bolus?
A No, I have not written that, no.

G Q It is similar, is it not, to your approach that you took to the letter of transfer to Dr McKeague, you were economical with what you were prepared to say about the fluid regime that you prescribed that night?
A The letter, as I have said, to Dr McKeague, was economical for very practical reasons, which I have indicated already. This letter, when taken as a deposition by the coroner was, as I understood it, when I attended the inquest the start of a process. As I recall I attended the inquest, this letter was available, the Coroner asked could it be put in as a deposition, I did not object to that. That was not the end of the matter as far as I was concerned, I was trying not to be obstructive or difficult by saying, "Well no, I need

H

to redraft it." I anticipated that if there were further questions that they would be asked. It was part of the process of the inquest.

Q But it is only if someone actually asks you the question, would it then be revealed that, in fact, you had intended that normal saline should be given?
A I wrote this letter to Mr Doherty at his request. He is not a technical, medical person, and I wrote it in that spirit. I did not write it with a view -- its original intent was not for it to be presented at an inquest. I attended as instructed, and I was asked could that letter be taken as a deposition, and I agreed.

Q As I understand you said this letter was prepared for the civil litigation?
A Yes.

Q In other words, as to what had gone wrong?
A Yes.

Q So why did not you say, "Well what had gone wrong here is it was supposed to be normal saline given in a bolus and it was not given"?
A The reason is if you remember I handed the notes to Dr Kelly. I never had a report or a conclusion back from Dr Kelly or anyone else who was involved in looking at it within the Trust as to what they believed happened, what information they had elicited. I was aware there were some discussions amongst the nursing staff, for example. I was never told what the conclusions of that were. So again I do not remember the thought process.

Q How did you know that that the IV fluid used was one-fifth saline if you had not looked at the records?
A I had looked at records. If you remember, Dr Crean rang and I then looked at the records.

Q So, when Dr Crean rang you, then you knew that only one-fifth saline had been given.
A I probably did. I do not remember noting it.

Q You knew you had given her 100 mls an hour.
A The 100 mls an hour was not what attracted my attention. At that stage, whether I actually followed it through to look at the first as distinct from the rest of the hours, I honestly do not remember. One hundred mls versus 30 mls, whether it is normal saline or 0.18%, is enough to say that is a significant difference.

Q That did not attract your attention?
A I have explained that I handed the notes to Dr Kelly as Medical Director immediately.

Q I think you have told us that you stayed in the hospital after seeing Patient A for over an hour.
A When I came in to see Patient A?

Q Yes.
A About an hour; thereabouts; that sort of time; I did not time it.

Q Did you check her again before you left?
A I checked her once and I do not recall checking her again before I finally left.

Q Did you check to see whether your instructions had been followed and that the type of fluid had now been changed?
A I did not check beyond what I have described in one of the reports; I have lost track as to which one.

Q The truth is, doctor, that what you said to Nurse Swift on that night was, "100 mls until she passes urine". That is what you told her, did you not?
A No, that is not what I told her.

Q You thought that this was a case of mild dehydration, did you not? You got it wrong.
A The idea that you would treat mild dehydration with fluid until somebody passes urine does not equate. If somebody has mild dehydration, then there is no great value in putting a drip up and trying to in some way force urine. With mild dehydration, what you do is give somebody some fluids to drink and see what happens. Mild dehydration would not be treated in that way.

Q You thought that she was going to pass urine quickly; she has taken some oral fluids; I have been called in to put an IV in; I have put the IV line in; we will put in 100 mls until she passes urine and then she will be recovered pretty quickly. Was that not your thought process on that night?
A It is a very long and complicated question and I do not know that I have all of the bits in it. I tried to describe my thought processes with regard to having the oral fluids and having an intravenous line both at the same time. If you are asking me, do I think that she might have got by without an intravenous line, I think that is quite possible. A number of children with moderate dehydration do.

Q Why did you presume that the rate of fluid that Patient A needed was going to be relatively small?
A I did not presume that it was going to be relatively small. The amount given intravenously was relatively small. The amount that somebody will take orally is difficult to predict, but I have seen her taking 100 mls and I have used the word something like "enthusiastically". My belief at the time was that she was going to continue to take oral rehydration fluid and my belief was that she was going to continue to take it enthusiastically, if I may put it like that. Exactly how much that would be you cannot predict exactly in advance and that is one of the inevitable limitations with oral rehydration.

Q I am using your words, "I presume the rate of fluid need was relatively small". If we look at page 137 again behind tab 9, it is in that same paragraph, just read on to the next sentence, "The 100 mls was approximately 10 ml/kg ..."
A Yes.

Q Just pausing there, that is a maintenance calculation, is it not?
A Ten mls per kilo?

Q Yes.
A No. Ten mls per kilo would be, as I think I have said before, in her case 100 mls. Maintenance would be 4 mls/kg per hour.

Q Let us just read on,

> "and to cover the possibility that the cannula might not last very long and the succeeding rate was relatively slow since I had seen her take oral fluid well and presumed the rate of fluid need was relatively small".

A Yes.

Q Why did you presume that the rate of fluid need in the future was going to be relatively small?
A The succeeding rate was relatively slow. My presumption was that that rate, the IV rate, was relatively small. There was no issue of presuming that her total fluid requirement was going to be any smaller than usual. I had seen her taking oral fluid well and my presumption/belief was that she would continue to take oral rehydration fluid well and therefore the amount that she needed on an ongoing basis intravenously was relatively small.

Q You did not give an instruction on that night that oral rehydration should continue, did you?
A I do not remember doing so, but the plan was that oral rehydration should be part of what was going on. I certainly never said that it should stop and, to emphasise my support of it, I actually made up the oral rehydration myself. There was no doubt in my mind when Nurse Swift spoke that she was clear that oral rehydration was a universally applicable part of treatment of gastroenteritis.

Q Let us stand back. If, as you say, you have concluded that this was moderate dehydration, then you have to try and make as accurate a calculation as you can, do you not?
A Yes.

Q We see that in the APLS behind tab 11, page 248 is the page numbering of the document and it is also page 93, it is at the bottom paragraph under the heading "Management of dehydration" and the second paragraph,

> "*Moderate and severe dehydration* will require more accurate replacement of fluid loss and although oral rehydration may sometimes be possible, intravenous therapy may be needed".

A Yes.

Q So, what you are trying to do is make a more accurate assessment of the fluid loss.

Do you agree?
A You are trying to make as accurate an assessment as possible. There is a limit to the degree of accuracy that you can bring to the assessment of fluid no matter what you try to do. If somebody had said seven per cent or eight per cent, there is no basis on differentiating between those two figures, it is just not possible ---

MR GRUNDY: I am not suggesting otherwise, doctor.

MS FOSTER: Can you let him finish.

THE WITNESS: Just to be entirely clear and to make sure that I do not leave myself open to suggestions of incompleteness, at the time, there was no evidence to suggest that that was possible. Over the intervening years, particularly over the last couple of years, there is some suggestion that it may be possible to be slightly more precise but, at that stage, there was no way of being any more precise than that. It is actually quite an approximate business, as I think even Dr Evans agreed, and the key points that you want to make sure are first of all that the child is not shocked. If the child is shocked, the child needs fluids very quickly intravenously if you can. If you cannot, you put it in intraosseously or some other way. That is the process you are engaged in. You do the calculations as accurately as you can, but there is a point beyond which you cannot go from the accuracy point of view.

MR GRUNDY: There is nothing in this document which supports a mix-and-match approach in dealing with moderate dehydration.
A There is nothing in this document that supports the idea that you have to use intravenous fluids at all, for example.

Q Just listen to the question. There is nothing in this document which supports a mix-and-match approach in the dressing and treating of moderate dehydration, is there?
A It says that oral rehydration may sometimes be possible; intravenous therapy may be needed. It does not say that the two are mutually exclusive.

Q If you then go on and look at the steps and how the calculations are made, there is nothing there which supports, in your calculations, how you then adopt a mix-and-match approach, is there?
A There is nothing that says you have to use the fluids all intravenously. It says that you can use oral rehydration therapy. It says that you can use oral(?) intravenous as well and then goes on to give calculation of the different types of fluids and so on. It does not say that you should not use both at the same time. Even if it did, in the circumstances that I have described where there was a child where I had cannulated one vein and I was not at all sure whether I was going to be able to cannulate another, even if it said something like "mixing and matching is a bad idea", I would still say, I have put up the intravenous line, I wish to try oral rehydration therapy, so that if that potentially last intravenous line stops working, I have some chance of continuing with oral rehydration therapy and knowing that it has a chance of working without having to go immediately to a central line for the reasons I mentioned earlier.

Q That is all very interesting, doctor, but you did not in fact give that instruction to anybody that oral rehydration should continue throughout the night, did you?

A That instruction had been given already by Dr Malik. He said to continue oral feeding or whatever words to that effect.

Q In your experience, are 17-month old children still being fed through the night or do you expect them to sleep overnight?
A If somebody is dehydrated, it induces intense thirst. Children who are dehydrated, moderately dehydrated, will not sleep well.

Q Just answer the question. Do you normally expect a 17-month old child to be sleeping through the night?
A A child who is dehydrated or not dehydrated?

Q A child dehydrated or not dehydrated. If you are putting intravenous fluids into them to address the dehydration, would you not be expecting the child to sleep through the night?
A If you are only putting intravenous fluids in, then the child may very well sleep through the night. If you are giving oral rehydration fluids, the child has to be awake to a greater or lesser extent to be able to take the fluids.

Q You have to wake the child up at particular intervals to give the oral rehydration, have you not?
A If the child is asleep, you may wake the child up. People who are dehydrated have a profound thirst. It is one of nature's responses to dehydration. Children, when they are hungry or thirsty, make a noise. That is their protective mechanism. They alert their parents to what is going on. So, you do not have to plan on waking a child up. As often as not, the child will wake the parent rather than the parent having to wake the child.

Q Are you really saying that your plan of management was, I will give some IV fluids and then I will leave it up to the child to wake up and somehow request some fluid?
A No, I was saying that I will give intravenous fluids and the child can have as much oral rehydration therapy as is possible by the oral route.

Q You did not say that to anybody, did you?
A I do not remember saying that specifically, but that is a standard part of the management of gastroenteritis. You offer fluid and you let the child determine, partly because you have to, how much the child is going to take.

Q If you were expecting this child to be woken up at particular intervals to make sure that she was making up the difference between the 30 mls you were giving her by way of IV fluid and what she actually required, you would have written that down or, at the very least, told somebody that, would you not?
A I was not anticipating. I was not trying to impose a rigid schedule. If you look at what I did when I went in, I put the Emla cream on and then I offered the child oral rehydration fluid. There is nothing rigid about that approach to it. If you go in to do nursing observations, then you have a bottle of oral rehydration fluid and you can offer it to the child at that point. It does not have to be nine o'clock on the hour and ten o'clock

on the hour. It does not have to be that rigid.

Q So, you were expecting that there was going to be no regime, it was simply, even when Patient A woke up and made some indication that she would like a drink, that it would be provided to her.
A If Patient A woke up and there was an indication that Patient A was thirsty, I would expect that fluid would be made available ---

Q What fluid would you expect ---
A ... oral rehydration fluid.

THE CHAIRMAN: I am sorry, you were talking over each other. I did not catch all of your last answer, doctor, if you could repeat that. I got the word "fluid".

THE WITNESS: I wonder if you could repeat the question.

MR GRUNDY: I think I interrupted you. You said, "I would have expected oral rehydration fluid to have been given".
A Yes. If a child is in hospital with dehydration and wakes up crying and appears to be thirsty, then oral rehydration fluid would be the thing to give. I certainly was not saying that that is the only situation in which you should offer the child fluid. As I have indicated already, I personally had offered the child fluid when I had come in to put up a drip. I was not called in to give the child oral rehydration fluid. It just part of what is a normal technique for dealing with gastroenteritis and dehydration.

Q Coming back to your thinking that the IV line might tissue and you might not be able to get any more IV fluid in, is that why you decided in fact to pump it in at 100 mls per hour because you thought that you might lose the line?
A The child was taking oral rehydration therapy and had taken 100 mls enthusiastically. I had no reason to think that the child could not continue to take oral rehydration fluid, which is a perfectly acceptable option in moderate dehydration. It is a recognised option in severe dehydration indeed, but not something that most people will do.

Q You had no idea whether this patient was going to continue to take oral rehydration or not, had you?
A I was as sure as I can be about that. If you do not have a lot of experience with oral rehydration fluid, you would possibly not be aware that most people who are not dehydrated do not enjoy it particularly as it is a rather soapy and salty type taste. If somebody takes it, then what they are saying, if I may put it like that, what they are telling you physiologically is first of all that they are dehydrated because nobody drinks it unless they are dehydrated and second of all that they are capable of responding to the thirst by drinking fluids. My feeling at the time was that, if I had brought the second 100 mls in, the child probably would have taken the second 100 mls as well.

Q Why did you not?
A I thought that 100 mls seemed a reasonable amount to offer first time round.

Q I do not follow that. You wanted oral rehydration therapy, you thought that you

might need a bolus of 200 mls. Why, if a child is going to take that all orally, are you not giving it all orally then?
A The point was made previously that, until you start using oral rehydration therapy, you cannot be 100 per cent sure exactly what is going to happen. There has always been a slight concern that if somebody has gastroenteritis and you put too much into their stomach, you increase the risk of it coming back immediately and, if you start with a smaller amount, you have a better chance of getting where you want to go. One hundred mls is not a small amount in the context of a child of this weight, as I have mentioned before. It is something like one seventh of the deficit as calculated and it also was the amount of grams lost, if I can put it like that, over the hours that the child had been in hospital without anything being given. To my way of thinking, it is a very reasonable volume to offer. If the child has tolerated that, which I understood she did, and if the next time 200 mls was given, that would not be an unreasonable thing to do either.

Q Did you consider, if I can describe it, Dr Evans's lumen point that oral fluids would just get stuck in the lumen?
A That is a well known phenomenon but a very rare occurrence. The articles and, again, I can only say that it is a point which has been well known for many, many years and those recommending oral rehydration therapy do so on the basis of the knowledge that this will happen occasionally. The phrase in one of the articles is if that is what happens what you do is you change to full intravenous treatment. So if the question is: did I consider it, yes, I did consider it.

Q Did you consider what if Patient A could vomit or have diarrhoea overnight?
A Yes, that is an inevitable possibility in somebody who has gastroenteritis.

Q Did you leave instructions as to what should happen in that event and how your fluid management plan should be changed?
A You will remember that when the child vomited at twelve o'clock, I think it was twelve o'clock Dr Malik's attention was drawn to the issue. I did not try to anticipate every possible variation of vomiting and diarrhoea that might occur overnight. If there was one vomit, for example, and the tummy was not swollen then it might be reasonable to say that is one vomit, we do not, therefore, need to stop oral rehydration therapy. We can try again. If there was two vomits or if the tummy was swollen that would be a different decision. You cannot predict every possible variation. It is a common occurrence that the ongoing observation of the vomiting and diarrhoea is a normal part of day-to-day paediatric medicine practice.

Q The answer is you did not leave any instructions as to how your fluid management plan might have to be changed if events occurred?
A No, I did not try to predict all of the possible outcomes. That is the whole point to nursing observation and, indeed, the whole point to Dr Malik being there. If there was some concern when, let us say, for example, the child vomited at midnight, if there was some concern that my particular regime or suggestions, that they could not understand how to adapt to it based on the combination of circumstances at the time then I am very easily contactable. I was in twice that night in any case and it would not have been a problem if there was an eventuality that they found any difficulty dealing with.

Q When did you make your fluid calculation?
A As I remember, when Nurse Swift asked me.

Q When she asked you, "What shall I put up?" you then made the calculation in your head?
A Yes.

Q There and then?
A There and then.

Q Matter of seconds?
A In a child, as has been indicated already by Dr Evans, you will approximate. So if a child is approximately nine kilos that is, in truth, not far off ten kilos and calculations based on a number of like ten, for example, for that particular child the calculations turn out to be very easy: 4 mls per hour, four tens are 40 is a very straightforward calculation.

Q So we can understand, it was not a question of you taking some time and working out how much replacement do we need, how much maintenance do we need. It was simply a calculation which you did in your head in between Nurse Swift asking you what should you put up and you answering her? Matters of seconds? Is that right?
A If you are doing those calculations, as I was at that stage, on a pretty much daily basis, particularly when you have got an easy number like ten kilos to work with it will not be in any way remarkable I do not think to be able to do them literally in a few seconds.
I doubt if I could do the same calculations with the same facility now and for numbers greater than ten kilos you get into a slightly more complicated calculation. The calculation for the first ten kilos is 4 mls per kilo for each of the first ten kilos. So if it is seven kilos it is 28 mls per hour, that is the standard calculation. If you go over ten kilos it is 4 mls per kilo for each of the first ten kilos and 2 mls per kilo for each kilo after that. So if it is 14 kilos you have to have 14 plus two fours are - and then it does start to become a little bit complicated and potentially difficult to do in your head. When it is ten kilos or less the rate of fluid per hour for maintenance, for example, is 4 mls per kilo per hour. It is not a difficult calculation to do.

Q When you eventually came to write down what your calculation or your approach to the calculation was on page 193, why did you not write down what you had calculated as being the replacement loss?
A I do not know why. Part of the reason - this was on the following day on the 14th? 193?

Q Yes.
A The part of the reason for not putting all of the details in I would guess is that when you find yourself writing something in retrospect - sorry, no, no. You are not asking me about in retrospect?

Q I am just asking when you were putting down, no doubt explaining what calculations you had done as to why you did not then write down the calculation you had done in your head for the replacement loss?

A Oh, I see. I am sorry. I misunderstood the question. If you are using oral rehydration therapy for replacement then the basis of it is pretty much *ad lib* fluids. You offer the child fluids, if the child is conscious and thirsty the child by and large will drink.

Q Do you not still have to calculate what the replacement loss is?
A Yes. We have already, I think, agreed moderate dehydration. That is a very standard calculation, 750 mls. I do not think there has been any disagreement at all about that.

Q I am simply asking you as to why you did not write that down?
A I do not remember why I did not write that down at that point.

Q As to how that was going to be addressed?
A What I was recording at that stage was a telephone conversation with Dr Crean about a child who had deteriorated unexpected and where he had notified me of something which I had not noticed, for better or worse I just had not noticed it. I was recording - it was not a comprehensive recording, it was my 30 mls per hour, 30 mls per hour, where did that come from? How would it have been different? I do not say that this was me sitting down in a calm collected fashion trying to make a full and detailed recording of what was happening. I would venture to suggest that the opposite was the case. If you look at even the way I have written it, the last sentence in the first paragraph:

> "My recollection was having said a bolus over one hour of 30 mls..."

I have actually repeated myself there. I cannot say for sure, this is not necessarily somebody who is calm making this record. This is a notification of something which has - something had gone wrong and there was something else which had gone wrong which I had not been aware of.

Q Let us examine that. Dr Crean rang you on the 13th. Is that right?
A Yes, that is what I believe, yes.

Q To inquire what fluid regime Patient A had been on?
A Yes.

Q Because, as we know, you had not indicated the regime in your transfer letter, had you?
A No, I had not, no.

Q It certainly was not recorded in the medical notes, was it?
A No.

Q Dr Crean would have seen the fluid chart?
A You mean the fluid chart as fluid given?

Q Yes.
A I would imagine so but I cannot really speak for him. I could not say for sure. He was not the person who was there on the night that we brought Patient A to Belfast. At

least he was not the person I had any contact with at that stage. So exactly how he became involved in the issue I do not know. I would guess that he was the person on duty for the next shift after Dr McKeague went off but I do not know.

Q Had you seen the fluid chart?
A I do not remember seeing the fluid chart. That was part of the reason, I think, why I was shocked. I would have thought that if I had seen 100 mls an hour for a child of this age it would have made an immediate impact on me.

Q Given that cerebral oedema was in your mind and you were giving mannatol did you not, therefore, look at the fluid chart to see what fluid had, in fact, been administered?
A Cerebral oedema was, as far as I can see from the sequence here, an idea introduced by Dr McKeague. At that stage he was requesting that mannatol be given, that has to be drawn up and so on. He was also requesting Claforan be given, the broad spectrum antibiotic. At the same stage one is trying to secure access to an ambulance which sometimes is easy but sometimes may not be particularly straightforward, if I can put it like that, there is a certain amount of requesting and trying to persuade and so forth. So I do not think that there necessarily was time for everything that I would have wished to do.

Q I am not suggesting that you necessarily had to look at it at that point in time. You brought the records back with you, did you not?
A I did, yes.

Q Did you not look at them when you bought them back or as you were bringing them back?
A I did not look at them in the ambulance and, if I may say and I do not mean to be flippant when I say this, there is possibly quite a good reason for that, that I am not a particularly good traveller in the back of an ambulance and, frankly, it is often not a particularly comfortable experience, shall we say. So I would not normally be doing any work of that sort on the way back. I did not read them the following day because, as far as I remember, I had a full day's work to do when I got back. If I got back at eight o'clock I may have, as I said, changed my shirt but it was then straight on to a full day's work.

Q When did you discover then that Patient A had been given one-fifth saline at 100 mls per hour?
A Dr Crean rang. I looked for the notes. I do not remember whether I found them that day, or not found them, was given them and my recollection is that it was a Thursday and I did have an out-patient at that stage on Thursday afternoon. If I was recording that on 14/4 my belief is that I was given the notes or I came across the notes, whatever, on that day. On the following day. The day after Dr Crean rang.

Q Certainly by 14 April you knew what, in fact, had gone on. Is that right?
A I had seen the notes by that stage. I do not think I would say that I knew what had gone on in the sense that if somebody suggests that you give mannitol that is not necessarily the same thing as knowing that there was cerebral oedema, for example. I had had, I think, a discussion with Dr Crean about what was else was going on and my

recollection, for example, was that there were further investigations afoot, the paediatric neurologist was to be called in and if that was the case I would not necessarily say that I was entirely clear what had gone on even when I spoke to him or when he spoke to me.

MR GRUNDY: Are you all right to continue, doctor? I know I have been questioning you for a while.

MS FOSTER: I just wonder, sir, I know this is an important part of the evidence so I am somewhat hesitant to interrupt but it has been over an hour and a half now.

THE CHAIRMAN: It has. How much longer do you anticipate that you are going to require?
MR GRUNDY: I was hoping to finish within the next 15 minutes but I am entirely in everybody's hands.

THE CHAIRMAN: If it is going to be that long, Ms Foster is quite right, we do have the hour point for a reason and I have also been recently reminded that it is not in the general interests of the health of those of us who sit for prolonged periods not to be getting about the hour a bit of brisk exercise and so I think we will take a break now, please, returning in 20 minutes which will be just gone twenty five past four.

MS FOSTER: The same thing applies, doctor, regarding not speaking to anyone.

(*The Panel adjourned for a short time*)

THE CHAIRMAN: Welcome back everyone. Yes, Mr Grundy?

MR GRUNDY: Thank you, sir. (*To the witness*) I think we were looking at page 192, Doctor, have you got that, behind tab 1.
A Yes.

Q Just so I can understand it, am I right in thinking that the first paragraph, where it comes down and stops at, "as above", and then you have got a full stop and a gap, that that is a record of the conversation you had with Dr Crean?
A Yes.

Q Then the rest is what you have added thereafter:

> "Patient A had had 50 mls of fluid/orally before I saw her and I gave her 100 mls."

Then you did your calculation, you did not tell any of that to Dr Crean?
A I do not remember if I did or not. From the point of view oral rehydration fluid I do not think that entered into the conversation because he had talked about 30 versus 100 mls and the volume difference is enough to say this is an important issue without following it any further, if I can put it like that.

Q Because what you said is:

"[He] rang to inquire what fluid regime [Patient A] had been on."

Why did you not tell him that the fluid regime Patient A had been on involved in mix and match approach?
A You mean the oral rehydration and intravenous fluids?

Q Yes?
A He rang me with an inquiry to alert me to something, I then went looking for the notes. I do not know that saying anything about the oral rehydration therapy makes any difference to what he rang me about. If he said he thought 100 and I said I thought 30 or whatever, the fact of the oral rehydration therapy in that context does not negate the concerns that he rang me about.

Q Well, what he wanted to know was what had Patient A been on and, as I understand it, you had not looked at the notes at the time you spoke to him, is that right?
A Yes, I did not have detailed information to give him at that stage. I did not have the notes.

Q Fine. So the question I asked you is therefore why did you not tell him what your plan was, namely the mix and match?
A It did not come into the conversation to the best of my recollection. He is an anaesthetist working in intensive care and would have maybe a slightly different focus, so that if he was talking about intravenous fluids that might be all that he would be concerned about or all that he wanted to draw my attention to. I did not have the information to give to him. This note was written the following day and it is my recollection of the conversation. It may be part of the conversation, I do not think I wrote anything down at the time and I think this was recollection when I got the notes. So it is possible that there may have been some discussion further to that. The alerting feature was this difference in volumes.

Q But why did you not tell him that your plan had been a bolus of 100 mls of normal saline?
A The way I have recorded the discussion is an inquiry about what she had been given and that is what I was looking for in the notes to try and find out what she had been given.

Q So what you were telling him was what you thought she had been given?
A During the course of the conversation, when he mentioned 100 mls I think -- and I do not know, I have not recorded which order, whether he said, "Was it 100?" or did he say, "Was it 30?", I do not remember the order in which that conversation took place.

Q You record is:

"I told him a bolus of 100 mls over one hour followed by [one-fifth saline] at 30 mls/hour."

A Yes.

Q

"He said he thought it had been [one-fifth saline] at 100 mls/hour."

A

You said:

> "My recollection was having said a bolus over one hour and 30mls/hour as above."

B Why did you not record that your plan had been a bolus of normal saline?
A He was inquiring about what she had been given. He was not ringing asking what the intention had been, he was raising an issue about what had been given. I went down to look for the notes to see if I could find out what had been given and part of that was my recollection was one thing and he was suggesting something different.

C Q Sorry, if I am getting confused, it is late in the day. As I understood it, you had not looked at the notes, at the chart, and therefore you thought she had been given a bolus of normal saline?
A When he rang?

Q Yes?
A Yes.

D Q The question I ask you therefore is why did you not tell him she had had a bolus of normal saline?
A I said that for somebody working in paediatric intensive care the word "bolus" would mean normal saline, that would be the normal meaning of the term in that context.

E Q Because he was suggesting, was he not, that all that Patient A had received was one-fifth saline?
A The main concern, the main focus of the conversation, as I remember it and from what I see in the recording was the volume issue, 100 mls per hour versus 30 mls per hour. That was the focus of the discussion as I remember it, as I recorded it. That is the issue that he was raising.

F Q Coming back to where we were a moment ago, given that Dr McKeague had raised the issues of cerebral oedema, given that you had administered Mannitol, are you really saying you did not know by 13 April, when Dr Crean rang, that, in fact, Patient A had been given the 100 mls per hour of one-fifth saline?
A Yes, that is what I am saying. You have to remember I started at nine o'clock the previous day. By the time he rang I had been pretty much on my feet for 28 hours or whatever. I also did say that I do not travel terribly well in ambulances. So I am sure I was not looking at the notes on the way back in the ambulance. So I had not got to looking for the information that he was wanting to discuss until he rang. I did not have time to sit down and look at the notes because, like I say, I had to start the next day's work pretty much as soon as I got back.

G Q Was it not the position, Doctor, that just as in the transfer note, just as in your letter behind tab 9, you were trying to be economical with the information you provided as to the IV fluid regime?

H

A

A You are referring to a number of different documents, written under different circumstances. The one behind number 9, which is the one to Mr Doherty, I had typed myself, and if I may say so now looking at it I have actually typed rather badly. I do not know whether I did that for any particular reason or whether it was something that people wanted quickly. I do not know that I had access to the notes when this was looked for, because if that was during the course of civil litigation I might not have access to the notes and that might have been pure recollection as best I could. I have not recorded, I do not think, if I had access to the notes at that point.

B

Q What I am suggesting doctor is that really it is the same theme throughout: that you were trying to cover your tracks as to what, in fact, you had decided the treatment should be for Patient A?

A No, that was not the issue. If I was trying to cover something up, I would not have put Dr Crane's name in the notes. That is, at best, a very foolish thing to do if you are trying to cover something up. As I said before, I do not know whether anybody contacted Dr Crean or not, but I wrote the name and he was there to be contacted if people wished. If I was trying to cover something up I could have drawn attention to that without mentioning a specific name. So I cannot understand how that action can be taken to be an indication of trying to cover something up.

C

Q Well it was really a way of trying to explain why 100 mls had been given, that this was the time when you were covering your tracks by suggesting that it was, in fact, a bolus of 100 mls was all that you had intended to be given that night?

A But I do not see how involving somebody like Peter Crean in the issue would be covering up. If he had been rung - which he may or may not have been - there would have been then information to say: Well, yes, I did ring him because of X, Y or Z.

D

Q This record, on its face, was inaccurate, because, would you agree, it did not specify what the bolus was to have been?

A No.

E

MR GRUNDY: It did not specify that your plan included this mix and match approach --

-

MS FOSTER: Sorry, I think he ought to be given a chance to answer whether he accepts it is inaccurate or whether he is accepting that it did not mention what the bolus was of, because there are two parts to that question and it is a very important question given the way it is charged.

F

MR GRUNDY: I thought he had answered it.

MS FOSTER: He said no. Forgive me, it is my error if I have got it wrong but it seemed to me that there were two questions but only one answer.

G

MR GRUNDY: I thought it had been one question and one answer, but I have got the answer, and no doubt we can look at it on the transcript and no doubt my learned friend can come back if she wishes to re-examine on the point.

H

(To the witness) It was inaccurate because it did not include your mix and match

approach?
A The mix and match approach is not my approach in the sense that it was the approach established before I arrived. It is an approach which was designed to take into account certain circumstances which prevailed at the time. I did not record the difficulty I had, or the possibility that there might be difficulty with further intravenous lines, for example. Part of the reason for not recording that is that anybody who works with children of that age knows that that is a constant concern. So I did not record the mix and match approach that you are referring to, because I did not see it as a mix and match approach, I saw it as an attempt to cover the possible developments that I have mentioned.
Q In fact that note was wrong, because you knew you had made a mistake, and told Nurse Swift, "Give Patient A 100 mls an hour until she passes urine."
A No, I did not tell her that.

Q Finally, as you said, there was not a named patient nurse system on operation on the ward at the time, was there?
A There was not, no.

Q How then did you ensure that the nursing staff on the ward were aware of your fluid replacement plan?
A I was very surprised when Nurse McManus said that there was no system or I think she said no system for allocating patients. I had no way of knowing that there was no system for allocating patients, nobody had ever said to me literally, "There is no way of allocating patients." Whenever I came to see a patient I would inquire something like, "Which nurse is in charge of this patient? Which nurse is looking after this patient?" and somebody would be identified. The fact that, as I think Nurse Swift was saying, people were mucking in and they might talk to me one minute and then see themselves as not having anything to do with that patient half an hour later, was not something I was aware of to be honest with you.

Q What did no named patient nurse system mean to you then?
A I was not aware of -- I was not conscious of there being no named patient system, except in the sense that there were no names above the bed. There is two different ideas mixed up in that, one is the question of allocation versus named allocation. I presumed - and it turns out, and I have only literally heard that last week - I presumed that there was some form of allocation when a shift of nurses came on, my assumption was that the person in charge would say, for example, "You do beds one to five, and you do beds six to ten" or, "You do the blood pressures" or, "You do the antibiotics", or whatever. The implication seems to be that even that level of organisation was not present. I was not aware of that.

Q Well why not?
A Because whenever I was ---

Q You have been there three years?
A Whenever I was involved with a patient and I said, "Which nurse is looking after the patient?" there always seemed to be somebody who was saying they were looking after the patient.

Q Just because it happened that Nurse Swift was in the treatment room when you arrived, it did not follow, did it, that Nurse Swift would be looking after Patient A that night?
A I did not ask her had she been allocated to look after the patient. I am afraid the natural presumption is if somebody is there when you go to put a cannula in and assists while you do it, the assumption is that she is there for a reason and the reason is to look after the patient. If she is deputising for somebody else who happens to be away, or whatever, then she could either have told me, "Well I am just standing in", or the normal practice would be for that nurse to relay it to whoever was the person who was the definitive person if there was one.

Q But is that not the problem which Dr Evans identified that if you are relying upon oral communication people can mishear, things can go wrong?
A I agree that people can mishear and things can go wrong. What I do not think would have corrected the problem in this case would have been writing more information down. It did say in the notes, in this situation, continue oral feeding and so on and so forth. There was no oral rehydration therapy given, as far as I could see, after I had left. It was written to continue oral feeding. I made it as clear as I could by actually physically doing it myself what I understood that to mean, and there seems to have been, as far as I could tell, no follow on afterwards. Writing something down can help standardised things and, if people are going to read what is written, then it can help prevent things going wrong. As regards the fluid prescription, Dr Malik contained the name of a fluid but contained no rate. So, writing that down did not help at all and, the only way that could have helped is if it had been read as the fluid was being attached to the cannula if it had been used to check as the cannula was being attached. So, the writing of things down, although I am not trying to downplay the importance of good record keeping in any way, there is nothing that says to me that those aspects of the situation would have been different if further details had been written down. What was written down was not used. So, if somebody had used the prescription sheet to check as they were attaching the fluid to the drip or if they had used, as it is supposed to be used, when you come on a hourly basis to assess the amount of fluid that has been given, is the drip running properly and so on and so forth, there would have been a number of opportunities for it to be recognised that there was no number written on the sheet.

Q Whose responsibility is that?
A The using of the sheet for checking when you are looking at the drip to assess the fluid is whoever is checking what fluid has gone in. That is a standard nursing responsibility.

Q The responsibility for making sure that the instructions are clear and would be followed was yours, was it not?
A The question you started with, as I understood it, was, would writing things down have been a failsafe that would have prevented what happened? The answer in that context – and it may relate to the disorganised nature of the nursing service, of which I was not aware of – was that what had been written down was not recognised as being complete. There were multiple opportunities to recognise, in the course of the standard day's work that every nurse does every day of the week, that it was incomplete. I do not check every prescription that is written for every patient who has my name attached to it. If it had been used to verify when the fluids were attached to the cannula, the standard

checking procedure would have been name of the patient, what fluid is here, what rate and you look at the bag and you look at the paperwork and the numbers on the machine and so on and so forth. So, the answer to my mind is, no, good record keeping is important and I am not trying to argue against that in any sense, but I cannot see how this could necessarily have been avoided by further and more detailed record keeping.

Q So, you would not do it any differently?
A No, that is not what I said. I would do it differently. If I had ---

Q Why, if it is not going to make any difference?
A If I had done it differently that night, I think that the same documentation would have been ignored in the same way as the documentation that was present was ignored, largely I suspect ---

Q I am sorry, what documentation was ignored? What instruction as written down was ignored?
A The documentation that was ignored was, for example, the fluid prescription sheet. That is meant to be a working document that you use when you are attaching the fluid bag to the cannula.

Q I am sorry to interrupt, but surely you were responsible, as it was your decision, for making sure that what was written down on that fluid prescription sheet was correct.
A I did not sign that fluid sheet. The vast majority ---

Q Why not?
A Dr Malik signed it. The vast majority ---

MR GRUNDY: Why? Why did you not sign it?

MS FOSTER: Would you, please, let him finish his answers because it may be that they are not one-word answers and there is something else that he wishes to say.

THE WITNESS: Dr Malik had written the nature of the fluid, had written dextrose 0.18% and he had signed it. It is a common occurrence for junior doctors to write up fluids. I do not check; nobody checks every prescription written by every other doctor to countersign it and make sure that they have done it right all of the time. I do not know why he did not have a number there. If that document had been used, if it had been looked at as the fluid was being connected, the standard checking procedure is, what is the name of the patient, what are you giving the patient and you look on the prescription sheet, you look on the bag and you actually have to consciously look at the bag because, besides the nature of the solution, the 0.18%, you actually have to look for other information like the date of expiry. So, you actually have to look at it. It is not glancing at it out of the corner of your eye. You then have to look separately. You have to look at the pump that delivers the fluid and you compare that with the rate. If that document had been used in that way, then it would have been noticed that there was no number there, for whatever reason. That then gives the chance to rectify that omission. If there had been a number written there and the document had not been used, whatever number was put in would not and could not have been corrected, no matter what the number written on the document was. So, it is not just a matter of saying that if you write everything

down, nothing will go astray. That just is not true. It is true maybe from a doctor's point of view. If I had written everything down, the last ten years would have been substantially different for me, I have no doubt about that whatsoever. I am not entirely persuaded that the outcome would have been different for the patient in question. If the written instructions were not being looked at, the fact that they were not as detailed as they might be or they should be does not mean that writing more detailed instructions would have prevented those problems.

Q That was a very long answer and I am not going to pick up on it all. As I understand it, what you are saying is that Dr Malik wrote down the wrong fluid.
A Dr Malik wrote down a fluid. He did not write any number. There are two issues ---

Q As I understand it, what he should have written down first, the first bag to be put up should have been normal saline.
A That is what I was saying in response to Nurse Swift's inquiry. She also countersigned the fluid. The whole point of having two names on pieces of paper like that is to make sure that one is checking what the other one is doing. Both left a prescription sheet without any number on. I do not know why they did that. I do not know how it came to happen, for example.

Q Leaving aside the number ---
A With all due respect, I cannot leave aside the number because this has been to a greater or lesser extent ---

Q Listen to the question.
A ... about numbers.

Q Listen to the question.
A I am sorry.

Q Leaving aside the number, both Dr Malik and Nurse Swift must have misheard what you said should be the fluid which should be administered. Is that right?
A If there was no number written, then there was something amiss with what was going on. If people had misheard me saying a different number from what I did say, then that different number should be on the fluid prescription.

Q I am not asking you about the number, I am asking you about the type of fluid.
A The dextrose 0.18?

Q Yes. You wanted normal saline put up.
A As a bolus, yes.

Q You expected normal saline to be put on the drip.
A Yes.

Q What is written on the prescription sheet is one fifth saline.
A That is correct, yes.

Q Can you give any explanation as to why the wrong fluid was written down when you gave the instruction?
A I do not know when it was written, nor do I know why it was written in that fashion. There was no numbering on it and, while I know that you want to disregard the number, the fact of the matter is that, if there is no number written down, there is a piece of information that, in order to set fluid running, has to be available in order to check it against the machine that you are using to pump the fluids in. If that procedure had been carried out, there quite possibly would have been a different outcome. If any other number of fluid had been written – and it does not matter in what detail it was written – if the person attaching the fluid was not going to read what was written on the prescription chart and check it again each time they come to it, there would be no protection from error. That is the whole point of having things written down and to have them checked whenever you are attaching the fluid. Why that was not done I do not know.

Q This was the team for which you were responsible, was it not, doctor?
A Yes. I am here being responsible for the actions of people who include nursing colleagues who were working in a way that I was not aware of. I am not saying that anybody hid anything from me in that regard but, if you had asked me up to this time last week what Nurse McManus was going to say, I would not have believed that she would have painted a picture of such lack of organisation. If people are working in a normal way, then you can reasonably expect to anticipate what is going to happen. If people are working in a way that you have no experience of, you have not been told about and you have no way of identifying, then you can used the word "team" if you wish, but it is a strange use of the word "team" if one part of the team is doing things their own particular way and you have no way of knowing what that way is. Teamwork does involve communication and that should be both ways. It should not be a matter of me communicating with nurses, if I can put it like – that is part of the issue – but, if there has not been communication in the other direction, then I am not in a position to know where the weak points in the system might be, where things that I think are well thought out do not fit in with everything else that is going on.

Q Is it not a weak point that if you are the person who is actually deciding what should be prescribed for a patient, you are the person therefore who ought to sign it?
A If I signed it, it might have made a difference, but I still come back to the point that the signing of it/writing of it is not the only issue in this context. The fluid was attached without it being counterchecked against the documentation that was available. The documentation that was available was inadequate and I think everybody accepts that, but it was not used. So, even if I signed everything and if I checked everything that was going on and if that was not used, it would not have made any difference. I am not saying that that is a reason for poor record keeping and I just want to emphasise that but, in this context, there were a lot of other issues that I had no reasonable way of anticipating.

Q And that was all done in your presence, was it not, in the treatment room?
A Which "all" are you talking about?

Q What you have just said: the bag being put up and it being checked against the documentation was all done in your presence.
A I have not said and I do not think Nurse Swift said that the drip was attached in my presence. I certainly do not recall it being attached in my presence. If it was to be

attached in my presence and somebody was to say to me, can you help check what I am putting up, then my normal response has always been, "Yes, of course. What are we putting up? Oh, it just says dextrose 0.18%" and that would have drawn my attention to an issue. If, for example – and I do not know if Nurse Swift said this – she attached fluid in my presence without asking me or without being aware of whether I was looking at it, that is not checking what is being done. I was not asked to be involved in the checking. I cannot say whether the fluid was attached while I was still there. She may well have drawn up the fluid in my presence but that is a daily occurrence and to have somebody drawing up fluid while you are doing something different and me paying no attention to what is going on would be a perfectly commonplace activity. There are fluids being drawn up all the time ---

Q I am sorry to interrupt you, doctor, but, if you want to keep talking, then, please, do so.
A I beg your pardon. I will excuse myself on the grounds that I am getting tired and I am sorry if I am talking too much. I beg your pardon.

Q Looking at the time, it is nearly five o'clock and I did say that I would finish in ten to 15 minutes, but I had not anticipated the length of the answers that you would give. Finally, perhaps, I want to ask you one question because you kept referring to it. On page 190, "admit & observe & encourage feeding". Do you not draw a distinction between encouraging feeding on the one hand in a 17-month old child and oral rehydration?
A The distinction I would make in the treatment of gastroenteritis between the traditional, maybe even the old-fashioned approach, of nil by mouth or encourage oral intake. When somebody has gastroenteritis, if they wish to eat food, which is unusual, then I would not think it is necessary to prevent them eating food. If, for example, somebody wanted to have a yoghurt, if a child of 18 months happened to be particularly keen on yoghurt and mum says, "She seems to be hungry/thirsty, can I give yoghurt?", my response will generally be, "Have a go if you think that will suit her".

Q All I am suggesting to you is that "encourage feeding" you have indicated that that means that what was going to happen thereafter is that they were going to encourage her to keep drinking Dioralyte.
A Yes.

Q It does not mean that, does it?
A That is how I would read it. I should say that, as Dr Malik is from Pakistan, possibly he may use words in a slightly different fashion. Certainly, I read that to mean "oral intake to be encouraged" and I still read that to mean that this is not a child who is to be nil by mouth. When I came in, I gave the child oral rehydration therapy. There is no doubt from that perspective what I read that to mean.

MR GRUNDY: I have no further questions.

THE CHAIRMAN: Thank you, Mr Grundy. Ms Foster, how long do you anticipate that you will be in re-examination of your witness?

MS FOSTER: I do not wish to sound unhelpful, but if I could phrase it this way: I think

possibly too long at this stage in the day for this witness.

THE CHAIRMAN: I asked the question baldly and I need an answer to the bald question. I am not suggesting for a moment that I am going to ask you to continue questioning today, but there will come a time when you will wish to re-examine and I need to know how long you anticipate that will take.

MS FOSTER: Including the doctor's answers, possibly 20 minutes.

THE CHAIRMAN: That would be helpful!

MS FOSTER: That sounds awfully disrespectful to my client and I did not mean it to.

THE WITNESS: If I need to be truncated, please, feel free to truncate.

THE CHAIRMAN: Not at all. Your answers are very important.

MS FOSTER: Sir, I had thought in my mind an answer to your question, but I would say 20 to 25 minutes. Possibly less, but that is my outside.

THE CHAIRMAN: The reason why I ask is that, as you know, it is also open to members of the Panel to ask questions and, as we have reminded ourselves from time to time in the last few days, we absolutely need to guard against the risk of this case going part-heard again. The doctor has made it very plain to us today how heavily this matter has weighed on him for so many years. It would be appalling if we were to find ourselves in the position where we had to adjourn, coming back who knows how many months hence.

MS FOSTER: Of course, sir. I am very sensitive to that, particularly with the fact that I have caused us a day's loss and I am entirely in your hands.

THE CHAIRMAN: These things do happen. I certainly do not want the doctor to feel in any way that he should be truncating his answers because his answers are of vital import certainly for the Panel to understand his perspective and what he says to these charges.

MR GRUNDY: I hesitate to interrupt, but I wonder if I might boldly suggest that it may be convenient for the Panel to start at nine o'clock tomorrow.

THE CHAIRMAN: Yes, that would save us half-an-hour, but my concern is that we are potentially going to be adrift beyond the mere saving of the odd half-hour here or there. Tomorrow is Wednesday and that gives us, on the current timetable, three full days to get through potentially an entire process. We must look at all this on the basis that it is an entire process and not one that---

MR GRUNDY: I was anticipating, sir, perhaps an hour in the morning to finish the doctor's evidence; submissions, I think, from my perspective relatively short because I have made a lot of the submissions already. I was anticipating perhaps between us another hour, an hour and a half for submissions, so having you out then before lunch tomorrow on the next stage. That gives us Wednesday afternoon, perhaps coming back

Thursday morning, at some point on Thursday morning. That then, assuming the case then continues, again, short submissions from me on sanction, probably a longer submission from my learned friend on sanction. Probably going to take us through to close of play Thursday, leaving Friday for the determination and I appreciate I might be cutting it fine but that is the best as I can see how we will progress.

MS FOSTER: I would respectively echo that almost entirely. Had you asked me first I think I would have said pretty much as my friend has said to you.

THE CHAIRMAN: The first point I would make is that this scenario has not taken account of the amount of time that I understand the Panel are indicating to me that they need to consider before they would ask questions of the doctor. We have the advantage that we have tonight when we can all of us individually consider and go over transcripts. Again, we have the advantage of the e-mail mail out of the transcript for today which will enable at least some of us to be reviewing that. We had been anticipating ourselves being here at nine o'clock so that we could give ourselves an hour of discussion in *camera* as to which questions we felt needed to be put. All of us have sat together. In previous cases we have found that where there are important questions to be asked it is often helpful if the Panel sit down privately first and deal with the plum and the duff, as it were, to ensure that we do not waste too much time.

So the real point is that I think there are some concerns on the Panel's side as to when we would be in a position for you to say that your case was complete and we are not so sure that it would be by lunchtime tomorrow.

What I think I will do at this stage is say that we will all continue to work on the basis that at this stage it is certainly not impossible for us to finish on Friday within time but whilst we do not wish to find ourselves adjourning this case for any great length of time, nor should we, and it is my responsibility to make sure that we do not, force ourselves through at such a pace that this doctor's case is not given the consideration that it deserves and that he deserves.

I suppose what I am leading up to is a suggestion that at this stage people look at their immediate diaries because if we do find ourselves in difficulty it is clearly not looking to be in difficulty by days but it may be that what we may find ourselves looking for is an additional day. If people could overnight talk to the Legal Assessor or the Panel Secretary it would be fine, if we could have an indication as to say over the period of the following week if there are any days on which any of you would not be available then in the event that we found ourselves needing an extra day it might be we would be able to beg a room, which is the first part, provided, of course, that we could all be here. If we can avoid that necessity that would be great but I do not want to put us under a pressure that forces us not to complete this case in the order that we should complete it.

MR GRUNDY: It occurs to me, it is just a thought, that if we get to the stage where counsel have completed all their submissions and that the extra time, all that is required is for the determination that - because I know I am not available next week, it would not actually then be essential, certainly from the GMC's side, that I am here and if needs be no doubt somebody else could cover the taking of the determination if that is all that is left.

THE CHAIRMAN: That is a good point and if were running out of time it would be because we have failed to complete our discussions and produce a written determination in time. Mr Grundy is quite correct that the completion of that process will not require his presence. The only potential danger is if we were to run into a matter of legal advice being required. On the whole I would look at that as being fairly unlikely and if it were I am sure there would be a member of the GMC team who could step in to cover that. If you are saying that were we to need a day during the course of the following week you would not be available but that in your view would not be a problem?

MR GRUNDY: That is as I see it. I do not see that my availability should hold up the process for the doctor.

THE CHAIRMAN: That is very kind and, I think, correct.

MS FOSTER: I have consultation obligations next week all of which, I think, should give priority to this.

THE CHAIRMAN: By that I take it---

MS FOSTER: I would make myself available when you needed me. I have no court commitment but several consultation obligations. They should all be moved.

THE LEGAL ASSESSOR: I have a week of public duties next week which I know the Lord Chancellor is very loath to unseat.

THE CHAIRMAN: That gives us some difficulties only in respect of drafting. The view has always been that the Legal Assessor is interchangeable. I think it is very unusual for a Legal Assessor to be drafted in during the final phase of drafting a determination but it is not impossible. At this stage we are really speculating because it may very well be that we can manage things in such a way that the case proceeds properly and completes on time but we must have a back up at this stage and, unless there is view from either counsel that it would be inappropriate to complete with a possible change in Legal Assessor, then I would not hold that as a problem either. Very well. So it is something we need to avoid if we can but at the same time we need to make sure we proceed properly with the time that we do have budgeted. We will give that some thought overnight.

So far as when we start tomorrow is concerned, I would suggest that if you wish to start at nine that is not a difficulty. Strictly speaking we should finish with your re-examination, Ms Foster, but we will then require some time for the Panel to consider before we put our questions to you, doctor. I hope that that period of consideration will reduce the amount of time taken to ask questions rather than increase it. Nine o'clock tomorrow morning then, please.

(The Panel adjourned until 9.00 am
on Wednesday 28 October 2009)