THE ORAL HEARINGS IN THE INQUIRY
INTO HYPONATRAEMIA-RELATED DEATHS
BANBRIDGE COURT

Chairman: The Honourable Mr Justice O'Hara

RAYCHEL FERGUSON
(LUCY CRAWFORD PRELIMINARY)

CLOSING SUBMISSIONS
ON BEHALF OF DR MURRAY QUINN

Introduction

1. These closing submissions are served on behalf of Dr Murray Quinn and deal with his involvement in the investigation following the events which led to the tragic death of Lucy Crawford on 13 April 2000. The Inquiry will be examining his role in the weeks after her death as part of its task to inquire into what, if any, further steps ought to have been taken by the Trust and others adequately to investigate and learn from these events in order to ensure, so far as possible, that a repetition could not occur. Dr Quinn has always indicated that he wishes to cooperate in the inquiry in every way he can.

Dr Quinn's instructions from the Trust

2. Dr Quinn, a highly respected Consultant Paediatrician at Altnagelvin Area Hospital, was asked by Mr Mills, then Chief Executive of the legacy Sperrin Lakeland HSS Trust ("the Trust") to assist with a case note review of the Lucy Crawford's notes. As Mr Mills said in evidence, Dr Quinn was not being asked to produce a report for medico-legal purposes, nor was he being expected to

interview doctors, staff or family. To use the description of Dr McConnell, Dr Quinn was being asked to produce an "initial rapid review of the notes" (Day 112: page 38). Dr Quinn's involvement ended immediately after he prepared that rapid review.

3. Dr Quinn agreed to do just that and no more. In his telephone discussion with Mr Mills, he made clear that he would not act as medical adviser and not provide a report. Mr Mills accepted that Dr Quinn's role was limited in this way in his statement at [WS-293/1 page 10 – answer (15)]. For the reasons which he gave to the Inquiry, he did not want to become further involved. He explained that to the Chairman, in answer to this question (at page 88 of Day 109):

> "… But why might you be so reluctant to become
> 9 involved to help in a complaints issue?
>
> 10 A. Because you require two external medical advisers, as
> 11 I understand it, to the complaints procedure. I have
> 12 been in the position to be a medical adviser on two
> 13 complaints procedures, formal complaints procedures, and
> 14 my understanding is that in all cases they would look
> 15 for someone outwith their area.
>
> 16 THE CHAIRMAN: I see. In 2000, that would mean not just
> 17 outside the Sperrin Lakeland area, but outside the
> 18 Western Board area?
>
> 19 A. That would be correct, chairman.

4. In a second telephone conversation with Mr Mills after he had had a chance to review the notes received from Mr Fee (a conversation which Mr Mills does not now recall), he agreed to discuss with those conducting the internal inquiry ("the internal review") his preliminary thoughts (which he had noted down in some handwritten notes [WS-279/1 pages 33-36] – typed copies at [WS-279/2 pages 6-10]). Once again, he made clear that he was not prepared to do more than give

the Trust his preliminary views and he recommended that the Trust should obtain an opinion from a consultant paediatrician from outside the Western Board Area. Although this suggestion is not now recalled by members of the inquiry team, it is to be noted that the expert who was eventually instructed (Dr Jenkins [034-050-153]) was the very same consultant suggested by Dr Quinn. As Dr Quinn remarked (Transcript Day 109 page 96) in answer to the following question:

> Q. You weren't being asked for a medico-legal report?
>
> A. Well, that has been confirmed, both I think in evidence to this inquiry and, on Wednesday, Dr Kelly was here and he stated that they weren't asking for a medico-legal report, and he also reported that I had said at the meeting with him that I was not producing one.
>
> Q. Yes.
>
> THE CHAIRMAN: It's also confirmed by the fact that they went to Dr Jenkins for the medico-legal report, which I think is what Mr Wolfe is referring to, the reality of what happened supports and is consistent with what you have said to us.
>
> A. Thank you, chairman. Yes. I haven't been asked, but my recollection is that the doctor I advised that they could use was Dr John Jenkins. Dr John Jenkins was subsequently used. I don't know if that's coincidence or was triggered by anything that I said.

5. Dr Quinn had two conversations with members of the inquiry team:

5.1. A telephone conversation with Mr Fee on 2 May 2000. Mr Fee's typed up record of that conversation is at [036-035-067] but, comparing it to the handwritten one, the typed version is by no means a transcript. A typed transcript of the handwritten note made by Mr Fee is at [034-042-103a];

5.2. A meeting with Dr Kelly and Mr Fee, three weeks later on 21 June 2000. A note of that meeting was made by Dr Kelly at [036a-047-101] but, as

was accepted, this record was also by no means complete. If one compares that note with Dr Quinn's handwritten notes setting out his preliminary thoughts, made in advance when he reviewed the case notes [WS-279/1 pages 33-36 – typed copies at WS-279/2 pages 6-10], one can see that although there is a correlation between both the content of and the order in which topics were discussed, other topics were also covered.

6. At the close of those discussions, Dr Quinn was reluctantly persuaded by Dr Kelly to agree to put his preliminary thoughts in writing which he did [017-021-039]. This document has, of course, been examined and dissected in very great detail.

7. It is submitted that the Inquiry should accept his evidence as to the limited nature of his role and reject any suggestion that he was being asked to or agreed to produce something more final or conclusive. The very limited nature of Dr Quinn's instruction is consistent with all of the contemporaneous material:

7.1. It is obvious from the documents with which he <u>was</u> supplied that he was being asked to do no more than provide a desk-top case review of the notes:

7.1.1. The covering letter from Mr Fee dated 21 April 2000 [033-102-296] asked him for an opinion which "would assist Dr Anderson and my initial review of events relating to Lucy's care";

7.1.2. He was, indeed, only provided with those notes. He was not even given a copy, save at the very last meeting, of the post mortem (and then only the short unsigned version);

7.2. The limited nature of his instruction is equally plain when one looks at the documents with which he was not supplied:

7.2.1. Although he would have derived little assistance from the various memoranda and letters from doctors and nursing staff obtained by the inquiry team between the date of his instruction and the date of his report, Dr Quinn was not provided with any of this;

7.2.2. He was not given a copy to retain even of the short post mortem report and was only shown this when Dr Kelly and Mr Fee came to see him on 2 June. The complete set of documents which were sent to Dr Quinn is included at file 162 and he has been careful to retain them in their original state (Transcript Day 109 page 100 line 8). No post mortem report is amongst them. No expert instructed to provide anything like a full report with final conclusions would do so without having been given a copy of the post mortem to refer to whilst such a report was being prepared. Just being shown the post mortem briefly was only consistent with this exercise being no more than a desktop review of the case notes and no more;

7.2.3. He was shown none of the documents which were appended to the final review report (see the appendix at [033-102-269]) dated 31 July 2000 apart from his own letter of instructions (item 12) and the short PM report (part of

item 10) a copy of which he was shown but not asked to retain;

7.3. Although he could have and ought to have set out, in his report, its limited scope (see below), it is quite clear from the introductory paragraph, that what was to follow were only preliminary conclusions:

> "I have reviewed the notes of this child as requested and will make a short summary and some comments on the possible sequence of events in this case."
>
> (underlining added)

7.4. Concern has been expressed throughout this part of the Inquiry about the extremely superficial nature of the investigations carried out by Mr Fee and others. The limited nature of Dr Quinn's instruction would be consistent with that approach. A detailed instruction would not have been consistent with that approach and would almost certainly have led to any conscientious expert, so instructed, insisting upon much greater inquiry.

8. Notwithstanding those limitations, it is equally clear that, by the time the review report was published on or about 31 July 2000, just over three months later, Dr Quinn's report had been elevated to the status of a final expert report and was being treated as if it could be relied upon to draw reliable conclusions as to what had occurred. How has this come about? It is submitted that much the most likely explanation is that, by the time the review came to be published in June, those responsible for the internal review had either overlooked or forgotten the very limited nature of Dr Quinn's instructions and the following important features of the evidence which the Inquiry heard:

8.1. that Dr Quinn had made clear that he was not prepared to do more than a case note review and was not prepared to produce a medico-legal report;

8.2. that these limitations had been expressly accepted by Mr Mills;

8.3. that Dr Quinn had not been provided with nor had he intended to seek any answers to the important questions which he had raised during the conversations, first, with Mr Fee and then with Mr Fee and Dr Kelly. In the notes of the oral discussions with Dr Quinn and in his report, he raises a number of critical questions to which answers had not been provided (e.g. why was the child floppy? Did she have a seizure? How much saline was run in?) to which answers were never provided as is clear from the report which he produced which raises the same questions again;

8.4. that Dr Quinn had not been provided with any of the statements, letters or memoranda from doctors and nurses as to what had occurred, all of which would have been a pre-requisite before any kind of final report could been prepared.

8.5. most importantly, that no information had been sought or obtained and passed on to him from Lucy's family. As Dr Quinn made clear, he would have needed to have a description of the fit from which Lucy had suffered before being able to draw even preliminary conclusions as to what had happened at 3 am. He also needed information from Lucy's parents to assess how ill she was. As he put it at Day 109 page 135-6:

> "…I think Lucy was much sicker than comes out in the
> 16 notes, and mum has said early on in her submission that
> 17 she'd asked the doctors to look at Lucy's eyes because
> 18 she felt there was something wrong with them, and

> 19 I think mum's observation -- if you go against mum's
> 20 observation, I learned very early in my career, you're
> 21 in trouble. Mum has the best perception of how sick her
> 22 child is. She then went on to say that the doctors and
> 23 nurses didn't seem to feel Lucy looked very sick. Prior
> 24 to the -- she also said there were many attempts taken
> 25 to put an IV line up.
>
> 1 Prior to the IV fluids being started, she made
> 2 a statement which said that Lucy was very floppy, her
> 3 sister came in and she didn't recognise her, she seemed
> 4 to be staring through her, and glassy-eyed, and she
> 5 asked the doctors to then look at her again."

8.6. that Dr Quinn's report was not provided to any of the clinicians and nurses whose input had been obtained, a failure rightly criticised by Dr MacFaul (at [250-003-063] at para 275));

8.7. that Dr Quinn had not been informed that his report was to form part of a final review report (as it did) which included many of the accounts given by doctors and staff, all material with which Dr Quinn had not been provided; and

8.8. that, on any view, Dr Quinn's short report raised more questions than it answered and demanded follow up input from an expert instructed to provide a fuller report.

9. It is quite inexplicable that that last step was not taken and the team sought to rely only upon Dr Quinn's report. As Dr MacFaul put it in his report at [250-003-059]:

> "255) Despite his reports shortcomings Dr Quinn had advised the Trust that:
>
> - He was not confident about the cause of the cerebral oedema
> - The fluid volumes were high
> - He was not clear about how much normal saline had been given at the time of the arrest.

256) The Trust should have taken further action in the form of setting up further investigation process, seeking an opinion from another expert review…"

10. Dr Quinn's actions must, in fairness to him be seen in that context. Although he accepted that he made errors (see below), had his advice been used simply for what it was intended, namely, a preliminary steer for the internal review based upon limited instructions and very little information, then the consequences of those errors would have been as limited as were his instructions.

Errors made by Dr Quinn

11. Dr Quinn accepts, with hindsight, that he made three errors which, although significant, have assumed disproportionate importance as a result of the unauthorised and unintended use to which his report has been put:

12. He accepts that describing the choice of fluid used as "appropriate" was wrong and potentially, although not intentionally, misleading. He explained to the Inquiry what he meant to say and, frankly and honestly, accepted the criticism that his words could have been misinterpreted. He took the view that the staff on duty thought that Lucy was not as ill as he suspected that she was. Whilst if they had been correct, the choice of Number 18 solution would not have been inappropriate, they should have appreciated that she was more ill than they thought, in which case normal saline would have been the appropriate fluid regime. He explained this at page 133-4 of Day 109:

"…I'll tell you why I said that: I felt that the
21 doctors in the Erne had underestimated how sick Lucy
22 was, and I say that because there are very few notes
23 actually on admission. They have not stated that she
24 looked sick, and that would be one of the first things
25 that I would write if I'm assessing a child, "Looks

1 sick", or" Does not look sick". They have not outlined
2 the degree of dehydration. They made a diagnosis of
3 viral infection. There was no treatment started and
4 there seemed to be no rush to put up an intravenous
5 infusion. In fact, it was some three-and-a-half,
6 four hours after admission -- is that right? -- that she
7 actually had a drip put up."

13. Secondly, Dr Quinn should have made clear, on the face of his report, the limitations upon which he had insisted and for which it could be used. Had this been a medico-legal report, no doubt this would have been included. His evidence was that he never intended his "short summary" to be used as a stand-alone expert opinion, let alone the final and only expert word on the clinical management of Lucy in the internal review report, even to the extent of it being referred to, years later, and without reference to him, at the Coroner's Inquest. The comments made in it were intended to supplement the views expressed in the oral discussions with Mr Fee and Dr Kelly. Although he did preface his observations by making it clear that it was a "short summary" containing "some comments on the possible sequence of events", he accepts that he ought to have made its and his limitations clearer in the event that it was to be read by those who had not been privy to his initial instructions. Had he done so, then it would have been obvious to any reader that it should be used only with caution. In fairness, however, had it only been used for the purpose for which it was intended, it would not have been necessary to articulate those limitations.

14. Lastly, Dr Quinn made a mistake when he allowed himself to be persuaded to put his thoughts in writing even allowing for the limited role which he had agreed to perform. He explained how this came about at page 171-2 of Day 109:

"…I think I can remember Dr Kelly's words pretty exactly.
19 He said, "You've done all the work, so why don't you

> 20 produce a report?" And at that stage I said I was not
> 21 willing to produce a medico-legal report. He said that
> 22 he needed something to deliver to Dr Anderson, who
> 23 wasn't there, for the purposes of the internal inquiry,
> 24 and it was at that stage that I agreed to produce
> 25 a summary report, written for those purposes only, for
> 1 that purpose only.
>
> 2 THE CHAIRMAN: In other words, if the two people who'd been
> 3 doing the review, namely Mr Fee and Dr Anderson, had
> 4 been there that day, instead of Mr Fee and Dr Kelly, you
> 5 would have declined to write a report because you would
> 6 have given them the information or the views which you'd
> 7 formed?
>
> 8 A. Yes. I strongly said that I was going to have a verbal
> 9 discussion with representatives of the trust and it was
> 10 at that meeting that I was asked to produce a report
> 11 in the words that I said."

Had he stuck to his guns and done only what he had agreed to do, he would simply have carried out a case review and the report would never have been prepared and there would have been no opportunity to misuse it or to rely on it on a false premise. Ironically, it was only by chance that Dr Anderson could not be present at the meeting on 21 June.

15. If those errors contributed, albeit unintentionally, to the failures of the internal review, then that is a matter which Dr Quinn greatly regrets.

Other alleged errors

16. That said, Dr Quinn's frank acceptance of where he went wrong should not lead the Inquiry to conclude that other criticisms of him are justified when they are not. Insofar as Dr Quinn is blamed for the following matters, it is submitted that the Inquiry should reject such criticism.

17. Failure to reach conclusions on cause of death. Dr MacFaul describes Dr Quinn's failure to "consider the relevant mechanisms in the generation of cerebral

oedema" to be a "major shortcoming". With respect, this betrays a lack of appreciation of the very limited information provided to Dr Quinn. Dr Quinn indicated in his report that he would be "surprised" if the volumes of fluid could have produced cerebral oedema causing coning. The last two words are underlined in these submissions because they are critically important.

17.1. It is submitted that Dr Quinn was justified in not reaching an opinion as to the likely cause of death on the information which he had.

17.1.1. As he repeatedly made clear, at every conversation with the inquiry team, he needed a description of exactly what had occurred at shortly before 3 am. Page 122-3 of Day 109:

> 6 Q. You then raise what I take to be some questions:
> 7 "Why floppy in the first place?"
>
> 8 A. Yes.
>
> 9 Q. Just take us through those, please.
>
> 10 A. Well, I think in the general practitioner's notes it
> 11 mentioned that she had been lethargic and perhaps
> 12 floppy. This was certainly an observation that her
> 13 parents had made, in particular her mum had made, that
> 14 she was unduly floppy, and can indicate that she was
> 15 iller than was perceived on admission to the hospital.
> 16 Was the episode a fit or coning? There's really
> 17 inadequate description of the event to let me be
> 18 absolutely definitive as to what the event was in and
> 19 around 3 am and after that. Was it an epileptic fit,
> 20 a tonic-clonic seizure, or indeed had she shown signs
> 21 that she had cerebral oedema to the extent that she
> 22 coned, i.e. pushed her brain down and caused irreparable
> 23 damage to vital centres?
>
> 24 THE CHAIRMAN: That's the point at which Mrs Crawford might
> 25 have been able to help because she was there at the time?
>
> 2 A. Indeed, chairman. In September of this year, through
> 3 the inquiry, I had the first chance to read what
> 4 Mrs Crawford said. I found it to be a very moving and
> 5 troubling document that Mrs Crawford had written in

> 6 terms of what Lucy was actually like and what happened
> 7 in and around 3 o'clock. I don't know if I'm allowed to
> 8 talk about it at this stage or not because it wasn't in
> 9 front of me at that time. I didn't see it until
> 10 September --

17.1.2. The information which he had was inadequate. Dr MacFaul agrees with Dr Quinn when he says this (at annex A to his report at [250-004-009]):

> "I agree with this statement - it is not possible to know whether the observed rigid attack was a seizure or whether it originated from brainstem compression".

17.1.3. The signs of coning are very specific (see the description of decorticate[1] and decerebrate posturing at [034-042-103d]). Before reaching a conclusion as to whether this had occurred or whether it was simply a type of convulsion, Dr Quinn needed a description either from the nurses who witnessed it or from Mrs Crawford. Indeed, he would have been justifiably criticised if he had drawn conclusions as to cause of death without such information;

17.2. He also should not be criticised for expressing preliminary surprise if the level of cerebral oedema was sufficient <u>to cause coning</u>.

17.2.1. Not every case of cerebral oedema leads to coning as is clear from the literature. Yet, significantly, when Dr MacFaul quotes Dr Quinn's view on this issue he fails to include these words (see e.g. [250-003-013] at para 11))

[1] A curious feature of the evidence is that, in his letter dated 115 May 2000 to Mr McConnell Dr Kelly indicates that the description of the seizure is "more in keeping with the child going to decorticate rigid" [0361-046-098]. From the material which has been produced to the Inquiry as being available at that time, there is absolutely nothing which would have permitted the inquiry team to have reached that conclusion because the process by which a child becomes decorticate rigid (described at [034-042-103d] is a very specific one. Whether or not, the inquiry team did have further information, it is clear that such information was not passed on to Dr Quinn.

17.2.2. Dr Quinn is a practitioner with considerable experience in this field and it was and remains his view that it is unusual for coning to have occurred in a child who has received this level of fluid. This was one of a number of possible causes which could not be ruled out (page 154 of Day 109):

> A. I think the fluids formed part of the risk for her
> 13 cerebral oedema. At that time, I didn't think the
> 14 timescale would allow that to happen over a four-hour
> 15 period solely in relation to the fluids that she
> 16 received. There were other aspects of the case which
> 17 needed to be explained. Why she stopped breathing, was
> 18 that related to the diazepam? Probably not. Was it
> 19 related to the seizure? Possibly. Was it related to
> 20 inadequate resuscitation? Possibly. So all of these
> 21 factors -- and the fluid run in after the seizure, the
> 22 normal saline being run in. All of those factors I took
> 23 into account and all of those, either singly or in
> 24 combination, could have caused her cerebral oedema.

17.2.3. In the transcript between pages 155 to 164 of Day 109 questions are put to Dr Quinn as if he was accepting that it was <u>likely or probable</u> (e.g. page 155, line 25, page 156, line 9, page 159, line 19 and page 164, line 21) that this was the cause. In fact, if one reads his evidence, he was careful to say that he considered that it was just one of a number of possibilities.

17.2.4. Had Dr Quinn been providing the last word on the cause of death (which plainly he was not), it might be a legitimate criticism to say that the expert should have dealt with "the relevant mechanisms in the generation of cerebral oedema" but this was, at that time, only one of a number of possible causes. Dr Quinn was asked in the letter of instruction to give an opinion on the "likely cause of cerebral

oedema". He simply did not have the material to do so and would have been criticised if he had. With respect, this criticism relies upon information not available to Dr Quinn and is misplaced and unfair.

17.2.5. There is another reason why it would not be fair to criticise Dr Quinn for his expression of surprise. He is not the only expert to have expressed reservations as to the likely cause of death. The Inquiry was invited to obtain expert evidence as to whether such volumes of fluid might lead to cerebral oedema causing coning but declined to do so, notwithstanding the memo from the Inquiry's specialist adviser, Dr Marcovitch, in which he indicated that it was "somewhat surprising" that the hyponatraemia progressed so rapidly. Although, as the inquiry reminded itself, that memo was intended not to have evidential weight, the purpose of the Inquiry's advisors is to "*help to identify the evidence that the Inquiry should call for and, if appropriate, the likely sources of evidence*" (Protocol No 4).

17.2.6. The Inquiry determined, for reasons of proportionality (Transcript Day 109: page 1-7), not to proceed to investigate this by way of further oral evidence. In the absence of a fuller exploration of this issue in the oral evidence, it would be unfair to criticise Dr Quinn for what amounted to no more than a preliminary expression of surprise.

17.2.7. Indeed, the closest the Inquiry came to looking at this in the oral evidence was in part of that from Dr MacFaul where he expressed a degree of hesitation in the ability of clinicians to identify (Day 117 page 65-6):

> "…Now, as far as causation of brain oedema is concerned of
> 24 itself, in a child without a brain illness, then that
> 25 was only information which became available more
>
> 1 generally available in the early 2000s. What we don't
> 2 know with Lucy, I suspect, is whether she had indeed
> 3 some kind of preceding encephalopathy. I don't want to
> 4 raise a hare, but I suppose I have to. Deaths through
> 5 that mechanism are so rare that one has to consider what
> 6 else might have been present, and I mentioned in my
> 7 report rotavirus encephalopathy because we do know that
> 8 Lucy had rotavirus infection and we do know that she had
> 9 a brain illness."

18. Volume of fluids. Secondly Dr Quinn is criticised for the way in which he dealt with the volume of fluid given to Lucy:

18.1. It has been suggested that Dr Quinn ought to have highlighted the volume of fluid as a significant error and was wrong to have described the volume as "not grossly excessive". That criticism is misconceived and can be dealt with shortly: Dr MacFaul's evidence is that, if a different fluid had been appropriate, the overall volume was not excessive [250-003-032). The error, therefore, lies with the choice of fluid rather than the volume. Dr Quinn's error was in failing to identify the type of fluid as being inappropriate rather than the volume;

18.2. Dr Quinn is criticised for including the whole period when Lucy was in hospital when calculating the rate of fluid administered. Again, this is an unfair criticism, particularly if it is suggested that he did that to lower the

calculated rate at which the fluid was being administered. Dr Quinn specifically referred to the hourly rate at which the fluid was being given in his report (page 1 at [033-102-270]) and in his oral discussions with Mr Fee/Dr Kelly. It is wrong and unfair to imply that he was attempting to conceal this. Calculating the rate over the whole period was a different exercise. He explained his thinking at page 173 of Day 109:

> "…I was trying to
> 10 take what fluids she'd had, including the oral fluids
> 11 she'd had before the IV fluids over the period of time,
> 12 from the time of admission to the episode of collapse.
> 13 I was trying to take into account all of the fluids
> 14 because, as I said, from when she was admitted, and
> 15 indeed before she was admitted, she was still losing
> 16 fluids into her bowel at that time and I wanted to take
> 17 account of all of the fluids going in at that period of
> 18 time, and I clearly stated in my documents that 100 ml
> 19 per hour was given. Well, at least 100 ml per hour,
> 20 some people would say.
> 21 So far from trying to reduce the volumes by doing it
> 22 over seven hours, I was trying to take into account all
> 23 of the fluids that had been given and in no way did
> 24 I avoid saying that she had been given 100 ml per hour
> 25 over at least a four hour period."

All of the experts who have given their views on these events have first carried out an assessment of how dehydrated Lucy was in order to assess her fluid needs. Plainly, in assessing dehydration levels, it is appropriate to take the whole period during which the child has been in hospital and include other fluids such as those taken orally. Not to do so would lead to a miscalculation. Dr Quinn was doing no more or less than that. He was not attempting artificially to reduce the fluid rate or to conceal the true rate. How could this be the case given that he actually refers to the rate at which fluid was given?

19. Independence. Next, a question mark was raised as to Dr Quinn's independence. Again, those who criticise him for this are missing the point that Dr Quinn was not instructed as an independent expert to advise the Trust in the context of possible legal proceedings but was there to give an initial desktop view. If the Inquiry accepts Dr Quinn's account, it was he who suggested that the Trust should look elsewhere for an expert opinion. Dr McConnell expressed misgivings about the choice of Dr Quinn as an independent expert, For that reason:

> "Dr McConnell advised [Mr Mills] that Dr Quinn could certainly review the notes and, indeed, this may be helpful"
>
> [318-002-001]

In the light of the very limited scope of Dr Quinn's instruction as envisaged by the director of Public Health, this is a criticism without substance. Indeed the fact that Dr Quinn was instructed tends to support the fact that his role was intended to be to carry out just a preliminary review, just as one might seek the views of an in-house medical adviser at the start of the conduct of litigation.

20. "Sweet-talk". Finally, there has been focus on the use of the verb "sweet-talk" in the press "doorstepping" of Dr Quinn. The Inquiry will have seen the video of the so-called "interview" with Dr Quinn. Under pressure, Dr Quinn used an unfortunate phrase which was pounced upon by those looking for a good televisual soundbyte in an otherwise important piece of documentary news. Dr Quinn [069A-057-195] said that he was "sweet-talked into writing a summary which is not the complete amount of discussion that I had at the time". Dr Quinn has explained what he meant by that verb. He was not intending, by that expression, to imply that he was persuaded to do something unprofessional and,

it is submitted, the Inquiry should not place importance on the use of this expression in the heat of the moment.

Conclusions.

21. A repeated concern of the Inquiry during the course of the evidence was whether or not the circumstances of Lucy's death were not only not investigated properly but deliberately suppressed. Having heard the way in which Dr Quinn gave his evidence as to his role in the preliminary stage of an investigation, a role for which he did not ask for or receive any remuneration and after which he had absolutely no further involvement, whatever views the Inquiry comes to as to the adequacy of the investigation, it is submitted that it can be confident that Dr Quinn was not a party to any attempt to cover up the failings and inadequacies of the treatment given to Lucy.

JAMES COUNSELL
OUTER TEMPLE CHAMBERS

18 October 2013

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CLOSING SUBMISSIONS

ON BEHALF OF DR MURRAY QUINN

Carson McDowell LLP
Murray House,
Murray Street,
Belfast
BT1 6DN
DX 403 NR Belfast

Ref LRL/M397