INQUIRY INTO HYPONATRAEMIA RELATED DEATHS

CLAIRE ROBERTS

SUBMISSIONS FILED BY THE BELFAST HEALTH AND SOCIAL CARE TRUST

1. The Trust does not consider it appropriate for it to make any submissions in relation to the clinical management of Claire Roberts at the Royal Belfast Hospital for Sick Children with one important exception. The Inquiry invested some considerable time and effort looking into the issue of whether clinicians involved in the management of Claire Roberts inappropriately altered the medical records relating to Claire Roberts. The Trust would simply submit that following this rigorous investigation, the only reasonable conclusion that can be reached is that there were no inappropriate alterations to the medical records relating to Claire Roberts.

2. In relation to governance issues, the Trust wishes to make the following submissions in relation to the issues specifically raised in the numbered paragraphs of the written Governance Opening prepared by Ms Anyadike-Danes.

3. Paragraph 20. In his 1992 paper 'Hyponatraemia and death or permanent brain damage in healthy children', Arieff presents evidence that fatal cerebral oedema due to dilutional hyponatraemia can occur in healthy children, following the administration of large volumes of hypotonic fluid (i.e. at rates faster than maintenance rates), to replace a fluid deficit. Arieff in the absence of making any reference to SIADH in this paper limits the message and subsequent learning points which can be taken from the paper. It is not agreed that there were clear lessons to be learned from the Arieff paper concerning SIADH. SIADH played a role in Claire's condition. If the opposite view is to be held, then it would have been reasonable to expect that the wider significance of SIADH would have come out at Adam Strain's inquest."

4. Paragraph 30. Commentary is made that there was no investigation into Claire's death when concerns were raised. This is not correct. When

concerns were raised following the UTV documentary, a timely case note review occurred which identified that hyponatraemia may have been a contributory factor to Claire's death. The fact that hyponatraemia may have contributed to Claire's death was communicated to Mr and Mrs Roberts. The matter was referred to the Coroner by the Trust at the specific direction of Dr McBride, the then Medical Director, for further investigation and determination of the cause of death. Dr McBride addressed these issues in his witness statement 269/1 and in particular in the first paragraph in his response to question 18 page 9 and also at question 23, page 12 and question 27, page 13.

5. Paragraph 44. The criticism that the on-call rota did not name the on-call consultant may be viewed as unfair because it is likely that there were two rotas. The Consultant rota would probably have been made out for 6 months or a year ahead, while the Junior doctor rota was probably made out monthly due to the changing staff and leave arrangements. A Consultant rota probably did exist in 1996.

6. Paragraph 73: Professor Young did not at any stage carry out a review of the communication with Claire's family. He formed some views about communication during the process of the review he carried out in relation to the role of hyponatraemia. However, he definitely did not carry out a review of the communication. He has been consistently clear about the limited scope of his review. If he had been tasked with reviewing communication he would have approached matters very differently.

7. Paragraph 161 (iv), and (vi). It is accepted that clinicians failed to notice the prescription errors in 1996, 2004 and 2006 but they were not the only ones not to notice these errors. Various medical experts during the Inquest and Police investigations similarly failed to notice these errors. (Dr Bingham, (14.04.05), Dr Maconachie (July 2005), Dr Evans (01.03.08), and Dr Gupta (09.09.08).

8. Paragraph 167. It has not been established that there were any missing Radiologist reports in the Claire Roberts case. The reports 090-033-114 &115

are in the notes and the hand-written report by Dr Kennedy is in the notes (090-022-058).

9. Paragraph 317. In relation to Dr Squier's suggestion that a specialist opinion should have been sought from a Consultant Chemical Pathologist. This is an alternative name for a medically qualified Consultant in Clinical Biochemistry. Therefore Professor Young as a Consultant Chemical Pathologist fulfilled the criteria for the expert input recommended by Dr Squier.

10. Paragraphs 326 and 328. In relation to the absence of a signed autopsy report. It could well be the case that the report in the notes is the original. It is on the special heavy duty paper used by the Pathology Department and is probably not a copy. There also are staple holes in the top left hand corners. This supports Dr Herron's view that a covering letter may have been sent with it and may account for the lack of the usual signature.

11. Paragraph 369. There was only one primary diagnosis inputted per patient episode. Claire's admission to Allen ward was one patient episode and her admission to PICU was a second. In this circumstance therefore it was correct for there to be two primary diagnoses inputted. This also explains why there is some duplication of the secondary diagnoses as they relate to the two episodes.

12. Paragraph 380. Although a formal complaint was not made by Mr and Mrs Roberts using the Trust complaints process either in 2004 or after the Inquest, it is now recognised that complaints can come in many forms and an expression of dissatisfaction however received requiring a response will activate the Trust's complaints procedures.

13. Paragraph 382. Dr McBride's recollection is that there was a face to face conversation with or a meeting attended by Professor Young to discuss his opinion.

14. Paragraphs 384 and 385. As Trust Medical Director Dr McBride led the introduction of RCA and a range of patient safety initiatives to the Trust in advance of this being deployed by the DHSSPS. See witness statement

269/1 at question 30 from page 18 onwards. In October 2004, while the programme of RCA training was established within the Trust it is accepted that the number of individuals trained and able to lead such RCAs was limited.

15. Paragraph 385. Dr McBride as Medical Director initiated the case note review into the circumstances of Claire's death and subsequently initiated the Coroner's investigation into Claire's death by directing that her death be referred to the Coroner for further investigation. Once concerns had been raised by Claire's parents following the UTV documentary, Dr McBride directed a case note review be conducted with independent expert input from Professor Ian Young. This is evidenced in an email from Dr McBride to Dr Heather Steen dated the 2nd November 2004 contained in the Litigation Office Coroner's file. In this Dr McBride proposes that "Peter Crean as the Clinical Governance lead, Prof Ian Young, Elaine (Hicks) and Brenda Creaney carry out a case note review to determine whether this case needs to be referred to the Coroner." Although the membership of the review team did not mirror the membership suggested in Dr McBride's e mail, the review team and in particular Professor Young did identify that hyponatraemia may have been a contributory factor to Claire's death. The matter was then referred to the Coroner by the Trust at Dr McBride's direction for further investigation and determination of the cause of death. By referring the matter to the Coroner, the Trust was at this stage actively promoting an investigation which could well have provided an additional forum for discussion and learning and could have served as a driver for dissemination.

16. Paragraphs 386, 387 and 388. Following the Coroner's Inquest there was a PSNI investigation into Claire's death. The Coroner had already drawn Claire's death to the attention of the Public Inquiry in his letter of the 18th April 2005. The Trust had been informed of Mr and Mrs Roberts plan to meet with Mr John O'Hara and their desire to have Claire's death included in the Public Inquiry. There would have been considerable difficulties in conducting a RCA with the potential to compromise ongoing statutory investigations. Indeed such an investigation by the Trust may have had the converse effect to that

described in paragraph 385 and rather than assisting the Inquiry may have compromised its investigations. It is also highly likely that the advice to health professionals by both medical defence organisations and legal advisors would have been not to assist in such an investigation as it may compromise their evidence in any future statutory investigations. In addition, there would have been considerable practical difficulties in performing a Root Cause Analysis at that time given the time that had elapsed from Claire's death and the ongoing PSNI investigations and the Public Inquiry.

17. Paragraph 390. It is acknowledged that given the definitions within the 2004 circular it would have appropriate to complete an SAI report in December 2004 when Claire's death was referred to the Coroner. However, the Trust did carry out a case note review and shared the findings openly with Mr and Mrs Roberts and referred Claire's death to the Coroner. In any event, the Coroner informed the Department of Claire's death once it had been referred to him. But it is acknowledged that this did not fulfil the requirements of the 2004 circular in respect of the Trust's responsibility.

18. Further, in the 2005 National Audit Office report "Safer Place for Patients: Learning to improve patient safety" noted that although "local reporting has improved, there have been delays in establishing an effective national system" and that underreporting remained a significant problem. These difficulties were also highlighted in the criticisms of the Health Select Committee in England, House of Commons Committee of Public Accounts "A safer place for patients: learning to improve patient safety". Fifty-first Report of Session 2005–06.

19. At the relevant time, these reporting requirements had just been outlined. Robust arrangements had not yet been firmly established and continued to evolve over the next number of months and years and indeed continue to do so. By way of context Circular HSS (PPM) 06/04 was issued 3 months earlier in July 2004. This is described as "introducing new interim reporting procedures for serious adverse incidents (SAIs)..." Paragraph 1 of the Circular HSS (PPM) 02/06 20th March refers. It is a matter of fact that these arrangements were not fully or comprehensively established within the HSC

by October 2004. Furthermore there was concern in the HSC at that time that the 2004 guidance was both poorly drafted and risked confusing an SAI reporting system to ensure regional learning with early alerts to the Department of matters likely to cause public concern or to be picked up by the media.

20. In the 2004 circular, the Department highlights correctly the situation as it pertained at that time. Paragraph 7 of the 2004 circular refers to "...a lack of uniformity in incident reporting and management in the HPSS. This also applies to the definition of what constitutes a serious adverse incident" This necessitated the revised circular on Reporting and Follow-up on Serious Adverse Incidents, Circular HSS(PPM) 02/2006, March 2006 and the Departmental guidance; "How to Classify Adverse Incidents and Risk, Guidance for Senior Managers Responsible for Adverse Incident Reporting and Management", April 2006. The developmental nature of these arrangements is also reflected in Circular HSS (PPM) 05/05 which is referenced at paragraph 390 of the Governance Opening.

21. Paragraph 390. It is worth considering the 2005 circular in full. Paragraph 2 states *"...there was a need for the Department to take a broader, more strategic approach to patient safety within the HPSS and to provide greater strategic direction on the recording, reporting and investigation of all adverse incidents and near misses."* This same circular also references the key findings of a report commissioned by the DHSSPS which was carried out by Deloitte and recognises the need for further work.

22. Paragraph 5 of Circular HSS(PPM) 05/05 states *"... the Deloitte report acknowledged that, within HPSS organisations, there is a consistent drive to improve the reporting and management of adverse incidents, based on a common belief and understanding of the benefits it can bring to patient and client safety and care. However, the report also noted inconsistencies in approach, including incident reporting systems, monitoring, collation, analysis and follow-up."* Paragraph 6 of the Circular highlights the report's key recommendations including the need for:

- *a consistent approach to the definition and coding of adverse incidents and near misses;*
- *more Departmental guidance on risk assessment, reporting structures and links to other organisations;*
- *the development of improved reporting systems to support the analysis and audit of incidents and the development of mechanisms to improve learning and knowledge;*
- *links between local reporting arrangements and national, statutory, and confidential reporting mechanisms;*
- *the development of guidance on local investigations and reviews; and*
- *improved training and development of staff in the use of risk assessment tools, such as root cause analysis.*

23. This Circular correctly reflects that systems at this time were still developing and evolving. Furthermore, the 2005 Circular goes on to acknowledge the need for further work, the broad details of which are referenced at paragraph 7. These included:

- *work to standardise definitions and coding;*
- *the development of formal links with the National Patient Safety Agency; and*
- *the development of a safety framework for the HPSS.*

24. In respect of reporting incidents to the Department paragraphs 9 and 10 clearly demonstrate the ongoing developmental nature of these arrangements within the Department. With reference to Circular HSS (PPM) 06/04, it states that in this circular it had *"indicated that the Department, in collating information on serious adverse incidents and near misses, would feed back relevant analysis to the HPSS. In line with this undertaking, a small group has been established in the Department, which reviews all incidents that are notified. It is planned that regular feedback will be issued to the HPSS, including an annual report."* Furthermore at paragraph 10 *"As the first step in this process, a briefing session has been arranged for safety managers on 15*

June, when the Department will be providing feedback on the operation of the reporting and management arrangements established by Circular PPM 06/04."

25. It should be noted that the picture across the UK as reflected in the National Audit Office report was no different at this time and arrangements were not fully established and were still evolving. Cultural change at a system level takes time. This is reflected in the picture nationally and locally. These arrangement and supporting processes continued to evolve and develop with further circulars and guidance being issued by the DHSSPS. This is reflected in the number of alterations of the SAI arrangements outlined by the Department from 2004 onwards. Specific guidance on "How to Classify Adverse Incidents and Risk" was not issued by the DHSSPS until April 2006. There remains no definitive guidance on the determinants and procure of external reviews.

26. Paragraph 393. In relation to the referral to the Coroner and the reference to Professor Young's statement that Dr McBride wished to be aware of the wishes of Mr and Mrs Roberts in this matter before making a final decision on referring Claire's death to the Coroner, Dr McBride has addressed this issue in 269/1 page 7, question 13 (e). At the time he recognised that the Trust had a statutory obligation to refer the death to the Coroner. He was cognisant from previous experience that the Coroner John Leckey would wish to know the wishes of the family. He also wished to be sensitive to the circumstances in recognising the families concern and distress in advising them of the Trust's statutory requirement to refer Claire's death to the Coroner. He was absolutely not however seeking Mr and Mrs Roberts consent to refer the death to the Coroner, nor was he awaiting their views before making a final decision. He was not making the referral to the Coroner without their being aware of this. The Trust's and Dr McBride's responsibilities were clear and he has outlined them in his response on pages 7 and 8 in response to question 13 (f).

27. Paragraph 395 further erroneously suggests that this decision was being left to Mr and Mrs Roberts. This is further implied by the reference at paragraph 407. This is a misrepresentation and is inaccurate. This is inconsistent with the minute of the meeting of the 7th December which on page 3, 5th paragraph clearly indicates *"...the Trust...will have to approach the Coroner for advice on the best course of action. The Coroner may suggest an Inquest which would be open to public scrutiny, or may suggest referring the case to the ongoing enquiry led by John O'Hara. Alternatively the Coroner may feel that no additional action is needed in this case. The Coroner may well be swayed by the wishes of the parents."* The minute at page 4, 1st paragraph indicates that the Trust would simply delay contacting the Coroner until Mr and Mrs Roberts had considered the matter. The use of the phrase *"...would not contact the Coroner until..."* clearly indicates that the Coroner would be informed by the Trust. At this meeting the Trust also offered *to "...approach John O'Hara QC..."* on behalf of Mr and Mrs Roberts. Subsequently Mr and Mrs Roberts made contact with the Inquiry themselves.

28. Paragraph 396 to 399. It is clear that Dr McBride suggested to Dr Steen that a number of individuals should take part in the case note review. This is evidenced in an email from Dr McBride to Dr Heather Steen dated the 2nd November 2004 contained in the Litigation Office Coroner's file. The criticisms relating to the apparent lack of expertise of Professor Young are without any shred of foundation. Professor Young was external to RBHSC and independent from any previous involvement in Claire's case. It was he who brought the issue of hyponatraemia to the attention of Mr and Mrs Roberts and to the Medical Director.

29. In his report at paragraph 61, page 15 and paragraph 351 page 74, Dr MacFaul raises questions about the competence of Professor Young in providing an external expert opinion on the contribution of hyponatraemia and the prescription of iv fluids to Claire's death. Dr McBride has addressed the specific point of his engagement of Professor Young in his witness statement 269/1 in response to question 4 (a). In reaching his decision to approach Professor Young, he considered a numbers of factors. Given the concerns

raised by Mr and Mrs Roberts that hyponatraemia may have been a factor in Claire's death, he required an individual with expert clinical and academic knowledge in clinical biochemistry and in particular an individual with expert knowledge of intravenous fluid management. He regarded it as essential that the individual was independent from any previous involvement in the case and whose professional standing was recognised. As Professor of Medicine at Queens's and Consultant in Clinical Biochemistry in the Royal Hospitals, Professor Young was in Dr McBride's view eminently qualified to provide an expert opinion.

30. Dr MacFaul failed to understand that the primary objective of the case note review was to establish whether or not hyponatraemia had contributed to Claire's death and if so established to refer Claire's death to the Coroner for further investigation as described in section 7 of the Coroners Act (Northern Ireland) 1959. This is evident from his comments in paragraph 61 and again at paragraphs 351, 352 and 372 and 373 of his expert report.

31. Dr McBride's primary purpose of seeking Professors Young's opinion and his involvement in the case note review was to ascertain whether hyponatraemia and the iv fluids prescribed in 1996 had possibly contributed to Claire's death and if so to inform Mr and Mrs Roberts and in such circumstances to cause a report of Claire's death to be made to the Coroner for further investigation.

32. It is a matter of fact that Professor Young correctly identified the potential contribution of hyponatraemia and iv fluid management to Claire's death and on the basis of his conclusions, at Dr McBride's direction, Claire's death was referred to the Coroner by Mr Walby for further independent investigation and determination of the cause of death.

33. It is the Trust's firm submission that Professor Young, Professor of Medicine at Queens's University Belfast and Consultant in Clinical Biochemistry in the Royal Hospitals had the necessary and appropriate expertise and was an appropriate person to provide an expert opinion on the role of hyponatraemia in Claire's death.

34. Dr Rooney's sole role was to liaise with and support the family given her professional training and experience. Dr Rooney was not in a position to advise on clinical matters and would have not have materially contributed to the clinical detail nor its interpretation as reflected in the minute of the meeting. It therefore follows that she would not have been in a position to determine the accuracy of the minute in such matters. That was a matter for those medically qualified who were present at the meeting.

35. Paragraph 400. Whilst there is criticism of and reference to the clinicians' failures to notice the prescription errors in 1996, 2004 and 2006 there is a failure to include any reference to the omissions of the expert witnesses to notice the same prescription errors as part of the Coroner's Investigation or subsequent PSNI investigation. Further, the primary focus of the case note review was concerns about the role of hyponatraemia in the death of Claire Roberts.

36. Paragraph 404. Dr Rooney was not in a position to advise on clinical matters and would have not have materially contributed to the clinical detail or its interpretation as reflected in the minute of the meeting or in any communication with Mr and Mrs Roberts further to their letter of the 8th of December. It therefore follows that she would not have been in a position to determine the accuracy any minute or the content of any response to questions of a clinical nature. That was a matter for those medically qualified who were present at the meeting and who were professionally qualified to comment.

37. Paragraph 405: The Trust submits that this is an incorrect summing up of the Royal's position by the Chairman. The Trust submits that the intervention of Mr McAlinden QC recorded in the transcript for 14th November, 2012 at page 6 line 25 to page 7 line 17 correctly states the Royal's position.

38. Paragraph 409. The admitting Registrar's diagnosis of "possibly encephalitis" refers to the A/E entry at 090-012-014 of "encephalitis?" Mr Walby was aware that the Registrar's ward note at 090-022-052 gave the differential diagnosis as 1. Viral illness and 2. Encephalitis (crossed out) and it was for this reason

that he referred in his letter to the Coroner of 16th December 2004 to a "provisional diagnosis of a viral illness".

39. Paragraph 413 (i). Mr Walby has explained in his evidence that he initially invited the witnesses to obtain their own legal advice and their statements were then submitted to the Coroner without being seen by Trust legal advisors. Following the letter from the Coroner dated 03.10.05 he sent the draft response of Dr Sands to the Trust solicitor before submission to the Coroner. It was and remains appropriate for legal advisors (either witnesses own, or Trust) to approve witness statements prior to submission to the Coroner.

40. Paragraph 413 (ii). In relation to this matter, the Trust is anxious that the Chairman pay due regard to the evidence given by Mr Walby and to the contents of his statement dated 28th November, 2013. It was appropriate for Mr Walby to suggest corrections and make redrafting suggestions to witnesses for the purposes of ensuring clarity, good grammar, proper punctuation and spelling and in order to ensure that relevant information was provided. For a considerable number of witnesses they may only be required to make a Coroner's witness statement once in their career and such assistance would be important. Further, Inquest statements from involved clinicians and nurses are primarily factual accounts of their involvement in the management of the patient. This is supported by paragraphs 4.35 and 4.36 of the paper prepared by Dr Bridget Dolan 308-013-236.

41. Paragraph 413 (iii). It is correct to say that Mr Walby encouraged clinicians to obtain advice from their medical defence organisations when preparing statements for Inquests. How and why the exercise of this fundamental right should be the subject of implied criticism is a matter of concern to the Trust. Further, the Guide to Membership from the Medical Protection Society (dated August 2004) advised members they can apply for help in relation to Inquests among other things.

42. Paragraphs 412 and 413. The following sets out the relevant chronology in relation to this matter:

(a) 30.01.04 HM Coroner, Mr Leckey writes to Belfast Medical Directors with 3 enclosures regarding a change in the investigation of deaths reported to the Coroner.

(b) 09.02.04 Mr Leckey faxes to Dr M. McBride a copy of a letter dated 22.09.03 Mr Leckey had sent to the Chief Constable regarding police concern as to how deaths in hospital are investigated.

(c) 10.02.04 Dr McBride emails Dr Carson and copies to CMO (Dr Henrietta Campbell) seeking clarification from the Department on the matter and cites a number of issues that immediately arise.

(d) 10.02.04 Dr Carson emails a reply confirming a meeting with Mr Leckey and the PSNI for 5th March 2004 and expands on its purpose touching on the draft Memorandum of Understanding (MoU) in England (between the Health Service and the police).

(e) 17.02.04 Mr Leckey writes to Mr Walby thanking him for a minor modification to the Junior Doctor Induction programme Mr Walby had made at Mr Leckey's request. He incidentally notes that Dr Carson was organising a round table meeting for 5th March 2004 to deal with issues of reporting Hospital Deaths and the investigation of Hospital Deaths. (Mr Walby was not otherwise made aware of or involved in the meeting.)

(f) 24.02.04 Mr Walby wrote to Mr Brangam enclosing the letter from HM Coroner to Medical Directors with the 3 enclosures. 129-006-001.

(g) 09.03.04 Mr Brangam makes a preliminary reply to Mr Walby's letter of 24.02.04.

(h) 14.03.05 Mr Gary Daly makes a substantive reply apologising for the delay because of an administrative problem in their office and enquired whether further correspondence had been received from the Coroner.

(i) 21.03.05 Mr Walby wrote to Mr Daly explaining the matter is in abeyance because he believed the Coroner was awaiting imminent revision of the Coroner's service. 129-003-001.

(j) 23.03.05 Mr Daly replies that he will diarise the matter for 6 months.

(k) 06.10.05 Dr Carson (Deputy CMO) issues a draft MoU (NI) among the Health and Personal Social Services, PSNI, Coroners Service, and the Health & Safety Executive and invites comments.

(l) 02.11.05 Dr McBride emails a reminder to Mr Walby about a request to comment on the MoU on 07.10.05.

(m)03.11.05 Mr Walby e mailed a reply to Dr McBride that took no issue with the draft MoU (which was why he had not replied earlier), but he pointed out that this MoU was hardly relevant to the hospital as it did not cover how the police manage things when the Coroner becomes involved in a straightforward hospital death (as the English MoU was going to do).

(n) 04.11.05 Dr McBride writes to Dr Carson with his comments and adds a paragraph reiterating the concern he had.

(o) 20.02.06 Dr Carson issues the MoU.

(p) 27.02.06 Mr Walby received the MoU and made a file note that changes suggested by Dr McBride (including Mr Walby's) had not been made.

43. Paragraph 412 and 413. The Trust is concerned that it is being suggested in paragraph 412 that in some way Mr Walby failed to follow the Coroner's advices in relation to the production of statements for Inquests. The Coroner's proposal was never implemented. The Coroner never implemented a new system whereby an investigating police officer took over the role of obtaining statements from clinicians and nurses. In effect, what happened is that requests continued to arrive from the Coroner for statements to be provided to him and this system of obtaining statements remains in place to the present day.

44. Paragraph 417. These criticisms are unfairly directed at Dr Rooney's involvement as she had no clinical expertise.

45. Paragraph 418. The fact that death was reported to the Coroner so that an Inquest could be held and the fact that the death was included in those to be investigated during the course of this Inquiry means that albeit belatedly, the death was going to be thoroughly and rigorously investigated. The Trust can and should be excused for considering that it should devote its resources to facilitating the progress of these investigations rather than commencing a further investigation of its own. In addition there was an ongoing PSNI investigation following the concerns raised in the UTV documentary. At that time there was no formal guidance in any part of the UK to guide a Trust in such circumstances. There was a degree of complexity in the circumstances which the Trust hopes will not be overlooked by the Inquiry.

46. Paragraph 430. Dr Scott-Jupp's view is not referenced. At 234-002-008 in the final paragraph he expresses quite a different view which he did not resile from in his oral evidence. Also at 238-002-057 paragraph 269 Dr MacFaul appears to indicate that there had been some reduction in i.v. fluids albeit less than intended.

47. Paragraphs 428-431. Mr Walby has explained in his evidence that his concern at the time was that if the Inquiry only received the Coroner's Verdict it would appear that no reduction of fluids had been made. The evidence in particular the calculations of Professor Young demonstrate that the clinicians did reduce the No. 18 solution to 2/3 rate. Drugs were administered in normal saline. Mr Walby wanted to be sure that he was correct in his opinion that there had been a reduction and so he consulted Dr Steen and Prof Young before making any suggestion about an amendment to the Inquest Verdict. It was not with a view to defensiveness but rather with a view to providing a correct analysis of the facts that this suggestion was made. Mr Walby wished Mr O'Hara QC to be aware that the doctors had taken action on receipt of the low sodium result which would not have been apparent from simply reading the Verdict.

3rd December, 2013.