THE CHAIRMAN: Good morning, everyone. Ms Foster, I think you were about to commence your re-examination.

MS FOSTER: Yes sir, indeed. Thank you very much.

JARLETH MICHAEL O'DONOHOE, recalled
Re-examination by MS FOSTER

Q Doctor, here I have the advantage of you for a moment, because I have the copy of the transcript of what you said yesterday, and I just want to remind you of a couple of answers that you gave and I have questions arising out of them.

MR GRUNDY: I think we probably have the transcripts here, if you would like the doctor to see them?

MS FOSTER: That might be an idea. Yes, if there was one available for the witness, I would be very grateful, thank you very much indeed. (*Same handed to the witness*).

Q This is a question that arises out of a number of the answers that you gave, but it relates particularly to the time at which you made the note that we have seen on page 192, going over to 193. So if you would be kind enough to turn that up, Doctor.
A Which tab is this in?

Q It is in the first tab where the medical notes are, thank you very much.
A Pages 192/193?

Q Yes, exactly so.
A Yes.

Q If you would look in the transcript with me, please, at page 76, so towards the bottom of that if you look at G on that page, you are being asked there about the telephone conversation that you had. If you go back to C, you will see that from the question:

> "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."

Then if I can take you down there is some discussion there as to what you put. That takes you down to F. The question is:

> "Why did you not tell him that the fluid regime Patient A had been on involved [a] 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 pause there and say where did you go to go looking for your notes? Was that whilst he was on the telephone or was that afterwards?
A No, that was after the conversation.

B Q You then say:

"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 he rang me about."

C So, at the time when he rang did you say to him anything about having the notes or not?
A I said something to the effect that I was working on the basis of recollection. If I had the notes, I would have looked at them and been able to access the information immediately.

D Q How soon after the telephone conversation did you have an opportunity to go and get those notes?
A I think it was later that day, or possibly early -- from the time I wrote the note, I think it must have been the next day, early the next day.

Q How long after you had seen those notes were you then able to write the note that we see there?
E A I think I wrote that note very soon afterwards, probably immediately afterwards. I mean immediately after I had had a chance to look for the notes.

Q Yes. How soon after you had looked at the notes and written that note did you get in the contact with Mr Kelly that you told us about?
A Dr Kelly, just to be technical, was the Medical Director.

F Q Yes.
A It was later the same day, not a long time. I could not tell you, a small number of hours possibly.

Q Did you wait for any reason or was that as soon as you were able to contact him?
A That was as soon as I was able to contact him.

G Q You have been asked not only about that document, but you have been asked about the letter that you wrote to Dr McKeague which I think should be as a loose document on your table, otherwise it may have found itself into the bundle.
A Yes, I have a copy here, I will just pull that out.

Q I am very grateful. I think it is a fair summary of the questions that were asked to say that some sinister inference is being drawn from the fact that on the face of that letter you put only, "IV fluids 11", and you gave no details of what was being said?
H

A I think that the words "IV" means intravenous, whether I meant intravenous fluids or intravenous cannula, I do not recall. It was a note written in haste at a time of trying to do a number of other things at the same time. It was written in the knowledge that normal procedure was that other information would be brought as well: this was not intended to be the only source of information.

B Q Did you expect to have an opportunity to see Dr McKeague face-to-face?
A Yes, or someone working in the paediatric intensive care, to receive the patient, if I can put it like that.

Q You were asked questions particularly in cross-examination about your thoughts of what had gone wrong effectively at the time it was going wrong, that is to say in the hour after the 3 o'clock collapse, do you remember that?
C A Yes, I remember.

Q It has been put to you - maybe not in these terms, but effectively - you knew very well, certainly by the time you left the hospital at Erne, that there was something wrong with what you had done regarding fluids, therefore you had a reason to leave materials out of documents that were created at that time.
A No, that is not true.

D Q What was your view as to what was going or had gone wrong at around the 3 o'clock mark?
A I did not have a very clear understanding of what had happened. One of the possibilities that I thought was - and in retrospect it may just be wishful thinking - to hope that it was something like a convulsion from which there was a very slow recovery. There are occasions in which you will have a convulsion and it takes some hours to
E recover. Having seen and documented the dilated pupils that may have been also wishing that was the case. I do not believe I had a very clear understanding of what was going on at the time we left. It was at the stage of: this is somebody who needs ventilation, who needs facilities that we just do not have, what can we do to secure access to those facilities? That was probably pretty much as far as my thoughts had gone at that time.

Q You said, in answer to a question from me about that time, that you do not recall
F seeing the fluid chart at the time you were beside Patient A's bedside at 3 o'clock in the morning?
A Yes, I do not recall seeing it.

Q At the time when you were there, and you were resuscitating her, did you have any reason to believe that the fluid programme was other than that that you had ordered
G up to the point when the saline had been put in freely?
A I had no reason to believe that. I do not want to start maybe saying too much about my thought processes, but I was very surprised ---

Q Can I just pause you there? Why not, Doctor, is it because you cannot recall?
A No, it would be starting to speculate, I suppose, as to what thoughts were going through my mind at that time and later.

H Q I see.

A I do not recall having seen the fluid chart. That is the direct answer to the question. The whys and the wherefores I do not remember, and I cannot say.

Q You did, I understand, that you do not wish to give a speculative answer or an answer based on speculation. If you go back to D15/50 at C and you are being asked the question at B:

B

> "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?
> A If you remember, there were questions asked about whether this child ..."

C We know there were unchallenged answers given by Nurse McManus about questions that she asked. Were you there while she was asking questions?
A Yes.

Q Were they, in your opinion, unusual questions to be asking or were they questions you might have asked yourself?
A No, in that context they were not unusual questions, no.

D

Q Once you had had your conversation with Dr Crean at Belfast and you yourself had checked the notes as to the fluid that had been noted as administered, what was then your thought about cerebral oedema?
A I do not know that I had had clear information from Dr Crean to say this is definitely cerebral oedema. My recollection is that he had said that they were asking the paediatric neurologist to review the situation that day, and I do not believe I had heard any news from that source by the time he asked me to check the notes. If he had said clearly or a paediatric neurologist had said clearly there is a definite cerebral oedema and you look at the fluid in that context, you say, if I can put it in that way, one and one is two. If you have not a clear idea as to what is going on, it is something that is unexpected but without a clear-cut diagnosis. In the context it did not leap out at me as that is what we were talking about. I understood from that conversation that they were still undertaking various investigations which were not complete at the time of that conversation with Dr Crean.

E

F

Q If I can take your attention to 191 in the middle, please, and the reference between the hole punches to mannitol. It says, "5 gm I.V. over ½ hour". I believe it to say that. What sort of a dose is that, and what would that be given for?
A That is a dose given for cerebral oedema, a dose at the request of Dr McKeague.

G

Q Do you have much familiarity with the administration of mannitol yourself?
A I have used it on occasion. It is not something I do very often.

Q Remaining in these notes, please. Your attention was drawn to the previous page (page 190) and it has been suggested to you that the entry, which you have indicated is yours, "[approximately] 2300 I.V. line inserted" that occurs below Dr Malik's handwriting, was written at a time that was probably not 11 o'clock, and you accepted that?

H

A Yes.

Q Do you recall whether or not the writing which we see there above it, "Urinalysis - Protein ++. Ketones ++. No leucocytes [and the] Na 137", was written in the record at the time you wrote "2300"?
A I believe it was.

B

Q Do you know at what time the entry with Dr McKeague's telephone number was written?
A I do not, no.

Q Did you see any of the notes being written that are on that sheet, aside from the one that you made?
C A I did not see them being written, no.

Q The ones, I should say, that you made. A further point is taken against you to suggest that your information given in the McKeague letter is somehow sinister. Is the fact that you do include information about the bloods, which appears in the record, but you do not include information about the IV because, you say, it appears in the record. Is there anything about the notation of the bloods that should be required for Dr McKeague but not the IV information?
D A For whatever reason I wrote the bloods in that way. The letter is an introduction, if I can put it like that, to the patient. The introduction here is the medical part of the information. There was other information going which would be an introduction to what maybe is a more traditional part of the nursing record, such as fluids and so on and so forth. So the fact that I included part of the information was the sort of information that I would have thought he would want to have that, for example, nursing staff at the
E Intensive Care Unit might not want to have. I do not know that I analysed it in all of that great detail. I think I put down the information that seemed appropriate that he would almost certainly want to know in the first instance, and there would be other information going as well.

Q If you look at page 190, and you can see there the bloods information written out, and the urinalysis, and then you see, "2300 I.V. line inserted". How does that compare with the information that you put in McKeague letter?
F A It is the same information, I think.

Q Where would you have got the information that you put in the McKeague letter?
A I would have taken that from the notes, I would imagine.

G Q It is also suggested that another document is sinister, and that is a document that appears at page 137, which is in another part of the bundle that we have produced, which is your statement, made to the Trust. Forgive me while I put my hand on it. My solicitor knows everything and will be able to put her hand on it immediately. I think it is tab 9 from memory.
A Is that the one addressed to Mr Doherty?

H Q Forgive my hesitation; you will find it under the first cover page under tab 9, headed 137 because it has come from another bundle.

A Yes, I have that letter.

Q You indicated that this was in respect of the civil proceedings that you had become involved with because of your connection with the Trust. What did you understand were the issues to be decided in that litigation? Was it anything to do with whether or not you had properly given a bolus or not given a bolus, or was it to do with fluid levels or was it to do with something else?

B

A I do not recall being told what the issues were.

Q Did you know at this stage that Nurse Swift was saying that you had not said bolus?

A No.

C

Q Did you know at this stage that there was any issue as to what a bolus meant in this context?

A No.

Q You were asked, or it was put to you in terms, in fact, that what you said to Nurse Swift was, "until the child passes urine". Is that an order that you have ever given for a child with this condition?

D

A No, I do not think so. I cannot remember ever saying or giving that instruction.

Q You cannot remember ever saying that?

A As an instruction for gastroenteritis.

Q Would that be in this hospital or would that be anywhere?

A In any other hospital I have worked in.

E

Q Have you met a paediatrician who has discussed with you or informed you that that is what he does or what should be done?

A No, there was - again I do not know whether it is in the paperwork - but there was discussion to the effect that somebody else had said that on another occasion around that in the same hospital, but I was not aware of that having happened.

F

Q That was something that Nurse Swift said in her evidence, I think, that somebody once said it to her.

A I think so. I have never heard it said. None of my colleagues had ever used that phrase and afterwards there was no discussion about, well this is the way we might have done it, or we might not have done it. I was not aware of that ever having been used as an instruction at that hospital.

G

Q You have heard all the evidence that was given by the nurses, certainly Nurse McManus, as to her view as to unworkability. Is there anything you would wish to add to that?

A The unworkability of the instruction?

Q Yes.

H

A At best it would be a very difficult instruction to implement. If you were going to implement it then when the child gets a damp nappy that, to me, is the point at which - if

A that is what you were trying to do - you say you have now reached the point at which what you have been asked to do has been implemented. I understood Nurse Swift to have said on the first section of the hearing that at that stage she knew that fluid would be reduced as it should be reviewed. So not only would it be very difficult to implement but, if you were trying to implement it, there was a clear point at which you would have implemented such an instruction.

B Q Yes. You were asked about - again in relation to the letter that we have just looked at - the fact that you said bolus but not of what and the fact that you have not there mentioned substance. Was it ever unclear to you what bolus would mean in this context?
A No.

Q Was it ever unclear to you what Dr Malik or a nurse would understand by bolus in this context?
C A No, and indeed if you go to later on that evening, when 500 mls of normal saline was given, although it was not described as a bolus, it was a very large volume of fluid given very quickly and that is what the working definition of a bolus is. So it was used later on that evening, when I was not there, with that meaning, the fluid was given in that way.

D Q We heard Nurse Swift say that she knew that saline could be used in that way for shock. Was she correct about that?
A Yes, you can. It would be a standard treatment for shock. It would be *the* standard treatment for shock.

MS FOSTER: Thank you, sir. I believe that that is it.

E THE CHAIRMAN: Thank you very much indeed, Ms Foster. As I indicated yesterday the Panel will now take some time to discuss *in camera* the questions that it will then put to the doctor, so may I ask all strangers to withdraw and we will call you back as soon as we possibly can.

STRANGERS THEN, BY DIRECTION OF THE CHAIR, WITHDREW AND THE PANEL DELIBERATED IN CAMERA

F STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: Welcome back, everyone. I hope that as a result of our taking that time there will be some economy in the questions that we put. Before any questions are put there is a general observation really from our medical members. It is, I will not go so
G far as to say it is customary but it is fairly usual that in cases such as this the doctor's CV is put forward. I do not know if there is a written CV for the doctor available? If there is, if we could just put that in as an exhibit?

THE WITNESS: I do not recall submitting one. I do not recall being asked to submit one.

H THE CHAIRMAN: You may very well not have been. It is certainly not an omission on your part. It is simply that there has been some leading through at the beginning of your

testimony by your counsel of your training and where you have been and so on which, of course, does have great significant to medical members and it is often put in as a document. If such a document is available that would be fine. If it turns out that it is not then I will pass on to one of the medical members to ask one or two elucidating questions on the information that we heard from you. There is nothing sinister about it, it is just being clear.

MR GRUNDY: You may have seen in the 2005 statement there is reference to a CV which would be slightly out of date but I have certainly got that CV. Actually the CV I have is, in fact, dated December 2000. I do not know if it is the same one?

MS FOSTER: Might we have a moment to have it copied, sir?

THE CHAIRMAN: That would be very helpful, then if there are any questions arising from that. We will mark that as D7 when it comes. Whilst we are waiting for that we will proceed with our specific questions. Mr David Sinclair will ask his questions first.

Questioned by THE PANEL

DR SINCLAIR: If you have got the transcript from yesterday, day 15, and if you would go to page 17, answer E, it is the question about lethargy, sleepiness, drowsiness. In it you say:

"I would describe the baby as tired rather than lethargic."

Dr Malik in his admission history, page 188, describes Patient A as:

"Now for the past 12 hours she is very sleepy."

My memory of 17 month old children is that they are not normally sleepy over a twelve hour stretch. I wondered if you could comment and square it with me with your description of how she was when you saw her with his history?

A Can I just ask which page?

Q Tab 1, 188 in the big black numbers. Half way between the punch marks.

A I cannot find it. 188?

Q 188, "History of presenting complaint", about half way through that paragraph.

A

"Now for the past 12 hours she is very sleepy"?

Q Yes:

"Now for the past 12 hours she is very sleepy."

I was wondering if you could square that with what you said yesterday:

"I would describe the baby as tired rather than lethargic"?

A What I was trying to get at with the word lethargic is what I might call a neurological state where a child is not mentally clear as distinct from a child who is unwell and tired. They are rather vague words which do not have very exact meanings. What I was referring to was that I did not believe this child to be neurologically impaired, if I can put it like that.

B Q What then is the difference between lethargic and semi-conscious where a child or anybody is rousable?
A Semi-conscious would be another step or two down the line towards complete unconsciousness. If lethargic was the beginning, as it were, semi-conscious would be a step down towards complete unconsciousness.

C Q What would be the difference for you?
A There would not be an exact difference but if a child clearly recognises who their mother is, for example. If I feel the need to put Emla cream on then my conclusion is that I need to wait for the time in order to reduce pain. When you get to, I think your phrase was semi-comatose, there would be relatively little need to take those issues into consideration. The point would be with semi-comatose you need to be now moving and the fluids need to be in now. That would be a clear indication of shock.

D Q Again, I think it was on day twelve but there was an exchange between you and your own counsel about anaesthetists and whether they dealt with oral hydration?
A Yes.

E Q I want to ask about your experience about the breadth of work that anaesthetists are involved in. I know from my own experience that amongst many other things they do assess hydration in patients pre and post-op; they control hydration in patients during surgery when they are in intensive care units or high dependency units. In these places many of them are conscious. So having unconscious patients and anaesthetised patients is only a small part of their daily routine. Does my view coincide with your view of anaesthetists?
A It would vary very much from anaesthetist to anaesthetist. There are some anaesthetists, for example, and I do not know the people in Belfast well enough to know how they spend their time but some anaesthetists will be in practical terms very close to full-time involvement in paediatric intensive care. You might then be called an intensivist but referred to as an anaesthetist. I do not know the individuals well enough to know what they actually do.

F It does not surprise me in retrospect if there was not a lot of discussion about oral rehydration therapy at the time. It is not a form of treatment that anaesthetists would have much occasion to use. I would have thought, in the sense that if you are assessing somebody pre or post op with a view to safety of surgery, for example, if there was any suggestion at all in most cases that a child was unfit for surgery because of gastroenteritis that would be away home, call your GP, or whatever, this is not our line of business. If the child was admitted acutely and there was a need for surgery and there was a question of gastroenteritis or dehydration then that would be pure intravenous treatment only because an anaesthetist would be in general anticipating nothing to be taken into the stomach with a view to the safety of the general anaesthetic.

G

H

So I am not saying that an anaesthetist would not be aware of the concept of oral rehydration therapy but it would not necessarily be terribly close to what they would be thinking about in terms of fluid terms. I do not recall it being raised in that discussion.

Q I was just speaking about anaesthetists and the jobs they do in the generality rather than the specific of Patient A?
A Many anaesthetists will do all the things you have said. Is that the---

Q Yes.
A Yes. I would not disagree with that, no.

DR SINCLAIR: Thank you very much.

THE CHAIRMAN: Ms Joy Julien is a lay member of the Panel.

MS JULIEN: Good morning. Could I ask you to turn to tab 1, page 191, half way down the page, just where "ICU" is, just below that, "mannitol 5 gm IV over ½ hour". Could that be described as a bolus?
A Yes, it would be given reasonably quickly, mannitol. That was the request from Dr McKeague, as I understood it and as I recorded it.

Q My second question relates to the 100 mls per hour for Patient A until she passes urine?
A Yes.

Q You said earlier on today that that would never be an instruction that would be given in relation to gastroenteritis?
A I think what I said was I have never come across it within my experience. If I may clarify what I was saying, the ward in question would have consultants from different specialties admitting the child to the ward. If the suggestion was that around that time one of the paediatric consultants had said it there would only either be myself or Dr Halahakoon , as I mentioned. It would be strange for a nurse who was that familiar with both of us, and there were only two of us, not to be able to say, "Yesterday or last week Dr Halahakoon said x, y or z." So I have some difficulty with the idea that another consultant unspecified in such a relatively small unit said it. I do not know where that - that remark I just do not understand.

Q You have never come across that. Could it be used as an instruction for any other condition?
A There are some, well, to give fluid until urine is passed, I cannot think of any situation in which I have done it. If you had a urinary catheter in place and you suspected a child had what is called pre-renal failure there is an idea of what we call a fluid challenge, in other words, give fluid and if the kidney can still respond it may respond by producing urine. If the damage to the kidneys has progressed to the point where the damage cannot be recovered from then there would not be any urine produced. So if you were looking at it in that context where there was the possibility of renal failure being considered I have heard the idea of a fluid challenge in the past. It is not something I have done for quite a long time or seen done for quite a long time.

Q But you have heard of it?
A I have heard of that phrase, yes.

MS JULIEN: Thank you.

THE CHAIRMAN: Dr Roger Smith is a medical member of the Panel.

DR SMITH: Good morning, Dr O'Donohoe. Just for the sake of the transcript, really, a small point from your CV. You told us in answer to your counsel that your MSc had been in 1978. It is true, is it not, that actually it was in 1986?
A Yes, you are right. I am sorry.

Q It is a very minor point.
A Yes.

Q Can I take you to C5, that is what has been described as a police statement. Would you go to page 2 where it says, "I received a second call..."?
A Yes, I have got that page, yes.

Q I would like to go to the second paragraph:

> "When I arrived at the hospital I was surprised to find that a saline drip was running freely."

First of all, what was a saline drip? What fluid was that?
A Normal saline.

Q Would it be true to say that when a doctor says saline they do mean normal saline?
A By and large.

Q When they do not qualify it?
A Yes.

Q "...running freely", what does that mean?
A That means that the plastic tube delivering the fluid has not been put into a pump to control the rate at which it flows. The rate at which most of the pumps in use at that time, as far as I can remember, were capable of running was up to 999 mls per hour, in other words, roughly a litre per hour. If you put something in running freely then the only conclusion is that you want it to run faster than it is possible to run with the pump. In other words, the pump would put it in 500 mls over half an hour, so, therefore, the intention in putting it freely was for it to run in faster than half an hour is all that I can say.

Q Running freely has two elements to it. One is that it is going in without a pump regulating it?
A Yes.

Q Secondly, it has an element of the rate at which it is flowing?

A Yes.

Q Unqualified, "freely" might suggest to me that it is completely open, as open as it can be and running in as fast as it can be. Is that what you mean in this statement?
A Yes. There was very little left and I did not know over what period of time it had been running. When I say "freely" that is what I mean and doing the back calculations the assumption was that the intension had to be that it was to be given more quickly than a pump could give it.

Q You go on to say, "I was surprised...". You had said you were surprised find it:

> "I was surprised because I had not instructed that this should be set up."

Why should that surprise you?
A If you are doing something like running 500 mls saline freely that is a very, very rapid rate of fluid administration. Far more rapid, for example, than would be common even in the context of treating shock. In the context of treating shock it would be 20 mls per kilo as the first dose, wait for a while to see what the response was, a second dose of 20 mls per kilo. Even then you can deliver, 20 mls per kilo is 200 mls, so even with the pump to make sure you do not accidentally give more than you wish, you can do that. So it was not something that I would have anticipated seeing and if there was an extreme situation with an extreme response called for then I suppose my perspective would be that I would be called to say, "Listen, something extreme has happened. We need to get a huge amount of fluids in", a thought process something like that. I did not understand why it had been felt necessary to do it so rapidly and it was not something that had been raised with me that it should be done and I would have thought that in somebody undertaking something that extreme, that unusual they would have felt the need to say so very clearly, very early.

Q So, your surprise had again two elements to it. One was that the fluid was going in at such a volume and at such a rate which would be usual and you were surprised because you had not been consulted/asked. Why should that surprise you because you were at home and something dreadful had happened? Why were you surprised that nobody had asked you?
A Firstly, being at home at that time in the morning, it is relatively easy to contact me. There would not be any difficulty, literally a couple of seconds to make a phone call. If you had done something of that nature, then I would expect it to have been clear immediately what the rationale was for it to be obvious that something completely out of the ordinary had happened. The child had had diarrhoea, but even diarrhoea described as large volume or whatever the phrase was would not be at all unusual. If that was the concern and shock was the issue, then 20 mls/kg would be the standard response. You know, 20 mls over 20 minutes or whatever and wait for a little while to see if that did the trick. I was certainly within the hospital within 20 minutes of being called. I just cannot make any sense of that.

Q You would not expect to be asked what to do in a crash call by your junior or nurses, would you?
A The way the hospital worked was that, if there was a crash call, my bleep would

A go off at home. So, if there was a crash-type situation, I would not have to be asked to come in.

Q To come in?
A The bleep would automatically go off, there would be a voice to say "crash", "arrest" or whatever in such-and-such a ward.

B Q Would you normally instruct the SHO, because it would be an SHO in the night, what to do as you were coming in?
A If I had been called, normally I would try to get through. If there was a phone number and I could get through quickly, then I would usually do so. If there was some difficulty with that, then it is a matter of trying to guestimate which I can do more quickly. Can I get in more quickly or will I get a reply from the phone call. The initial management of resuscitation is something that it would be expected would be normal for an SHO to undertake for the first while to start to allow somebody more experienced to attend.

C Q Why would you be worried that this fluid was going in at such a volume and at such a rate?
A It is a fluid volume which I have never seen used in that way. It is two-and-a-half times the amount you would use as your starting dose in shock. We have had a lot of discussion about the degree of dehydration and so on and so forth. This was not a patient I saw as having been in shock when I was there last. If you have one vomit and diarrhoea, that would not be enough usually to precipitate such dehydration so quickly that you would anticipate using ... It is one of those things where I just did not understand what it was for or what it was about, what it was meant to be for, and giving large amounts of fluid volume has all sorts of complications. We had a lot of talk about cerebral oedema and so on and so forth. Fluid overload is even possible, that if you give enough fluid, you go from being dehydrated to over-hydrated, as it were, and in heart failure.

D Q The consequences could be serious.
A Of too much fluid, yes, certainly.

E Q You arrived and there are those of us who know that a crash call is a pretty awful situation. It tends to be somewhat chaotic. Even if there is a system, it appears to be chaotic.
A Yes, I think that would be reasonable.

F Q What conversation did you have with those in the room when you arrived?
A Step one is to try very briefly to orientate yourself as to what is going on and, in that context, this was a child I had seen some hours previously and my opening question tends to be something like, "What has been going on? Who has been here with the patient? What has been going on?" That takes maybe two seconds to ask. You then need to look at the patient and, applying the advanced paediatric life support, airway, breathing, circulation and so forth, and the ideas ---

G Q I am sorry to interrupt you, but do you remember what you said or what was said?
A I do not remember what exact phrase I used, no.

H

Q Do you remember what general area you inquired about?
A It was a general inquiry. It was not in the first instance that I said, "Has there been further vomiting or diarrhoea?" I do not think that I asked specific questions in the first instance. The first question I suppose tends to be very general to try to identify who has information to give you as much as anything else and, once you identify who might have information to give you, then the questions become more specific. If the first question does not elicit a clear answer, it is sometimes a matter of then repeating the same question trying to identify who has been here and, if Dr Malik said, for example, that there was this strange episode, which he had on the phone, then the next question becomes something like, "Did you see this yourself? Are you describing this to me firsthand? If you did not, who told you?" and trying to backtrack until you got to the facts, as it were.

Q Do you think that you asked him that?
A Yes, I am sure that I asked him about a further description and it was a very unclear description. I remember thinking that this most likely, just on the basis of what you see every day, probably is a febrile convulsion, but it was not the sort of description you usually get of a febrile convulsion. As I understand, the mother was with the child and mothers, if they are present, describe jerking, eye rolling and so on and so forth. Not all febrile convulsions are exactly the same, so it is possible to have one that either is different or, because of the extremely frightening nature of the episode, the description you get may initially be difficult to understand.

Q So, your starting point was that common things occur commonly and febrile convulsions are very common.
A Yes.

Q You do not remember saying to Dr Malik, "Why is this fluid going in?"
A I do not. At that point, I slowed it down. I say 30 mls, although I do not say so specifically. That means put the pump back on and go back to the rate that, on a quick assessment, was not going to cause any problems.

Q Did you put the pump back on?
A I said that I reduced the flow to 30 mls. Whether I physically put the pump, I do not remember. It would depend on which pump it was. Some of them I would have been able to use independently and some I would have to tell the nurse. When I say "reduce", I suppose I meant that it had been flowing freely and that was not what I wanted and to pick a rate to restart, as it were, and 30 mls was the rate.

Q There comes a point in a resuscitation or crash procedure where things, as it were, settle down and stabilise sometimes in a bad situation and sometimes better, but there would have come a point where you would end up presumably with a stable fluid entry and bagging this patient, bagging meaning ...?
A You apply a mask to the child's face and use a plastic bag to inflate the lungs to support the breathing.

Q So, that is ventilation by hand.
A By hand bagging, yes.

Q So, the situation presumably did calm down and there was then time for reflection.
A Yes. It did not calm down very satisfactorily very quickly. I think I acknowledged that I had difficulty trying to intubate the child for example and there was some time, and

I do not remember how long it took Dr Auterson to attend, so there was a period before it began to settle.

Q Was there then opportunity to talk to the people who were involved?
A I do not remember having a clear opportunity to identify who could give me information about each particular period of time. I do not remember being able to get a coherent account of what had happened. Some of what happened that night I did not know chronologically at the time. For example, my recollection is of Nurse Jones saying that she filled in the fluid chart shortly before we left. I do not think that I knew that happened when I wrote the letter of transfer, for example. So, if I had been writing the letter of transfer at that point, I would still have been trying to find where the IV fluid charts were and, if Nurse Jones was filling them out at the same time as I was writing my letter, they would physically not have been available to me.

Q So that I am clear as to what you are alluding to there, are you alluding to the fluid balance chart that we see at page 43?
A Yes. There was the one with 100 and 100 and then there was the issue of 100 and 200 and some incorrect additions.

Q And you are alluding to the fact that evidence was adduced that she may have done that in retrospect?
A I think she agrees that she did not it in retrospect. That was my recollection. At the time, I do not remember in detail, but my recollection was in the time leading up to the transfer.

Q So that I am clear about that, are you saying that you were aware that she was doing it then?
A No, I was not aware that she was doing it.

Q Or are you saying that you were not aware?
A I was not aware. I think your question was something to the effect, did I get a clear story of what was going on?

Q So, you are saying that it may have been happening in the background but you were not aware of it?
A I was not aware of it.

Q Let us go down into the second paragraph and I think it is the sixth line where it says, "I spoke to Dr McKeague". You telephoned Dr McKeague in Belfast.
A Yes.

Q Can you remember what you said to him?
A I gave an outline of a child admitted with gastroenteritis with an unexpected and

substantial deterioration, which I did not understand. We had some further discussion, which has been alluded to, and he ended up, as I recall, recommending a combination of Claforan and mannitol as treatments further to what we had done ourselves and the implication of the Claforan, which is a broad spectrum antibiotic, although often not stated in that context, is, could you have missed a case of meningitis in this child? I did not believe that was the case because all of the story as it had developed and so on and the blood test and so on did not look like that was the case but, if somebody says Claforan, they are suggesting either a septicaemia or the possibility of a meningitis and that may explain part of one of the questions that was raised already this morning: if you give mannitol, does that not mean you were aware that there was a cerebral oedema issue, for example? Dr McKeague raised the issue of Claforan and mannitol together and the thought process is something like, could there be meningitis and might we give some mannitol in case there is an element of cerebral oedema related to meningitis, for example?

When I left to take the child to Belfast, I did not have a clear understanding of what was going on. I do not think, from my conversation and from what I recorded with the antibiotics and the mannitol, that Dr McKeague was saying, "This sounds like cerebral oedema secondary to anything other than meningitis". I was not convinced of that diagnosis in the sense from what I had seen but that was, I think, the tone of that conversation, looking for things that had not occurred to us previously.

Q You agreed with me in the context of febrile convulsion that this was a common situation and that common things occur commonly and, in this context, that would be a reasonable thing to think of, but this case started as a case of fluid balance, did it not?
A Yes.

Q Dehydration?
A Yes.

Q And it ended in a tragedy. Can you explain why it is that you did not return to first basic principles and look at the problem now as a fluid balance problem because it would be right, would it not, to think about the treatment you had given to a patient for the condition they came in with and track back and see what has happened?
A It certainly would. If you look at the timing of the intravenous fluid chart being recorded, all I can say is that, if I asked to be shown that, I was not shown it. In the context of what you refer to as the sometimes slightly chaotic nature of the resuscitation situation, you may ask once, you may ask twice but, if it does not become available, you may then pass on to other issues which need to be dealt with like the practicalities of transferring the child or trying to intubate the child. I am not trying to suggest that the unfilled fluid chart was deliberately withheld from me, but there may have been reluctance to let me have immediate access to that sort of information because it was felt it should be filled out before that sort of exercise was undertaken.

Q When you transfer somebody to a colleague who you feel can help better than you, help more because they have more facilities, you give them relevant information.
A Yes.

Q That is a given.

A Yes.

Q And you were transferring to an ITU.
A Yes.

Q Again, can you explain to me why fluid balance was not a part of the transfer information when the problem started as a fluid balance problem.
A The problem started as a fluid balance problem in a child that I would have anticipated in the normal course of events would recover over the course of a day or two. The catastrophic events in the middle of the night were not something that I anticipated or understood, to be honest about it. I do not think that I was able to reach a clear-cut diagnosis, not even halfway to a diagnosis, before transferring the patient. Again, there was no question about the letter of transfer and why was there no fluid information contained on it. It is quite possible that the situation was that the information was being written on the fluid sheet as I was writing the letter of transfer and if I asked, for example, "What is the fluid balance situation?" the reply would be something like "All those are being prepared to transfer. We are putting hole punches in the paper so that they are not loose and do not fall around" or whatever. Again, I am not saying that was done in the spirit of concealing anything but the most likely explanation for that circumstance that I can think of on reflection is that the one which has the numbers of what had been given was not made available to me, that it was being filled in around or about the time that I was writing my letter of transfer.

Q I would have thought that you would have said to Dr McKeague, "This little girl came in and she was moderately dehydrated, we set off such-and-such fluid and, for reasons that I just cannot comprehend, things have gone wrong". That is basic information, is it not?
A I think that under those circumstances you start or I tend to start from the other end, which is the problem you have in front of you. The problem we had in front of us was a child who had deteriorated drastically and who needed ventilatory support, which we did not have facilities for. That was the basis for the request for a transfer. It did not occur to me that this was a fluid balance issue. I accept that, in retrospect, that probably should have occurred to me, but I did not leave the hospital thinking that this was primarily a fluid balance issue.

DR SMITH: Thank you very much.

THE CHAIRMAN: Doctor, just myself left. As you know I am also a lay member.

The room in which you left Patient A when you first left the hospital, was that the same room in which you found her when you returned later on in the early hours of the morning?
A No, I do not think it was. I think on the first occasion it was what was referred to as a treatment room, which is a room in which patients, when they arrive first, are usually or often received. By the time I came the second time, she had been transferred to a single space. That is the picture I have, of there being a larger space which would be one of the single rooms or what is sometimes known, at that stage, as a double bedded bay.

Q So the treatment room is a smaller room than the single space room?
A Yes.

Q It would help me to visualise if perhaps using, for example, the rectangle that we have made up by the various desks in this room. Would the treatment room have been larger, smaller or about the same size as this space?
A Somewhat smaller, maybe a quarter, maybe even a third smaller than that space. So you would fit a bed in, you could fit, let us say, two people abreast possibly on each side of the bed, type of thing.

Q So a fairly tight space in reality?
A Yes, there was not an awful lot of space -- in the treatment room?

Q Yes.
A Yes, the double bay space would be significantly bigger and probably slighter bigger than the space we are dealing with here.

Q So, perhaps double the size of a treatment room?
A Yes.

Q Something of that order?
A Something of that order, I would guess, yes.

Q It just helps me to visualise, thank you.

In answer to questions from Dr Smith a few moments ago, I think you were saying that on your return to the hospital, when you were surprised to find the saline drip running freely, he asked you about what the potential consequences of such an occurrence were. I think you said that too much fluid going into the patient could be very serious. Did I get that right?
A Yes, that is right.

Q By the consequences being serious, are you referring to fluid overload?
A Yes.

Q Is a symptom of fluid overload cerebral oedema?
A You can get fluid overload in general in the sense that you have too much fluid and your heart and lungs cannot cope with it. So it can be generalised through the body. The primary concern, the usual concern is somebody with 500 mls running very quickly, that will produce what would be called heart failure, I suppose, for want of a better term.

Q That is respiratory arrest, is it?
A Yes.

Q In this case, I think, at the end of the paragraph to which you were referred, you said, "I took over but it was clear that there was no respiratory effort."
A Yes.

Q You appreciate I am not a medic, so I am struggling here, but it sounds to me as though a cerebral oedema was not inconsistent as a potential consequence of that saline drip running freely when you first arrived?
A No, it was not. Cerebral oedema can occur purely from fluid overload by itself. But certainly in the situations where I have seen it, it tends to occur in the context of something else. If you give children normally a large volume of fluid, it will produce the widespread -- the respiratory arrest, the fluid overload effectively to the heart and lungs much more commonly and much more likely than cerebral oedema. Particularly, I suppose, if you take it that it was normal saline, the implication would be that that would be more likely to produce a general fluid overload than a cerebral oedema, a localised cerebral oedema with no general fluid overload.

Q But at the time you came in, recognised the problem, corrected the problem as best you could, and am I right in saying, my recollection is that you indicated that you made no real investigation at that point by way of inquiry of those in the room as to how it was that this unauthorised drip or bag was up?
A I did not make any detailed inquiries. I think I did ask a question, I think the response was something like people referring to the fact that there had been diarrhoea, from which I understood them to be suggesting that a worry would then have been that the catastrophic episode might have related to a sudden onset of shock, for example. That would be the only logical sequence that I could think could have explained it. I did not get a logical sequence. There was a referral to the fact that there had been diarrhoea, but it was not a detailed question exactly, you know, "What did you think you were doing? What time did you start this? Why were you doing that?" because at that point there was a cardio -- I beg your pardon, there was a resuscitation situation, a respiratory arrest and the focus - again to come back to the APLS - airways, breathing, circulation and securing the adequacy of all those. So there was not a great deal of time to make such inquiries, particularly when, if I may say so, there was no nurse, for example, forthcoming to say, "I was the person who was in charge here, and up to such and such I did such and such and then I handed over to ..."

You may recall the amount of time that was spent trying to elicit the chronological sequence earlier in this proceeding. If you can imagine yourself in the position where you are trying to undertake resuscitation and trying to extract that sort of information, I do not believe it is humanly possible under those circumstances to do it.

Q So you then moved on to your telephone conversation a little while later with Dr McKeague. From what I understand you to have said today, you had told him about the presenting history when Patient A first arrived and you also told the doctor about the current position?
A I made a reference to it. I think I started from, if I can put it like that, from the other end, "The reason I am ringing you" - and I am paraphrasing now, I am not quoting - "The reason I am ringing you is that we have a child that needs to be transferred to you. The reason for transfer is because there has been a disastrous unexplained episode" - and when I say unexplained I mean unexplainable by me at the time - "The child will need to be in a place where she can be ventilated and, therefore, the request is can you take the patient? The reason" - and again I am not pretending to be able to quote - "The reason the child was in hospital was because of gastroenteritis." I could not see the connection between the two at the time. That is what I am saying.

Q No, I understand that. I am just seeking to understand what was said in that telephone conversation.
A Again if I refer you back to the question of the Claforan and mannitol.

Q We will come on to that in a moment.
A Sorry, yes.

Q What I would like to establish, first of all, is whether it is possible or likely that your telephone conversation included discussion as to what you had instructed the patient to receive by way of fluids?
A I do not recall that being a topic of conversation in the sense that it was, if I can put it this way, a relatively straightforward case of gastroenteritis with a disastrous outcome. The connection between those two was not obvious to me at the time.

Q Quite.
A The conversation, for example, about the Claforan, the antibiotic, and the mannitol, that says to me one of the discussions on the phone was, "Have you given this child antibiotics, in case it might be a manifestation of something like meningitis, for example". Which we had not given antibiotics and it turns out it was not meningitis. That sort of possibility does divert your attention to what you had been thinking about before ---

Q Clearly it is a possibility, but what I would like to explore is what you might have said in terms of what had been done in your hospital or what you had instructed to be done. You have indicated that when you arrived back at the hospital you were surprised to find this saline drip running freely. Might you have mentioned that to the doctor?
A I do not remember doing so. I may have mentioned it, but I cannot say that I remember mentioning that or not.

Q No, I understand that, nine and half years is a very long time. What I was seeking to do was to either rule in or rule out possibilities. You have indicated one possibility as to why this particular combination of drugs might have been suggested by the doctor. If, in fact, you might have mentioned to him, "One extraordinary thing was, when I came in I found that a saline drip was running freely which I had absolutely not authorised and I wonder whether that might have any significance." That might explain, might it not, why he suggested that you administer a bolus of mannitol?
A It might, but it would not explain the Claforan, because that would not be relevant in that context.

Q No, indeed. But, as you have indicated, at this stage he was likely, as you were, to be trying to cover a number of bases?
A Yes. I have lost the thread of the question, I am sorry.

Q I suppose what I am really saying is that the suggestion of the two drugs would not be inconsistent, would it be, with the doctor saying, "Well, I think we should guard against meningitis, but we should also guard against fluid overload, and therefore I am going to suggest to Dr O'Donohoe these two drugs."
A Yes, if I can take the words "fluid overload"? If you mean fluid overload in the

general sense I was talking about, the heart and the lungs and so on, mannitol would not be the drug you would normally use. You would use a drug like Lasix, for example, to try and clear that fluid. So if that was the thought, I do not think he would have recommended mannitol, I think it would have been something different.

Q Thank you very much, that is very helpful.

Finally, if I can turn to this question? A great deal of time has now passed since the tragic events into which we have been inquiring and we have heard that you have continued in your practice. What I would like to ask you, if you can tell us relatively briefly, is what, if any, changes you have made to your practice as a result of the specific points of learning that may well have occurred as a result of this case? So I am not interested particularly about changes in your practice that do not relate to the specific areas that we have been examining in this case, is that clear?

A Yes. There have been substantial changes in my practice and in the practice on the wards in regard to recording fluid prescriptions and documenting fluid intake and output. That is something that I have been very substantially involved with. Nurse McManus referred you to her involvement in retrieving documents from places she had worked and that was undertaken as what one might call a multi-professional -- everybody trying to find out what is the best thing we can all do. That has been implemented. That was implemented on the ward before the National Patient Safety Agency made its recommendations, so that is one thing that has changed.

Q I do not want to interrupt, but I just want to get this coming out as smoothly as possible. You started on general ward changes.

A Yes.

Q So let us continue with those.

A Yes.

Q When you have completed those, if you could turn to the very specifics of your own individual practice then that would assist me greatly.

A Yes. I am hoping I am answering this question correctly, but as I mentioned there was a *pro forma* in which patients, when admitted, certain details were to be collected. That changed in that the standard fluids calculation procedure was included in that, with a view to that being calculated for every patient, written down, "This is the way we are doing it for this patient", with a view to being verifiable by every member of staff. So that it would not be an issue of, "You were the doctor, you prescribe the fluids and I am the nurse, therefore I just put fluids up". That the spirit in which that would be done is that if a doctor made a calculation, which turned out to be incorrect, there was an open invitation for that to be pointed out.

The third component relating to the ward in general was that there was appointed a nurse whose title was something like practice development coordinator, and people might recognise it by a slightly older title of something like a nurse teacher or a nurse tutor, and one of the first things she undertook was an extensive training of nurses on the ward about fluids and asked me to have the medical input to that. That involved something like 100 nurses over the two sites. She devised an assessment questionnaire to assess the degree of learning and so on. That has actually continued and even slightly resurfaced, if

A I can put it like that, in that over the last month or six weeks there has been concern about the possibility that if there is swine flu then children may need to be ventilated in Intensive Care in the Erne Hospital by nursing staff, who have very little experience in dealing with these issues, and an approach was made to the paediatric department, the medical paediatric department, for someone to provide some training in that and I was asked to undertake that, which I have done.

B In terms of SHOs when they started, when they start working, we had established or had been trying to establish at that time, but had not been entirely successful, the idea that each time a new doctor starts there would be a day's resuscitation training provided. That was something that I encouraged and promoted strongly, if I may put it that way. It got to the point where people who would potentially teach on that knew that on the first Friday of February and August I would be looking for something to happen. Everybody on the ward knew that when that happened there was no point booking in a lot of patients and so on, because people were going to be otherwise occupied.

C This was not the only area in which ongoing attention needed to be paid to what you might call induction of new medical staff when they started, and the procedure that I was involved in setting up was that there was a day's training on a variety of topics which had caused concern or where there was possible areas of difficulty, followed by the resuscitation. Each afternoon, for the following week, there were a variety of topics for formal instruction. I did not do all of them and involved my colleagues the best I could in undertaking that. So there was a fairly substantial change over the course of -- it would have taken a couple of years to get those things established, but there were very substantial changes, I think.

D Q Now in respect of your own practice. If I can give you a specific pointer, especially in relation to the way in which you give instructions and then ensure that those instructions are clearly understood.

E A Some of the training activities, for example, I came across the idea of the shared mental model idea; in other words trying to ensure that we all are understanding when each person is talking. There are various techniques that have been suggested to remove limitation of that, but one is to ask people to repeat back what you have told them. Up to the time this episode happened I would guess I was reluctant to do that, on the grounds that it might seem somewhat insulting or whatever to say to somebody, "Can you repeat back what you have said to me?" On a bad day one occasionally might have got the response, "Are you saying I am not paying attention?" That was maybe the reason for being inhibited about doing that previously. Once there is a general discussion about it, "This is the question that will be asked and is not a personal suggestion that you are not paying attention or that you do not know what you might be doing, but it is the way of ensuring a greater safety, greater clarity about what we are doing".

F Q Are you saying that you now do that?

G A Yes.

Q So far as your own use of language is concerned, you have seen the interest that has been aroused over your use of an instruction along the lines of "give a bolus" without qualification. How has your practice changed in regard to the language you use in the instructions that you give?

H

A I would be much more precise and use even a different technique. The APLS training course is one that we are all asked and required to do every four years. I was recommended or suggested I might, as a result of one of them, undertake the training to become an instructor in the APLS technique. From that there are useful techniques as to how you might try to make sure that there is a consistent message and that you concentrate on what you might call the teaching and communication aspect of those things, something that, I think, in the past possibly had been neglected.

B

I suppose the fact may be that if you are on a one in two and you are around a large number of hours there is sometimes the feeling that I have said this a thousand times before. Again, that is a trap that occasionally I have found myself, or even some of my colleagues talking to nurses, medical students and I suppose I am now the person who tends to say, "Excuse me, do you know what that word means?" It is interesting that stopping people in the course of normal conversations it is still not uncommon, and I mean no criticism of anybody when I say this, but there are assumptions that people know what we are talking about. It is not that we are trying to be obscure or difficult or clever by pretending we know a lot of difficult words. Some things just become part of second nature and you start to assume that everybody else knows what you know.

C

Q Within your practice now what do you do to safeguard against that sort of difficulty?

D

A The difficulty about instructions being understood?

Q Yes, of somebody misinterpreting what you have said where you think what you have said will be understood in one way, how do you now? If you have made any changes to your practice, what are they that would enable you to say with confidence that could not happen any more?

E

A The first change, if I may say so, is that I am now reluctant about the idea of saying this could not happen any more. I think step one maybe is to say, well, the impossible may happen. A disaster that you would not anticipate may very well be just around the corner no matter how we all try to do the best we can. That, I think, is actually the starting point in the whole issue.

F

There has been a sea change in attitude to episodes like this when they happen in the sense that there is now, I am sure in many hospitals, a procedure whereby if there is a difficulty, if there is an untoward episode, even minor untoward episodes that do not cause any harm, they are notified and looked at and lessons learned if possible. Again, I was asked to be the person to coordinate the response to some of these episodes. It is interesting that over the last two or three years when I have been involved in that there have been still a significant number of fluid episodes relating to children, not patients within the paediatric ward but there are surgery patients admitted under the care of surgeons, for example, gynaecology, various other issues in adolescents and it has been possible to say, "Listen, what you have done from the fluid point of view is not the way it should be done here. The ward has decided that as a paediatric ward this is the way we do it" in accordance with the guidelines and I think there was a reference to the Department of Health in Northern Ireland having---

G

Q I am sorry to push you but what I am interested in are the specific changes that you have made to your practice as a result of those points of learning that have occurred?

H

A You mean what I would do?

Q What you do. If there is anything that you have not yet told us about this is the time to tell us, please.
A In terms of recording, for example, there would be a constant alarm bell, if that is the right word, in my mind saying, "Have you recorded enough information to try to ensure that this could not happen again?" "Have you recorded enough detail what you intend?" "What have you said to the parents to make sure that they understand what is going on?" What the instructions have been to other members of staff. It is something that I have become very aware of and there have been occasions, if I am to be entirely honest, where I have looked at a set of notes the following day and said, "I thought I had recorded everything I should do" and you find that there is something that twelve hours later, a day later looks very obvious and it is a constant exercise in looking at what one is doing and trying to find where there are residual defects, if I might put it like that.

I believe it is clear from the point of view of relationships with nurses, for example, or other colleagues, even junior colleagues, that the point is made that nobody is God and if I do something which does not seem to be appropriate or consistent - and all of my colleagues are agreed, this is a conscious decision - people should make sure that that is drawn to our attention. If there is a procedure to be followed we should all try and follow the procedure and not look to make short cuts or presume that we can do better or be cleverer because we have been around for some years and just because we could do it does not mean we should do it. One has to take into account the prospective of other people who may not understand what may very well seem obvious to me or some of my more senior colleagues.

THE CHAIRMAN: Thank you doctor. That concludes the questions from the Panel. I will now ask the advocates if either of them have any questions arising out of the questions raised by the Panel?

MR GRUNDY: Not from me.

MS FOSTER: Two very short ones, in fact.

<u>Further re-examined by MS FOSTER</u>

Q It was about a question that you were asked right at the very beginning and you were asked it by Ms Julien concerning mannitol and she asked whether that could be reasonably called a bolus and it could. I just wanted to ask you in the context of gastroenteritis could the word bolus on its own reasonably mean mannitol or something like that?
A No, no. You would not use mannitol in gastroenteritis. There would be no ground for using it.

Q The last question was this - the phrase stuck in my mind as graphic - when asked about the specific points of learning for yourself by the Chairman you said that you had a constant alarm bell in your head. Is it because of this case that you have that constant alarm bell?
A Yes. If I was to summarise the situation by saying I---

Q If you could do it shortly, please?
A I will. I think I have a short phrase. I do not believe there has been a day passed since that time when I have not been aware of what happened.

Q With respect to the constant alarm bell, that is to say that an alarm bell that sounds in respect of your notes, is that an alarm bell that is still ringing ten years on in the context of your practice?
A That is still every single day.

MS FOSTER: That is it, sir, thank you.

THE CHAIRMAN: We will take 20 minutes then, please, ladies and gentlemen, returning at ten-to twelve.

(*The Panel adjourned for a short time*)

THE CHAIRMAN: Welcome back, everyone. Doctor, your testimony is concluded and, if we can make room for you, you could return to your place with your legal team.
(*The doctor returned to his seat*)

MS FOSTER: Thank you, sir. That is the case for Dr O'Donohoe.

THE CHAIRMAN: Thank you very much indeed, Ms Foster. Mr Grundy.

MR GRUNDY: Sir, it falls to me now to address you with regard to the stage we have reached which under the Rules is Rule 27(2):

> "On the conclusion of the proceedings ... the Committee shall consider and determine:
>
> (i) which, if any, of the remaining facts alleged in the charge are not admitted by the practitioner have been proved to their satisfaction, and
>
> (ii) whether such facts as have been so found proved or admitted would be insufficient to support a finding of serious professional misconduct, and shall record their finding."

Of course, the burden is upon the GMC to prove the outstanding facts. The standard of proof is the criminal standard so that you must be sure.

I can hopefully shorten my submissions because I have already addressed you at the submission of no case to answer with regard to the outstanding facts and serious professional misconduct. I do not propose to repeat all that I have previously said but, clearly, what I said there was equally relevant.

The only additional evidence that you have had since then is the evidence of the doctor.