PUBLIC RECORD

Dates: 26/04/2021 - 10/05/2021

Medical Practitioner's name: Dr John HANRAHAN

GMC reference number: 3420535

Primary medical qualification: MB BCh 1985 National University of Ireland

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment not found proved	Not Impaired

Summary of outcome

No action (warning not considered)

Tribunal:

Legally Qualified Chair	Ms Christina Moller
Medical Tribunal Member:	Dr Thandla Raghavendra
Medical Tribunal Member:	Dr Louis Savage

Tribunal Clerk:	Mr John Poole

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Jonathan Holl-Allen, QC, instructed by DAC Beachcroft.
GMC Representative:	Mr Nigel Grundy, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 07/05/2021

Background

1. Dr Hanrahan qualified in 1985 from University College, Dublin, and went on to train in Paediatric Neurology. He obtained a Diploma in Child Health in 1988 and became a member of the Royal College of Physicians in Ireland in 1990. He gained a MD Degree from University College in 1997 and is a Fellow of the Royal College of Paediatrics and Child Health. He has been practising as a Consultant Paediatric Neurologist in the Royal Belfast Hospital for Sick Children ('RBHSC') since July 1998.

2. The Allegation that has led to Dr Hanrahan's Tribunal relates to events following the death of Patient A at the RBHSC on 14 April 2000. Concerns were raised about his contact with the Coroner's Office and in relation to the death certificate.

3. In summary, Patient A was admitted to Erne Hospital, Enniskillen, at 19:30 on 12 April 2000 with a history of drowsiness, diarrhoea and vomiting. Whilst under the care of Dr B, Consultant Paediatrician, Patient A was found to be dehydrated and given intravenous (IV) fluid replacement. Subsequently, her serum sodium levels fell significantly, Patient A became restless and had a seizure at around 03:00 on 13 April 2000. Five hours later she was transferred to the Paediatric Intensive Care Unit (PICU) at the RBHSC at 08:00 on 13 April 2000.

4. Dr Hanrahan became directly involved in Patient A's care after her transfer to RBHSC; she was effectively brain-dead without prospect of recovery by this time. As on-call Consultant for Paediatric Neurology, Dr Hanrahan was asked to provide a neurological opinion and to confirm brain stem death. He recorded differential diagnoses, including infection, haemorrhagic shock encephalopathy, metabolic disease and (unrelated) cerebral oedema. Patient A was pronounced dead at 13:15 on 14 April 2000.

5. A hospital post-mortem was performed and a preliminary report (provisional anatomic summary) dated 17 April 2000 was produced. On 14 April 2000 Dr Hanrahan spoke to Mrs C, a member of the Coroner's Office staff about the death. She made a note of this conversation, to indicate that Patient A's death did not require a Coroner's post-mortem, but that a hospital post-mortem could help ascertain the cause of death. A death certificate was issued on 4 May 2000, prior to the final post-mortem report being received on 12 June 2000. Handwritten entries on the death certificate gave cause of

death as cerebral oedema, with dehydration and gastroenteritis also noted. Pre-printed words on the death certificate meant that the text, read as a whole, said: cerebral oedema due to (or in consequence of) dehydration due to (or in consequence of) gastroenteritis.

6. The GMC's case is that, in the context of Patient A's death being both unexpected and unexplained, Dr Hanrahan failed to provide sufficient information to the Coroner's Office in relation to the facts and circumstances of Patient A's death, in order that proper consideration could be given as to whether an inquest was required. It is also alleged that subsequently Dr Hanrahan failed to alert the Coroner's Office that results of the preliminary hospital post-mortem were inconclusive as to the cause of the cerebral oedema, or to raise concerns about fluid management at Erne Hospital. Patient A had been rehydrated with excessive quantities of Solution 18, a hypotonic solution later withdrawn from use in children.

7. It is also alleged that Dr Hanrahan failed to adequately oversee the drafting of Patient A's death certificate and that he permitted the cause of death to appear on her death certificate as cerebral oedema due to dehydration, which was inaccurate and illogical. It was also alleged that he knew the presence of cerebral oedema was due to hyponatraemia, not dehydration, and that his conduct was dishonest.

8. The matter first came to the GMC's attention following the Inquiry into Hyponatraemia-related deaths in the years around 2000 in Northern Ireland (IHRDNI)('the Inquiry') which investigated the deaths of four children, including Patient A. The Inquiry was set up in 2004 but it did not hear evidence until 2012-2013, with its final report being published in January 2018. The Allegation against Dr Hanrahan relates to events surrounding the death of Patient A alone.

9. In February 2003 an inquest had found the death of another child had been caused by dilutional hyponatraemia due to excess IV fluid administration. After this inquest, the death of Patient A was further investigated. A further post-mortem report dated 6 November 2003 was obtained by a Coroner in relation to Patient A. In February 2004 there was an inquest into Patient A's death and the Coroner found that her death had been due to: I – (a) Cerebral oedema, (b) acute dilutional hyponatraemia, (c) excess dilute fluid; II – gastroenteritis.

10. In November 2004 a complaint was made in relation to Dr Hanrahan's involvement in the case of Patient A, but closed by GMC Case Examiners with formal advice to Dr Hanrahan in September 2010. The Inquiry published its report in January 2018. In August 2018 a decision was taken to re-open the initial investigation in relation to Dr Hanrahan's conduct.

The Outcome of Applications Made during the Facts Stage

11. The Tribunal granted the GMC's application, made pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), that the Allegation be amended. This was not opposed by Mr Jon Holl-Allen, QC, who represents Dr Hanrahan. The Tribunal's full decision on the application is included at Annex A.

12. The Tribunal granted a Rule 17(2)g application made by Mr Holl-Allen on behalf of Dr Hanrahan. Some elements of the Allegation were dismissed on the basis that the GMC had not established a case to answer. The Tribunal's full decision is included at Annex B.

13. After this, the Tribunal also granted a further Rule 17(6) application by the GMC, which was not opposed by Mr Holl-Allen. This allowed the wording of the Allegation to be clarified, following Mr Holl-Allen's half time submissions and consequent deletions.

The Allegation and the Doctor's Response

14. The Allegation against Dr Hanrahan to be considered by the Tribunal, after amendments, is:

1. You failed to adequately notify the Belfast Coroner's Office ('the Coroner's Office') of the facts and circumstances relating to Patient A's death in that:

~~a. on telephoning the Coroner's Office on 14 April 2000 you did not report that the~~
Removed in accordance with Rule 17(6)

~~i. clinical diagnosis for Patient A included hyponatraemia~~;
Dismissed following Rule 17(2)g application

~~ii. cause of Patient A's death was unclear~~;
Dismissed following Rule 17(2)g application

b. ~~thereafter~~, following the production of the final hospital post mortem report, you did not notify the Coroner's Office:
Amended in accordance with Rule 17(6)

~~i. that the results of a preliminary hospital post-mortem ('preliminary post-mortem') regarding Patient A were inconclusive as they did not establish a cause for the cerebral oedema;~~
Dismissed following Rule 17(2)g application

ii. of any concerns regarding the management of the fluids that Patient A had received. To be determined

~~2. Your actions described at paragraph 1 breach your duty under section 7 of the Coroner's Act (Northern Ireland) ('Act') 1959.~~ Deleted in accordance with Rule 17(6)

~~3~~ 2. You failed to adequately oversee the issuing of Patient A's death certificate by Dr B on 4 May 2000 as: Amended in accordance with Rule 17(6)

a. the death certificate was inappropriately issued on the basis of the preliminary post-mortem result; To be determined

b. you permitted the cause of Patient A's death to appear on the death certificate as cerebral oedema due to dehydration when this was:

i. inaccurate; Admitted and found proved

ii. illogical. Admitted and found proved

~~4~~ 3. When you: Amended in accordance with Rule 17(6)

~~a. established contact with the Coroner's Office as referred to at paragraph 1a, you knew that you should have informed them:~~

~~i. that Patient A's clinical diagnosis included hyponatraemia;~~

~~ii. that the cause of Patient A's death was unclear;~~

~~iii. of any concerns regarding the management of the fluids that Patient A had received;~~

Dismissed following Rule 17(2)g application

b. permitted an inaccurate description of the cause of death to appear on Patient A's death certificate as referred to at paragraph 2~~3~~b, you knew that the presence of cerebral oedema was:

i. not due to dehydration; To be determined

ii. due to hyponatraemia. To be determined

~~5~~ 4. Your behaviour as described at paragraph:
Amended in accordance with Rule 17(6)

~~a. paragraph 1a and 3b was dishonest by reason of paragraph 3a 4;~~

Dismissed following Rule 17(2)g application

b. 2b was dishonest by reason of paragraph 3b. To be determined

The Admitted Facts

15. At the outset of these proceedings, through counsel, Mr Holl-Allen, Dr Hanrahan made admissions to paragraphs 2bi and ii of the Allegation (as amended), shown above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced that these sub-paragraphs of the Allegation were admitted and found proved.

The Facts to be Determined

16. In light of Dr Hanrahan's response to the Allegation made against him and the successful Rule 17(2)g application made on his behalf following the close of the GMC's case, the Tribunal is required to determine the remaining paragraphs and sub-paragraphs of the Allegation.

17. The Tribunal received video-link evidence on behalf of the GMC from Dr B, Consultant Paediatrician. At the relevant time in 2000, Dr B was working as a Senior House Officer in the RBHSC. In his statement Dr B said that Dr Hanrahan had suggested causes of death for completion of the death certificate for Patient A.

18. Dr Hanrahan provided a witness statement dated 19 March 2021 and also gave oral evidence at the hearing.

Expert Witness Evidence

19. The Tribunal relied on expert evidence from Dr F, Consultant Paediatric Neurologist. Dr F provided an expert report dated 8 January 2021 and also gave evidence to the Tribunal via video-link.

Documentary Evidence

20. The Tribunal considered all documents provided in the joint hearing bundle, including:

- Patient A's medical records;
- Note taken by Mrs C, Coroner's Administrative Officer, of a call received from Dr Hanrahan on 14 April 2000 in relation to Patient A's death;
- Preliminary (Hospital) Post-Mortem (provisional anatomical summary) of Patient A, 17 April 2000;
- Patient A's Medical Certificate of Cause of Death, 4 May 2000;
- Final (Hospital) post-mortem report of Patient A, 12 June 2000;
- Post-Mortem report of Patient A, 6 November 2003;
- Redacted evidence from the inquest, 2012-2013;

- Relevant extracts from the Inquiry into Hyponatraemia-related Deaths, January 2018.

Legal Advice and the Tribunal's Approach

21. The Legally Qualified Chair ('LQC') gave advice in the presence of Dr Hanrahan and both counsel. There was no comment on it from either barrister. The LQC's advice to the Tribunal was as follows.

22. The burden of proving disputed facts is on the GMC. There is no burden on the doctor to disprove anything in the Allegation. The standard required is the civil standard, the balance of probabilities. The Tribunal will determine whether a disputed fact is more likely than not. There is no sliding scale in relation to the standard of proof, but the more serious the allegation, the more cogent the evidence may need to be to find it proved to the civil standard. Hearsay may be given less weight than direct evidence, as it will not have been tested in cross-examination.

23. *Sharma v GMC 2014 EWHC 1471* cites *Re H Minors 1996 AC 563* as authority for the proposition that the more serious the allegation, the less likely it is that the event occurred and hence the stronger should be the evidence before the Tribunal concludes that the allegation is established on the balance of probabilities.

24. However *Re B children 2008 UKHL 35* confirms that, while the seriousness of an allegation, or its consequences, may necessitate more careful consideration of the evidence, it does not affect the test to be applied. The House of Lords in *Re B* endorsed the general approach that a serious allegation will require careful analysis of evidence taking account of inherent probabilities and other matters requiring the application of good sense.

25. Although there is no heightened standard of proof in regulatory proceedings, the inherent probability or improbability of an event is itself a matter to be taken into account in weighing the probabilities and deciding whether, on balance, an event occurred or not. The more improbable it is that the registrant would have behaved as alleged, the more cogent and credible the evidence needed to prove on the balance of probabilities that he did: *Virdee v GPhC 2015 EWHC 169*.

26. The Tribunal will consider the entirety of the evidence heard, in the context of documents provided. Clear reasons should be given if the evidence of one witness is preferred over that of another in relation to any key issue in dispute. A Tribunal should:

    - Analyse evidence logically to reach conclusions on any inconsistencies
    - Address counsel's submissions: *GMC v Lamming 2017 EWHC 3309*
    - Make clear its findings of fact on central disputed issues.

27. In *R v Barton & Booth [2020] EWCA Crim 575* the Court of Appeal confirmed that the test for dishonesty is that set out in *Ivey v Genting Casinos 2017 UKSC 67*. In *Ivey* the Supreme Court provided that the correct test of dishonesty is that which is used in civil cases:
First, the Tribunal must ascertain the state of the individual's knowledge or belief as to the facts. The reasonableness of the belief is a matter of evidence going to whether or not he genuinely held the belief, but it is not a requirement that the belief must be reasonable; and
Second, the Tribunal must then consider whether that conduct was dishonest by the standards of ordinary decent people. There is no requirement that the individual must appreciate that what they have done was, by those standards, dishonest.

28. *Wisson v HPC 2013 EWHC 1036* confirmed that good character is clearly relevant when the credibility of a doctor is an issue. Both counsel agreed that Dr Hanrahan is entitled to a full good character direction, since his limited admission does not relate to any issue of dishonesty.

29. Dr Hanrahan is a person of good character who has no previous disciplinary matters recorded against him. Good character does not provide a defence, but it is an important factor capable of assisting Dr Hanrahan. It is relevant to the Tribunal's considerations in two ways:

    First, Dr Hanrahan has given evidence. Good character is a positive feature of Dr Hanrahan which the Tribunal will take into account when considering whether or not this evidence is accepted as credible.
    Second, the fact that Dr Hanrahan has no previous adverse regulatory findings, cautions or convictions goes to the likelihood of him now acting as alleged by the GMC.

30. Judging the weight to be given to Dr Hanrahan's good character and its relevance at the Facts stage is a matter for the Tribunal, taking account of all the evidence and submissions by both counsel.

31. The Tribunal has to reach a conclusion on each paragraph separately, but it is entitled, in determining whether or not each paragraph is found proved, to have regard to relevant evidence in regard to any other paragraph. It may consider the evidence in the round.

32. Although an assessment of credibility and reliability is not required in every situation, a Tribunal should provide an adequate explanation if it concludes that what was inherently improbable has been established: *McLennan v GMC 2020 CSIH 12*.

33. In relation to whether dishonesty had been proved, the Tribunal in *McLennan* had erred in failing to make a finding on the appellant's knowledge. It had recited, but not applied, the test in *Ivey*. It had not considered the possibility of carelessness. It had not explained how ordinary decent people would have considered the appellant to be dishonest. It had been important for the Tribunal to address why the appellant might have been dishonest.

34. When considering dishonesty, a Tribunal is not always required to identify a benefit or motive for the making of any false statements: *Kefala v GMC 2020 EWHC 2480*. Dr Kefala's conduct and explanations, over time, were not consistent; the High Court said that it was not possible readily to determine the doctor's motivation. However, the Tribunal should ensure that it gives adequate and clear reasons for its decisions. The reasons will be adequate if it is clear to a witness why their account was not believed.

35. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Hanrahan does not need to prove anything. The standard of proof is that applicable to civil proceedings, the balance of probabilities.

The Tribunal's Analysis of the Evidence and Findings of Fact

36. The Tribunal has considered each outstanding paragraph of the Allegation separately and has evaluated the evidence in order to make its findings of fact.

Paragraph 1bii

37. The Tribunal considered that, in order to find that Dr Hanrahan failed to take a particular step, the GMC must first establish that he was under a duty to do so. The GMC's case is that Dr Hanrahan was under a duty to notify the Coroner's Office, following the production of the final hospital post mortem report, of any concerns regarding the management of the fluids that Patient A had received.

38. The Tribunal took account of and gave weight to Dr F's evidence, where it pertained to his area of expertise, paediatric neurology, but not in relation to other issues, such as liaison with the Coroner's Office, as he said he had minimal experience of this in cross examination. Dr F's report said:

> 'On 14 April 2000, I cannot see any written evidence that Dr Hanrahan was aware of the fluid management [Patient A] had received at Erne Hospital. It is recorded in the Inquest minutes of 5 June 2013 that Dr Hanrahan had "a vague remembrance of some talk in the unit at the time" about [Patient A]'s fluid regime "perhaps not being appropriate", although he justified that he had discounted the importance of this because the serum sodium of 127 had not appeared to be low enough to indicate that fluid management had caused or contributed to the cerebral oedema. Dr D also stated according to the Inquiry report that there was agreement whilst [Patient A] was on PICU that [her] fluid therapy had not been appropriate.'
>
> 'At later dates, I think Dr Hanrahan had responsibility in raising concerns about the fluid management because he had supervised completing the death certificate, which was inadequate in its explanation of what happened to [Patient A]. The death certificate included a causal chain that death was caused by cerebral oedema which

had been caused by dehydration. The route from dehydration to cerebral oedema needs some reference to the management of the dehydration, i.e. fluid management, received at Erne Hospital, which Dr Hanrahan acknowledged had been a concern to other clinicians on PICU even if not to himself. I note Dr Hanrahan on 9 June 2000 discussed the case with parents including going over the events before her death and encouraging them to talk to XXX[Dr B] to "clarify events in the Erne", and also talked to XXX [Dr B].'

39. Dr Hanrahan gave evidence that there was no sense at the time that anyone thought Patient A's fluid regime was a factor in the catastrophic outcome. In his statement, he said: 'I did not think it was a factor as there had not, on my understanding, been a significant fall in the sodium level.' The Tribunal accepted Dr Hanrahan's evidence that his responsibilities (as a consultant paediatric neurologist) did not include fluid management, which would have been under the remit of the consultant intensivists. He had been asked to assess Patient A in relation to brain stem death. Although Dr F refers to Dr Hanrahan having some awareness of concerns about fluid management, no evidence has been adduced to show this related to Patient A specifically. The Tribunal accepted Dr Hanrahan's account that he was unaware – until a colleague's chance remark in 2004 – that the crucial serum sodium level of 127 mmol/litre had been taken after a bolus of saline was administered, so did not provide an accurate level for the serum sodium at the time of Patient A's seizure.

40. The Tribunal determined that, Dr Hanrahan was not under a duty, following the production of the final hospital post-mortem report, to notify the Coroner's Office of any concerns regarding the management of the fluids that Patient A had received. This was because he and his colleagues were oblivious, at this time, of the risks associated with use of Solution 18 (no longer in use) or the fact that Erne Hospital had administered two and half times the correct volume of fluid to Patient A, 100 mls/hour instead of 40 mls/hour. He had assumed, not unreasonably, that the level of 127 mmol/litre was the nadir (low point) because blood tests would usually be done at the time of a catastrophic event, such as a seizure, as opposed to waiting until corrective measures to raise sodium levels had taken effect, when test results would be of limited diagnostic relevance. In accepting his evidence, the Tribunal gave weight to Dr Hanrahan's good character, in assessing the likely veracity of his description of his state of mind in 2000. The Tribunal also took account of the absence of any apparent motive for him to conceal or misrepresent clinical information; he had not been involved, at any stage, in the clinical care preceding Patient A's death. Accordingly, it found paragraph 1bii of the Allegation not proved.

Paragraph 2a

41. Dr Hanrahan is alleged to have failed to ensure that Patient A's death certificate was issued appropriately on 4 May 2000, because the wording on the death certificate was based on the preliminary post-mortem result.

42. The Tribunal considered Dr F's evidence in relation to this allegation:

'This was inappropriate. The preliminary post-mortem was an anatomical summary. It indicated that there was oedema of the brain but provided no useful information to narrow down a chain of causes for the cerebral oedema. Thus there was no more information than there had been at the point of death on 14 April 2000.'

43. The Tribunal accepted Dr F's expertise as a Consultant Paediatric Neurologist but not in relation to other issues. In cross-examination by Mr Holl-Allen, Dr F acknowledged that, as a Consultant Paediatric Neurologist, he had little experience of reporting deaths to the Coroner's Office and he could not recall having any training on how best to report deaths to coroners or how to complete medical cause of death forms.

44. The GMC did not adduce evidence of any relevant guidance or standards provided to clinicians at the relevant time as to the correct stage for a death certificate to be completed, when the cause of death was unclear, or otherwise.

45. The Tribunal found that the GMC had not discharged the burden on it to establish, on the balance of probabilities, that a death certificate should not have been based on a preliminary post-mortem report, nor that Dr Hanrahan had failed to adequately oversee Dr B's completion of relevant sections. Dr Hanrahan has accepted that the death certificate was inaccurate and that it was illogical for it to indicate that Patient A's cerebral oedema was due to dehydration, as it does when both the handwritten and pre-printed words are read together. This is the key issue of concern, not the fact that it was based on a hospital anatomical summary. Had the preliminary post-mortem found that the cerebral oedema was due to dilutional hyponatraemia, there would have been no reason to question reliance on a preliminary post-mortem report in drafting the death certificate.

46. The Tribunal therefore found paragraph 2a not proved.

Paragraph 3bi

47. Dr Hanrahan told the Tribunal that, if he had stopped to think at the time, the wording in the death certificate indicating that cerebral oedema could be caused by dehydration would not have added up. He accepted that, even in 2000, he should have known that cerebral oedema would not have been caused by dehydration. Dr Hanrahan acknowledged that he failed adequately to consider the likely cause of cerebral oedema. However, he did not say that he knew cerebral oedema could not be caused by dehydration. Dr Hanrahan described his approach as ''thoughtless'' and the Tribunal found as fact that this was an accurate description of his state of mind at the relevant time.

48. Therefore, the GMC has not proved to the civil standard that it was more likely than not that Dr Hanrahan knew, when discussing the death certificate with colleagues in 2000,

that the presence of cerebral oedema was not due to dehydration. Accordingly, the Tribunal found paragraph 3bi of the Allegation not proved.

Paragraph 3bii

49. In relation to paragraph 3bii of the Allegation, Dr Hanrahan told the Tribunal that, in 2000, he genuinely believed the serum sodium level to have been measured around the time of Patient A's seizure at 03:00, the logical time for blood to be taken for the serum sodium level to be checked. His evidence was that it was only in 2004 that he discovered from a colleague that a bolus of saline had been given to Patient A before the blood tests which disclosed a serum sodium level of 127 mmol/litre. He had in 2004 what he described as a ''light bulb moment'' when he realised that the serum sodium level was likely to have been much lower than 127 mmol/litre when Patient A had her seizure at 03:00, before the administration of the saline bolus. However, in April and May 2000 he believed that the nadir had been 127 mmol/litre. In evidence he acknowledged that he had not scrutinised the nursing record from Erne Hospital closely enough to appreciate that saline had been given after the seizure, but before blood was taken for relevant tests. Dr Hanrahan's evidence was that a serum sodium level of 127 mmol/litre would be insufficient to cause anything but transient non-specific neurological sequelae; also, that any seizure caused by serum sodium of 127mmol/litre, even with a rapid drop from a higher level, would be transient and not cause permanent damage. Dr Hanrahan maintained in his evidence that a serum sodium level of 127 mmol/litre would not in itself cause any catastrophic outcome. This was not contested by the GMC.

50. The Tribunal determined that the GMC has not established on the balance of probabilities that Dr Hanrahan knew that the presence of cerebral oedema was due to hyponatraemia when the death certificate was completed. The Tribunal therefore found paragraph 3bii of the Allegation not proved.

Paragraph 4b

51. Dr Hanrahan's behaviour as described at paragraph 2b cannot plausibly be described as dishonest by reason of paragraph 3b as the Tribunal has found paragraph 3b, not proved. It follows, therefore, that paragraph 4b is also not proved.

52. The Tribunal took account of Dr Hanrahan's good character in relation to his (lack of) propensity to act as alleged, as well as the likely veracity of his account of events. In over two decades of clinical practice Dr Hanrahan has not had any adverse regulatory findings; his evidence was not inconsistent with such documents as were provided to the Tribunal. His explanation for permitting an inaccurate and illogical cause of death to appear on the death certificate as being due to thoughtlessness, as opposed to dishonesty, was plausible in the context of his lack of knowledge of the sequence of events at Erne Hospital. The Tribunal accepted that the logical point to test serum sodium level was at the time of an adverse clinical event, not after measures to raise serum sodium had taken effect. Dr Hanrahan's assumption that 127 mmol/litre represented the nadir was based

on an incorrect inference, but it was understandable in the context of clinicians relying on colleagues to test blood at the appropriate point. Permitting an inaccurate and illogical form of words to appear on the death certificate was found as fact to be thoughtless, but it was not a deliberate or dishonest attempt to mislead relevant authorities.

Conclusion

53. The Tribunal accepted Mr Grundy's submission that Patient A had an eminently treatable condition, gastroenteritis; also that the sudden, unexpected death required to be investigated. However, the Tribunal accepted Dr Hanrahan's evidence that he lacked sufficient information as to the sequence of events at Erne Hospital to be under a duty to flag up potential errors to the Coroner. As consultant paediatric neurologists are not responsible for fluid management, there was less of an onus on Dr Hanrahan to check the fluid chart, than his intensivist colleagues.

54. Dr Hanrahan gave evidence that he had encouraged Patient A's parents to put their concerns in writing, indicating that any false impression given by the death certificate was unlikely to have been a deliberate attempt to cover up mistakes made by clinicians in another hospital.

55. The Tribunal found as fact that Dr Hanrahan lacked awareness of risks associated with use of Solution 18 in 2000, as it was in standard use at the time. It was understandable for him to be unaware of an article in a specialist pathology journal in connection with a previous similar case in Belfast.

56. Dr Hanrahan has admitted that he was thoughtless in connection with completion of the death certificate. His evidence to the Tribunal is not inconsistent with that given to the Inquiry. The Tribunal accepts that Dr Hanrahan did not act dishonestly. In June 2000 Dr Hanrahan was not aware that dilutional hyponatraemia was relevant to the cause of Patient A's death. Any concerns about fluid management would only be relevant to the Coroner if they had causative significance, so there is no culpability attached to this omission. The Tribunal accepted Mr Holl-Allen's submission that Dr Hanrahan had no obvious motive to mislead, in connection with the facts and circumstances surrounding Patient A's death. The Tribunal found the outstanding paragraphs (contested) of the Allegation not proved.

The Tribunal's Overall Determination on the Facts

57. The Tribunal has determined the facts as follows:

    1. You failed to adequately notify the Belfast Coroner's Office ('the Coroner's Office') of the facts and circumstances relating to Patient A's death in that:

~~a. on telephoning the Coroner's Office on 14 April 2000 you did not report that the~~
Removed in accordance with Rule 17(6)

~~i. clinical diagnosis for Patient A included hyponatraemia~~;
Dismissed following Rule 17(2)g application

~~ii. cause of Patient A's death was unclear~~;
Dismissed following Rule 17(2)g application

b. ~~thereafter~~, following the production of the final hospital post mortem report, you did not notify the Coroner's Office:
Amended in accordance with Rule 17(6)

~~i. that the results of a preliminary hospital post mortem ('preliminary post-mortem') regarding Patient A were inconclusive as they did not establish a cause for the cerebral oedema;~~
Dismissed following Rule 17(2)g application

ii. of any concerns regarding the management of the fluids that Patient A had received. Not proved

~~2. Your actions described at paragraph 1 breach your duty under section 7 of the Coroner's Act (Northern Ireland) ('Act') 1959.~~ Deleted in accordance with Rule 17(6)

~~3~~ 2. You failed to adequately oversee the issuing of Patient A's death certificate by Dr B on 4 May 2000 as: Amended in accordance with Rule 17(6)

a. the death certificate was inappropriately issued on the basis of the preliminary post-mortem result; Not proved

b. you permitted the cause of Patient A's death to appear on the death certificate as cerebral oedema due to dehydration when this was:

i. inaccurate; Admitted and found proved

ii. illogical. Admitted and found proved

~~4~~ 3. When you: Amended in accordance with Rule 17(6)

~~a. established contact with the Coroner's Office as referred to at paragraph 1a, you knew that you should have informed them:~~

~~i. that Patient A's clinical diagnosis included hyponatraemia;~~

~~ii. that the cause of Patient A's death was unclear;~~

~~iii. of any concerns regarding the management of the fluids that Patient A had received;~~

Dismissed following Rule 17(2)g application

b. permitted an inaccurate description of the cause of death to appear on Patient A's death certificate as referred to at paragraph 2~~3~~b, you knew that the presence of cerebral oedema was:

i. not due to dehydration; Not proved

ii. due to hyponatraemia. Not proved

~~5~~ 4. Your behaviour as described at paragraph:

Amended in accordance with Rule 17(6)

~~a. paragraph 1a and 3b was dishonest by reason of paragraph 3a 4;~~

Dismissed following Rule 17(2)g application

b. 2b was dishonest by reason of paragraph 3b. Not proved

Determination on Impairment - 10/05/2021

1. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out above, Dr Hanrahan's current fitness to practise is impaired by reason of misconduct.

The Evidence

2. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received a further bundle of documents from Dr Hanrahan at this stage, including testimonials from colleagues and patients.

Submissions

3. Mr Grundy said that the GMC had no submissions in relation to misconduct or impairment.

4. Mr Holl-Allen submitted that Dr Hanrahan's fitness to practise is not impaired by reason of misconduct. The Tribunal has found all paragraphs of the Allegation not proved, except paragraph 2b of the Allegation, which was admitted at the outset of the hearing. This failing was admitted by Dr Hanrahan before the Inquiry in 2012.

5. Mr Holl-Allen submitted that Dr Hanrahan's failure in allowing the production of a death certificate in terms which were inaccurate and illogical does not amount to misconduct. Although it was a clear error, it cannot properly be regarded as deplorable or constituting serious professional misconduct.

6. Mr Holl-Allen submitted that, in any event, Dr Hanrahan's position is overwhelmingly strong on the issue of current impairment. His error, even if serious, was made 21 years ago in difficult and unusual circumstances, with no concerns raised in the two decades since.

7. Mr Holl-Allen took the Tribunal through the positive testimonials provided in support of Dr Hanrahan, alluding to his clinical skills and good character. Dr Hanrahan made an error in 2000, but it cannot reasonably be said that it casts such a serious shadow that Dr Hanrahan's fitness to practise is currently impaired. Accordingly, he invited the Tribunal to find that Dr Hanrahan's fitness to practise is not impaired.

The Relevant Legal Principles

8. The LQC gave advice on the approach to considering Impairment to be taken by the Tribunal. Counsel had no comments on it.

9. The Tribunal must follow a staged process in regulatory proceedings. It has made findings of fact, so must next consider misconduct, then impairment and finally, if current fitness to practise is found to be impaired, sanction: *Cheatle v GMC 2009 EWHC 645*. The fact that the second part of this stage is separate from the first indicates that not every case of misconduct results in a finding of impairment: *Cohen v GMC 2008 EWHC 581.*

10. The word misconduct in the Medical Act 1983 section 35C(2)(a) connotes a serious breach indicating that a doctor's fitness to practise was impaired. It is important to set the matters complained of in the context of a doctor's whole practice: *Calhaem v GMC 2007 EWHC 2606*. Misconduct was described as a wrongful or inadequate mode of performance of professional duty in *Mallon v GMC 2007 CSIH 17*.

11. In *Remedy UK v GMC 2010 EWHC 1245* the High Court said that misconduct is of two principal kinds. First, misconduct going to fitness to practise in the exercise of professional medical practice. Second, morally culpable or otherwise disgraceful conduct, outside or within professional practice. Conduct falls into the second category if it is dishonourable or attracts some kind of opprobrium – that fact may be sufficient to bring the profession of medicine into disrepute and it does not matter whether or not directly related to the exercise of professional skills. Action taken in good faith and for legitimate reasons, however inefficient or ill judged, is not capable of constituting misconduct within the meaning of section 35 merely because it *might d*amage the reputation of the profession.

12. Impaired is an ordinary word in common usage, not defined in the Medical Act. At the impairment stage, there is no burden or standard of proof. It is a question of judgment for the Tribunal. Impairment may be based on historical matters or a continuing state of affairs, but it is to be decided at the time of the hearing. To do this the Tribunal must look forward, taking account of any changes in practice, conduct or attitude since the matters found proved occurred.

13. Personal mitigation has less relevance, but an effort to accept and correct remediable errors should be taken into account. It is accepted that everyone sometimes makes a mistake. A one-off incident will need to be investigated and any harm put right but, unless very serious or with very serious consequences, it is unlikely in itself to indicate a fitness to practise concern.

14. In determining impairment the Tribunal must consider whether or not the facts found by the Tribunal indicate any risk of harm, breach of a fundamental tenet of the medical profession, or likelihood of bringing it into disrepute, or dishonesty in the past or future: *CHRE v Grant 2011 EWHC 927* citing *Fifth Shipman report*.

15. The need to maintain public confidence in the medical profession, or declare standards of behaviour, may mean that a doctor's fitness to practise is impaired by reason of certain acts of misconduct of themselves. This is because the public simply would not have confidence in him, or in the profession's standards, if the Tribunal regarded that sort of conduct as leaving fitness to practise unimpaired. Thus a finding of impairment may be necessary to reaffirm to the public and doctors the standard of conduct expected of them: *Yeong v GMC 2009 EWHC 1923.*

16. *Chaudhury 2017 EWHC 2561* reminds the Tribunal of the importance of the overarching objective, the tripartite public interest and the need for a proper balancing exercise of all three elements of the public interest test. The Tribunal will decide this case on its merits.

17. The Tribunal reminded itself that, at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgement alone. The Tribunal adopted a two stage process: first whether the facts found proved amounted to misconduct, and, if so, whether current fitness to practise is impaired by reason of misconduct.

18. The Tribunal must determine whether Dr Hanrahan's fitness to practise is impaired today, taking into account Dr Hanrahan's conduct at the time of the events and relevant factors since then such as any likelihood of repetition.

The Tribunal's Determination on Impairment

Misconduct

19. In determining whether Dr Hanrahan's fitness to practise is currently impaired by reason of misconduct, the Tribunal first considered whether the facts proved amounted to misconduct.

20. Taking account of all the evidence, the Tribunal did not consider that Dr Hanrahan's actions in relation to the completion of Patient A's death certificate constituted misconduct. Dr Hanrahan made an error which he has admitted, by permitting the cause of death to appear in terms which he later accepted were inaccurate and illogical. As he has acknowledged, he was thoughtless, but had no intention to mislead. His error did not constitute serious professional misconduct, nor can it properly be regarded as deplorable; it would not attract opprobrium or bring the medical profession into disrepute. His actions were taken in good faith, despite being ill judged. His error was not repeated in the subsequent 21 years of practice, nor anything similar alleged.

21. The Tribunal has concluded that Dr Hanrahan's error did not fall so far short of the standards expected of a doctor as to amount to misconduct. Taking account of all the circumstances, his error cannot be described as very serious.

22. The GMC adopted a neutral position in relation to impairment. Mr Grundy did not argue that patients are liable to be harmed by Dr Hanrahan in the future, nor that he is liable to breach a fundamental tenet of the medical profession or bring the profession into disrepute. The Tribunal has found that his behaviour was not dishonest. It is not necessary in this case to find Dr Hanrahan's current fitness to practise impaired in order to reaffirm to doctors, or other members of the public, the standard of conduct expected of registered medical practitioners. Had the Tribunal considered Dr Hanrahan's actions in 2000 amounted to misconduct, it would not have found his current fitness to practise impaired.

23. The Tribunal took account of the overarching objective in the Medical Act and considered that Dr Hanrahan does not pose a risk to the public . This case does not require a finding of impairment, in order to maintain public confidence in the medical profession or to declare and uphold proper professional standards or conduct for registered medical practitioners.

Confirmed
Date 10 May 2021 Ms Christina Moller, Chair

ANNEX A – 26/04/2021

Rule 17(6) application to amend the Allegation

1. At the outset of the hearing, Mr Grundy, Counsel for the GMC, made an application to amend the Allegation in accordance with Rule 17(6) of the GMC's (Fitness to Practise) Rules 2004.

2. Mr Grundy submitted that paragraph 2 of the Allegation, which refers to a breach of duty under section 7 of the Coroner's Act (Northern Ireland) 1959, should be deleted, as it potentially amounts to a criminal offence.

3. Mr Grundy provided the Tribunal with a revised draft of the Allegation with the proposed deletion of paragraph 2 and necessary consequential amendments.

4. Mr Holl-Allen, QC, on behalf of Dr Hanrahan, supported by Grundy's application.

Legal Advice and the Tribunal's Decision

5. The Tribunal had regard to Rule 17(6) of the Rules:

> *(6) Where, at any time, it appears to the Medical Practitioners Tribunal that—*
>
> > *(a) the allegation or the facts upon which it is based and of which the practitioner has been notified under rule 15, should be amended; and*
> >
> > *(b) the amendment can be made without injustice,*
>
> *it may, after hearing the parties, amend the allegation in appropriate terms.*

6. The Tribunal granted the GMC's application, because it was satisfied that the proposed amendment was appropriate and could be made without injustice to Dr Hanrahan or the GMC.

ANNEX B – 04/05/2021
Rule 17(2)(g) Application on behalf of Dr Hanrahan

Submissions on behalf of Dr Hanrahan

1. Following the close of the GMC's case, Mr Jonathan Holl-Allen, QC, on behalf of Dr Hanrahan made an application under Rule 17(2)(g) of the GMC's (Fitness to Practise) Rules 2004, as amended, ('the Rules') which states:

> *'17(2) The order of proceedings at the hearing before a Medical Practitioners Tribunal shall be as follows—*
>
> *...*
>
> *(g) the practitioner may make submissions as to whether sufficient evidence has been adduced to find some or all of the facts proved and whether the hearing should proceed no further as a result, and the Medical Practitioners Tribunal shall consider any such submissions and announce its decision as to whether they should be upheld;'*

2. Mr Holl-Allen's application related to paragraphs 1ai, 1aii, 1bi, 3a and 4a of the Allegation. He submitted that if the Tribunal upholds his application in relation to paragraph 1a of the Allegation, paragraphs 3a and 4a will fall away as they are contingent on paragraph 1a being found proved.

3. At the outset of his submissions, he reminded the Tribunal of the case *of R v Galbraith [1981] 1 WLR 1039 ('Galbraith').* He submitted that the Tribunal must determine whether or not the GMC has adduced sufficient evidence, in respect of the paragraphs of the Allegation identified above, that, if the evidence is taken at its highest, the Tribunal properly directed as to the law, would be able to find these matters proved on the balance of probabilities.

Paragraph 1bi

4. Mr Holl-Allen anticipated that the GMC would not resist the application in regard to paragraph 1bi of the Allegation. Dr F's expert opinion was that it was appropriate for Dr Hanrahan to wait for the final post-mortem report. Mr Holl-Allen submitted that there was no culpable failure in respect of paragraph 1bi.

Paragraph 1ai

5. Mr Holl-Allen submitted that paragraph 1ai of the Allegation could not properly be found proved as the GMC evidence could not establish a culpable failure by Dr Hanrahan.

6. Mr Holl-Allen submitted that, in order to prove a culpable failure under paragraph 1ai, the GMC would have to show that no reasonably competent consultant paediatric neurologist in the position of Dr Hanrahan on 14 April 2000, would have omitted to mention that Patient A was suffering from hyponatraemia before her death. Dr F's evidence was that, while he would have reported hyponatraemia to the Coroner's Office, there would have been a reasonable body of consultant paediatric neurologists who would not have done so. Mr Holl-Allen asked Dr F this question directly in cross-examination and Dr F was clear and unequivocal in his answer.

7. Mr Holl-Allen submitted that it was clear from Dr F's evidence that the distinction between a consultant paediatric neurologist and a consultant intensivist was particularly relevant in determining whether or not Dr Hanrahan should have reported hyponatraemia to the Coroner's Office on 14 April 2000. Dr F said that the consultant intensivists had responsibility for fluid management, and that a reasonable body of consultant paediatric neurologists in Dr Hanrahan's position would not have reported hyponatraemia to the Coroner's Office on 14 April 2000.

8. Mr Holl-Allen submitted that Dr F did not, at any point, give evidence that a serum sodium level of 127 mmol/litre or a fall from 137 to 127 were *per se* associated ordinarily with serious injury or death.

9. Mr Holl-Allen submitted that, taking account of all the evidence and the concession made by Dr F under cross-examination, paragraph 1ai of the Allegation must fall away, applying the principles in *Galbraith*.

Paragraph 1aii

10. In respect of paragraph 1aii of the Allegation, Mr Holl-Allen submitted that the GMC has not adduced sufficient evidence for the Tribunal to find that Dr Hanrahan did not report that the cause of Patient A's death was unclear on 14 April 2000.

11. On 14 April 2000, Dr Hanrahan spoke to Mrs C, an administrative officer at the Coroner's Office. Mr Holl-Allen submitted that the evidence made it clear that Dr E, a pathologist in the State Pathologist's Office was also involved in the case on that day, but whether or not Dr Hanrahan spoke directly to Dr E is unclear.

12. Mr Holl-Allen referred to various documents in the evidence bundle, including Mrs C's short note of Dr Hanrahan's call on 14 April 2000; there was no record of the content of any conversation which Dr Hanrahan may have had with Dr E. Mr Holl-Allen also alluded to the contemporaneous clinical records; Dr Hanrahan initially reviewed Patient A at 10:30 and listed differential diagnoses, with a question mark by each one.

GMC submissions

13. Mr Grundy endorsed Mr Holl-Allen's precis of the relevant principles in *Galbraith*. He also accepted that proof of paragraphs 3a and 4a would be contingent on paragraph 1a being found proved.

Paragraph 1bi

14. Mr Grundy conceded that the Tribunal should not proceed to consider paragraph 1bi of the Allegation, because Dr F considered it appropriate for Dr Hanrahan to wait for the final post-mortem report, as opposed to informing the Coroner's Office of the preliminary post-mortem results.

Paragraph 1ai

15. Mr Grundy submitted that, taking the GMC's evidence at its highest, a properly directed Tribunal would be able to find paragraph 1ai proved on the balance of probabilities.

16. He submitted that the Tribunal should assume that Dr Hanrahan did not report to the Coroner's Office on 14 April 2000 that the clinical diagnosis included hyponatraemia; also that this was a culpable failure, because, in the circumstances, it was his duty to do so.

17. Dr F's evidence was that Dr Hanrahan could have used alternative non-medical wording, such as 'low sodium' in his call to Mrs C. Mr Grundy submitted that it was important to highlight the low sodium reading which had fallen over a relatively short period of time from 137 to 127. This should trigger further inquiry into the cause of death, including questions about the administration of fluid to Patient A; she had gone from being dehydrated to developing hyponatraemia and her death was unusual, as well as unexpected. Mentioning low sodium would have drawn this to the attention of the Coroner, who should then have investigated by way of an inquest.

18. Mr Grundy reminded the Tribunal that Dr F expressed surprise that Dr Hanrahan had reported the death, as opposed to the intensivists involved. Mr Grundy submitted that, for whatever reason, Dr Hanrahan took it upon himself to be the lead and reported the matter to the Coroner instead. In so doing, Dr Hanrahan was under a duty to give the full facts and circumstances of the death. In support of his submission, Mr Grundy invited the Tribunal to consider the following comments made by Dr F in his report:

> *'…Dr Hanrahan ought to have mentioned or raised the issue of hyponatraemia (as well as the context of other physiological treatment and investigations) to the Coroner's office on 14 April 2000. This was a case of death in hospital without a known cause in a child who had been alive and awake at the point of admission less than 48 hours earlier. The hyponatraemia was mentioned in terms of actual serum sodium values in the hospital autopsy request form completed by the registrar [Dr*

D] on 14 April 2000 for the hospital pathologist, and indeed included some detail about the specific fluid types that were administered at Erne Hospital, which would have entailed an examination by [Dr D] of available Erne Hospital records already available to RBHSC clinicians on 14 April 2000.

…On 14 April 2000, Dr Hanrahan should have reported the clinical diagnosis for [Patient A] included hyponatraemia when discussing with the Coroner's office. Without this piece of information (and other details contained in the Erne Hospital records and partly cited on the hospital post-mortem request form), it was not possible to have a valid and useful discussion with the Coroner's office if [Patient A] should have a coroner's post-mortem or not…

Since Dr Hanrahan had de facto accepted the role of discussion with the Coroner, rather than deferred to the PICU intensivist…, it was important that Dr Hanrahan informed the Coroner's office of the details of [Patient A]'s care up to the date of her death. He should not have dismissed or diminished isolated facts such as the hyponatraemia..'

19. Mr Grundy submitted that on the evidence, it is open to the Tribunal to find on the balance of probabilities, that there had been a culpable failure by Dr Hanrahan in omitting to report the clinical diagnosis of hyponatraemia.

Paragraph 1aii

20. Mr Grundy submitted that the Tribunal could expect that if Dr Hanrahan had made it clear to the Coroner's Office and/or Dr E that the cause of death was unclear, this would have been included in Mrs C's telephone note. He argued that, however Dr Hanrahan had expressed it to the Coroner's Office, the salient points would have been recorded in Mrs C's note. He submitted that the Tribunal was entitled to infer that, if Dr Hanrahan had told the Coroner's Office that the cause of death was unclear, this would have precipitated a Coroner's Inquest.

Legal Advice and the Tribunal's Approach

21. The Legally Qualified Chair (LQC) advised the Tribunal that, following *Galbraith,* in cases in which there is some evidence to support an allegation, the question is whether or not the GMC evidence is such that a properly directed Tribunal would be able to find it proved on a balance of probabilities. Where the evidence taken at its highest is such that a Tribunal cannot properly conclude that a relevant paragraph is made out, the Tribunal is obliged not to proceed in relation to that part of the Allegation. But if the Tribunal is satisfied, following submissions, that on one possible view of the facts, the Tribunal could properly conclude that an allegation is well founded then it must proceed to consider it. Counsel had no comment on this advice from the LQC.

22. The Tribunal reminded itself that, at this stage, its purpose is not to make findings of fact but to determine whether sufficient evidence (taken at its highest) has been adduced by the GMC such that a Tribunal, properly directed as to relevant law, could find the relevant paragraphs proved to the civil standard. The Tribunal considered submissions from both counsel as well as evidence presented thus far, both oral and documentary.

The Tribunal's decision

Paragraph 1bi

23. The Tribunal accepted submissions from counsel that paragraph 1bi should not proceed. Dr F said that it would have been appropriate for Dr Hanrahan to wait until the final post-mortem report, rather than reporting the preliminary post-mortem findings to the Coroner on 14 April 2000. On that the basis, there was no culpable failure. Therefore, there was insufficient evidence on which paragraph 1bi could be found proved on the balance of probabilities. Mr Holl-Allen's application in relation to paragraph 1bi was granted.

Paragraph 1ai

24. The stem of paragraph 1a alleges a failure by Dr Hanrahan to notify the Coroner's Office of certain facts specifically in a telephone call on 14 April 2000. However, in order to establish a culpable failure, the GMC must show that there was a duty on Dr Hanrahan to report to the Coroner's Office on 14 April 2000 that Patient A's clinical diagnosis included hyponatraemia.

25. In cross-examination, Dr F gave evidence that there would have been a reasonable body of consultant paediatric neurologists in April 2000 who would not have reported that the clinical diagnosis included hyponatraemia to the Coroner's Office. The Tribunal considered the context: Dr F's evidence was that any need to report hyponatraemia would have been more apparent to the intensivists than to Dr Hanrahan, a consultant paediatric neurologist. In April 2000 he may not have been as alert to the implications and consequences of hyponatraemia.

26. Dr F was asked to accept that, whilst some consultant paediatric neurologists would have mentioned hyponatraemia, a reasonable body would not have done so. His response to Mr Holl-Allen was, 'Yes, I would accept that'. The Tribunal considered that the GMC evidence, taken at its highest, on paragraph 1ai is such that a properly directed Tribunal could not find it proved on the balance of probabilities. Accordingly, the Tribunal granted Mr Holl-Allen's application in respect of paragraph 1ai of the Allegation.

Paragraph 1aii

27. The Tribunal considered that Dr Hanrahan had an obligation to report to the Coroner's Office the facts and circumstances of Patient A's death, but not necessarily in a telephone call to an administrative officer on 14 April 2000.

28. No evidence was adduced by the GMC to indicate that Dr Hanrahan had not given information to Dr E directly or to the Coroner's Office (other than to the administrative officer) indicating that the cause of death was unknown. The Tribunal accepted Mr Holl-Allen's submission that there was evidence to support his contention that Dr E had information, which could have come from Dr Hanrahan directly or indirectly.

29. The Tribunal took account of the following exchange between Mrs C and the Chairman of the Inquiry in regard to her note on 14 April 2000, specifically the written line 'Spoken to Dr E':

> *'THE CHAIRMAN: Can I just check with you, when it says ''Spoken to [Dr E]'', does that mean that you have spoke to [Dr E] or that Dr Hanrahan has spoken to [Dr E], or can't you remember?*
> *A. I can't recall'*

30. Elsewhere, the Tribunal noted that Dr Hanrahan had communicated to his registrar, Dr D, that Patient A's death was unclear. The Tribunal noted Dr D's note which recorded:

> *'Coroner ([Dr E] on behalf of Coroners) contacted by Dr Hanrahan – case discussed, Coroners PM [Post mortem] is <u>not</u> required, but hospital PM would be useful to establish cause of death + rule out other [Diagnosis]'*

This suggests that Dr E was, to some extent, aware of the facts and circumstances of the death.

31. Elsewhere, Dr Hanrahan had recorded in Patient A's clinical records:

> *'If she succumbs, a PM would be desirable – coroner will have to be informed..'*

This note does not indicate a lack of openness on Dr Hanrahan's part.

32. Mrs C's note was short and she told the Inquiry that she could not recall anything more about what Dr Hanrahan told her about the circumstances of Patient A's death. Mrs C did not tell the Inquiry that her note was a verbatim record of the conversation or that it was comprehensive.

33. The Tribunal considered that Mrs C's short note on 14 April 2000 is insufficient evidence from which to infer that Dr Hanrahan failed to report that the cause of Patient A's death was unclear. Mrs C may or may not have identified and recorded salient points made by

Dr Hanrahan on the telephone, such as the lack of clarity about how Patient A died. The Tribunal found that the GMC evidence taken at its highest, is such that the Tribunal could not find paragraph 1aii proved on the balance of probabilities. The GMC has not adduced sufficient evidence to show factually that Dr Hanrahan failed to report that the cause of death was unclear.

34. Accordingly, the Tribunal granted Mr Holl-Allen's application in respect to paragraph 1aii of the Allegation.

Paragraphs 3a and 4a

35. Having granted Mr Holl-Allen's application in respect of paragraph 1 of the Allegation, the Tribunal also accepted that paragraphs 3a and 4a also fall as they are contingent on paragraph 1a.

Conclusion

36. The Tribunal granted Mr Holl-Allen's application in its entirety.