IN THE INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

CLOSING SUBMISSIONS ON BEHALF OF DR ANDREW SANDS

Key
References to the "Children's Hospital" are shorthand references to the Royal Belfast Hospital for Sick Children. References beginning with T refer to the transcript of the oral hearings. They are followed by the date of the oral hearing referred to, followed by the page number, then the line number. So, for example, T19/10/12 P1 L3 is the transcript for 19th October 2012, page 1, line 3.
References to documents used by the Inquiry adopt the Inquiry's own referencing method.

PREAMBLE

1. No one can be anything but sympathetic to the situation which Jennifer and Alan Roberts find themselves in. They lost a child, their daughter Claire, 17 years ago. They have known, since 2004, that there are issues relating to fluid management in RBHSC that may have impacted on the care of their child. This Inquiry is looking into those issues, with a rigour and fullness of which no one can legitimately complain.

2. The Terms of Reference need no repeating. Nor would the Inquiry benefit from unedifying efforts to subject them to some tendentious gloss. Summarised in the shortest terms – and at the risk of a sacrifice of precision in the furtherance of brevity – they appear to require the Inquiry to identify problems of the past, comment on whether those problems have been adequately addressed in the meantime, and provide guidance for the future.

3. This task inevitably casts the Chairman in the exacting dual roles of historian and adviser. The Chairman will have to determine relevant historical facts, and recommend what should happen as of now.

4. Dr Sands realises that this process demands that the Chairman assess past matters, some of which are provable by hard, persisting, documentary evidence, and others which require taking a view of probabilities of issues without the benefit of incontrovertible proof, and which require the formulation of conclusions basedon a combination of direct and circumstantial evidence.

5. It is no part of the function of Dr Sands' representatives to identify comment on the honesty or dishonesty of other witnesses, unless such issues have had some impact on Dr Sands. Suffice it to say that these submissions are predicated on the basis that Dr Sands told the Inquiry the truth, and that any holes in his recollection represent precisely that, as opposed to holes in his integrity. Simply, Dr Sands wants to assist the Inquiry. He trusts that the Inquiry will have perceived him as a manifest witness of truth.

6. Against this background, Dr Sands does not consider that close parsing of the transcript will be profitable. Rather, it is thought that succinct analysis of where the evidence called leaves him, in the context of 22nd October 1996, will be more helpful. However, for ease of reference, portions of the transcript are quoted in what appears below. (Counsel for Dr Sands is well aware of the Chairman's exhortation not to cite reams of evidence to him in the written submissions. But it is submitted that the evidence of Dr Sands merits particularly close attention, given that he was such a frank and reliable witness.)

THE BASIS OF ANY FINDINGS

7. There is ample authority for the proposition that the findings of a public inquiry are not tied into one particular standard of proof. Even if the standard of proof *is* potentially a live area of discussion in relation to other witnesses, or tranches of the Inquiry, it seems unlikely that the position of

Dr Sands calls for the invocation of some enhanced standard of proof: he is not accused of criminal wrongdoing; nor dishonesty. His starting point is very basic. He invites the Chairman to disavow any suggestion (implied or explicit) that he anything other than a manifest witness of truth, and to consider him to have been a reliable and measured witness, whose evidence should be given significant weight when findings of fact come to be made.

STRUCTURE OF THE REMAINDER OF THESE SUBMISSIONS

8. The remainder of these written submissions is arranged under the following headings[1]:
   (i) The context of, most likely facts comprising, and analysis of the involvement of Dr Sands with Claire Roberts on 22nd October 1996.
   (ii) The attack on the integrity of Dr Sands.
   (iii) Concluding remarks.

CONTEXT OF, MOST LIKELY FACTS COMPRISING, AND ANALYSIS OF THE INVOLVEMENT OF DR SANDS WITH CLAIRE ROBERTS ON 22ND OCTOBER 1996

9. The substantial area falling under this heading can usefully be dealt with under a number of further sub-headings, arranged as follows:
   (i) Dr Sands in October 1996.
   (ii) Overview factual narrative of 22nd October 1996 so far as is relevant to Dr Sands.
   (iii) Did Dr Sands realise that Claire Roberts was gravely ill on 22nd October 1996? If so, what did he do about it? Should he have considered other differentials?

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[1] By way of explanation, heading (i), comprises the bulk of Dr Sands' submissions, and seeks to address the principal issues aired, so far as they relate to Dr Sands, both in the Salmon letter to him dated 19th September 2012, and the oral hearings as they unfolded, and is, as will be seen, in turn divided into a number of further sub-headings; heading (ii) addresses the suggestion that the *"encephalitis / encephalopathy"* addition to the note of Dr Sand's morning ward round visit to Claire Roberts on 22nd October 1996 was a self-serving forgery, many years after the event; and heading (iii) is self-explanatory.

(iv) Why did Dr Sands go straight to Dr Webb, without first consulting Dr Steen?

(v) Did Dr Sands contact Dr Steen some time on 22nd October 1996?

(vi) Was it reasonable for Dr Sands to rely as heavily as he did on the involvement of Dr Webb? What were Dr Sands' expectations of Dr Steen? And were those expectations reasonable?

(vii) Was there sufficient clarity over who had overall consultant responsibility for Claire Roberts through the afternoon of 22nd October 1996?

(vii) Communication.

(viii) Note-keeping.

(ix) Knowledge of symptomatic hyponatraemia in 1996.

(x) Fluid management.

10. These are dealt with in turn, as follows.

Dr Sands in October 1996

11. From 1st April 1996 to 6th August 1996 Dr Sands was a locum registrar in paediatric cardiology. He then became a substantive paediatric registrar on 7th August 1996. It follows that, as at 22nd October 1996, Dr Sands had been in a substantive registrar posting for 10 weeks and six days. It therefore hardly needs saying that he was inexperienced at the time of Claire's death.

12. It is, of course, all too easy for *all* concerned in this Inquiry to see the highly experienced paediatric cardiologist (Dr Sands, as he gave his evidence on 19th October 2012) and, in doing so, to lose sight of the inexperienced paediatric registrar (Dr Sands in October 1996, 16 years earlier). But those representing Dr Sands are confident that the Chairman will maintain sight of the fact that, just as paediatric medical practices, procedures and standards evolved and improved immeasurably since

1996, so the inexperienced registrar of 1996 is not to be judged by the standards of the senior consultant in 2012/13. It follows that the Chairman is respectfully invited to scrutinise the actions of Dr Sands in 1996 by the *standards of 1996*, and *by reference to Dr Sands' level of experience in 1996.*

Overview factual narrative of 22nd October 1996 so far as is relevant to Dr Sands

13. On 22nd October 1996, Dr Sands' first contact with Claire Roberts is likely to have been between 11am and 12.15pm, and more probably between 11am and 12-noon. His last contact with her appears to have been around 5.15pm. The following paragraphs address what those representing Dr Sands suggest most likely happened in that timeframe, and the evidential foundation for saying so.

14. Dr Sands was leading a ward round in the Allen Ward when he came to Claire Roberts: see 090-022-052. There is no dispute that the notes of the ward round were taken by Dr Stevenson, a Senior House Officer at the time. The note made by Dr Stevenson is, regrettably, untimed. But there is a body of material which may assist the Chairman in narrowing down the window of time in which the round likely took place.

15. The note taken by *Dr Stevenson* includes the following (at 090-022-053):

    "Imp Non fitting status

    Plan Rectal diazepam"

16. A drug prescription chart records that the *time of administration* of the rectal diazepam, as *per* the recorded plan, was 12.15pm. There is no reason to suppose that this record is wrong. The compelling inference is that the ward round must have started some time *before* 12.15pm. Dr Sands further confirmed that the rectal diazepam was not administered until he had

confirmed it with Dr Webb. Dr Sands' evidence is that he had to find Dr Webb first. He said (T19/10/12 P32 L18 to P33 L7):

"My memory is that I left the ward round after we'd seen Claire and that I went to find Dr Webb at that point. I would have probably gone first to Paul Ward because that's where Dr Webb's ward base was. I don't think that's where I found him; I think I found him elsewhere in the hospital at that stage. So I think it took me a little time to find him, but not so very long. I think while there, my memory is that I described briefly Claire's findings to him and asked him if it was okay that we give a dose of rectal diazepam because that's what we had suggested on the ward round. But I think it wasn't actually given or prescribed until 12.15. So I believe I checked with him that he was comfortable with that before it was given and it was given around about or shortly after 12.15."

17. The Chairman replied:

"So if that recollection is correct and it fits, then you spoke to him some time perhaps between 11.30 and 12?"

18. Dr Sands responded:

"Perhaps around 12-ish, yes".

19. (The Chairman will, of course, recall that, for the first time in the life of this Inquiry, Dr Webb advanced a "two contacts from Dr Sands" theory, where he offered a scenario where Dr Webb was paged by Dr Sands *before* lunch, rang him back to give brief advice over the phone, and then spoke face-to-face with Dr Sands *after* Dr Webb had given his lunchtime talk. Whilst this does not withstand scrutiny, for reasons that will be developed in subsequent paragraphs, for the purposes of the timeline it is also consistent with Dr Sands having to get in contact with, then speaking to, Dr Webb *before* 12.15 – again, therefore, probably at 12ish.)

20. Dr Webb attended Claire's bedside as a result of his discussion with Dr Sands at 2pm. (The relevant entry in the clinical notes is timed at 4pm, but that cannot be right. First, it is followed by a note by Dr Stevenson timed at 2.30pm – 090-022-054. Second, it has been acknowledged by Dr Webb, and appears to have been acknowledged all round, that 2pm is the correct time.)

21. Dr Sands' own recollection is that the ward round was late morning (11am-12noon). Again, this is consistent with the surrounding evidence.

22. Dr Webb's 2pm note (090-022-053) starts with the words *"Neurology – Thank you"*. A substantial note follows, with a three-point plan at the end of it (090-022-054). Dr Webb saw Claire Roberts again, sometime during the afternoon. Dr Stevenson made the relevant entry – untimed again – in the notes on this occasion, but his note includes *"S/B Dr Webb"* (090-022-055). Dr Webb saw her yet again at 5pm, and made a full note, again with a three-point plan at the end of it. Point three reads:
"Add IV [sodium] valproate 20mg/kg IV bolus followed by infusion of 10mg/kg IV over 12 hours."

23. Dr Sands thinks he may have been present with Dr Webb when Dr Webb saw Claire at 5pm, but in any event administered the sodium valproate at 5.15pm (090-026-075). Dr Sands' shift had, by then, ended, and he considers he would probably have conducted a handover to Dr Bartholomé before leaving the Children's Hospital, although has no specific recollection of the same (T19/10/2012 P227 L9 to P230 L25).

<u>Did Dr Sands realise that Claire Roberts was gravely ill on 22nd October 1996? If so, what did he do about it? Should he have considered other differentials?</u>

24. Mr Roberts has suggested that no one appears to have realised just how ill Claire was during her time in the Children's Hospital on 21st and 22nd

October 1996. But the evidence of Dr Sands was that he *did* consider her very unwell when he saw her during the ward round. And the surrounding evidence supports that.

25. Of course, as the Chairman is well aware (and has said on a number of occasions, and in a number of ways), human memory is fallible, and prone to error. It is also recognised, on behalf of Dr Sands, that the human mind is prone to fill in the gaps in recollection, so as to piece together the fragments of actual recollection in a way that makes a coherent story. It is further recognised that the human mind is prone to weave into the story being recalled from the past what it *knows now* about that story. This can lead to a genuine, but mistaken, belief that one had a particular insight into matters *back then* which has, in fact, only *developed since.*

26. Applying what is set out in the preceding paragraph practically to Dr Sands' evidence, the question is: Did Dr Sands *actually know in real time* that Claire Roberts was really ill neurologically, or is it something he *since learnt*, as a result of the outcome and aftermath, and is thus now genuinely, but mistakenly, imposing that knowledge on his recollection of what he actually thought on 22nd October 1996?

27. It is submitted that the answer is that Dr Sands *did* know in real time that Claire Roberts was very ill neurologically. The reason for saying this is actually very simple. Actions speak louder than words. What did Dr Sands do when he saw Claire Roberts on the ward round on 22nd October 1996? He immediately consulted Dr Webb, Consultant Neurologist. This is because his *"impression of Claire on the ward round"* was of *"her being neurologically very unwell"* (T19/10/2012 P38 L17-19).

28. Of course, Dr Sands appears to have been leading the ward round on the morning of 22nd October 1996, with Dr Steen not actually physically in the

Children's Hospital at the time he reached Claire Roberts. So, in spite of his very limited experience, having only been in this, his first substantive registrar posting for a matter of weeks, Dr Sands had, as the Chairman put it (T19/10/2012 P59 L16-17) *"to step up to lead the ward round if the consultant is not available."*

29. Dr Sands acknowledges that the ward round appears to have been relatively late. He said (T19/10/2012 P70 L2-10):
"I also take Dr Steen's point about the ward round seeming to be relatively late. I do take that point. However, it was me doing it, I probably would have been a fair bit slower than Dr Steen about going round, and that may be partly why it was maybe running behind, if you like, by Dr Steen's standards. But I do take the point that it seemed to be quite late by the time we were getting to see Claire."

30. When Dr Sands reached Claire, he considered her to be *"neurologically very unwell"* (T19/10/2012 P38 L19). As an inexperienced registrar, he responded to this concern by immediately tracking down an experienced paediatric neurologist. Claire's presentation was *"not something I could countenance managing myself…not something I had experience of, so therefore it was outside of experience that I'd had prior to this."* (T19/10/2012 P242 L15-18)

31. It is submitted that it takes a very significant degree of concern for a very inexperienced registrar break off the ward round to go straight to a specialist consultant about a particular patient. This is extremely powerful, circumstantial proof that Dr Sands recognised that he was dealing with a *patient whom he felt was neurologically unwell***.** In short, Dr Sands' evidence on the matter now is supported by his actions then.

32. And so it was that Dr Sands got clearance from Dr Webb to administer the rectal diazepam (which in turn was administered at 12.15pm – 090-026-075). He derived reassurance from the fact that Dr Webb *"took me*

seriously…listened to me, he took me seriously and I was pleased that he agreed to come and see Claire" (T19/10/2012 P169 L16-18).

33. In fairness to Dr Webb, Dr Sands added the following to the piece of evidence cited in the preceding paragraph:
"I'm not sure that he specified exactly when or how quickly he would come or be able to come." (T19/10/2012 P169 L18-20)

34. Dr Sands does not, however, appear to have realised that Dr Webb was going to be another two hours before attending, as is plain from the following portion of his evidence:
"I think in this case I felt that Dr Webb was going to come and see Claire quite soon. Perhaps I felt he would see her even maybe sooner than he did. I suppose I went to him feeling that he might even be able to come right away." (T19/10/2012 P35 L15-19)

35. So as far as Dr Sands was concerned, he was dealing with a child he considered to be *"neurologically very unwell"* (T19/10/2012 P196 L20), but that, upon referring the matter to Dr Webb, he *"believed she was being looked after by a paediatric neurologist, and had had these neurological problems, that they were being addressed by the best person possible"* (T19/10/2012 P196 L21-24).

36. Thus it is submitted that Dr Sands *did* recognise that Claire Roberts was severely unwell. He responded by getting a senior specialist, whose specialism was, he felt, most engaged by Claire Roberts' presentation (rightly, as it turns out). He then returned to the note, and added a further differential diagnosis he had already considered, namely encephalitis.

37. There has, of course, been some suggestion that Dr Sands should have listed yet more differential diagnoses. But, putting to one side for now the

huge dollop of retrospective wisdom which such a criticism entails, the Chairman will recall the evidence of Dr Scott-Jupp, to the effect that giving an extensive list of differentials is to be deprecated: T12/11/2012 P203 L12-19. Frankly, taking a step back, this is just applied common sense. Listing every *possible* diagnosis is no more good practice in medicine than it would be good practice in law for the barrister to burden the tribunal with the whole unfiltered array of *possible* submissions that (s)he can think of. Thus it is submitted that any suggestion that Dr Sands' was improperly narrow in his focus is, in the context of an inexperienced registrar in 1996, unfair. On the contrary, he focussed – with a commendable maturity, given his relative inexperience – on what he perceived to be the *likely* and *real* issues.

Why did Dr Sands go straight to Dr Webb, without first consulting Dr Steen?

38. The referral to Dr Webb also raises the following question: Why did Dr Sands go direct to Dr Webb, without first contacting Dr Steen? The answer appears to be threefold:
    (i) Dr Sands *would* have contacted Dr Steen if she had been available somewhere in the Children's Hospital at the time he was having concerns about her presentation. But Dr Steen was not there.
    (ii) In all the circumstances, the priority was to get specialist consultant input.
    (iii) In any event, Dr Sands *did* speak with Dr Steen, at some point in the afternoon, probably on the phone, about the presentation of Claire Roberts, and the referral to Dr Webb.

39. This analysis directly mirrors the evidence of Dr Sands on the point. He said the following (T19/10/2012 P73 L1-9):

    "I think there were two reasons for going looking for Dr Webb. One, it was my understanding that I couldn't get Dr Steen in that way…

    …

"…And the other reason was I believe that Dr Webb, rather than somebody else, some other consultant perhaps, was the best person to help."

40. Dealing with each of these reasons in turn: First, it seems plain that Dr Steen was not present on the Allen Ward at the time Dr Sands saw Claire Roberts on the morning ward round. In his evidence, the following exchange took place between Dr Sands and Senior Counsel to the Inquiry (T19/10/2012 P74 L3-8):

"Q. And however transient [Dr Steen] *had been, if you had been able to see her, you would have wanted her to contribute to Claire's care?*

A. Yes.

Q. So anything she had to say would have been recorded?

A. Yes."

41. So it appears that Dr Steen simply was not there. And when the Chairman asked Dr Sands whether the sequence of events meant that not only was Dr Steen not there, but that she was not contactable, he said (T19/10/2012 P79 L23-25 & P 80 L1-10) that he could not *"be absolutely certain"* she was not contactable but –

"…my feeling is that I didn't think I could get hold of Dr Steen quickly enough. I may have already tried at this stage…I can't be certain of that…but my feeling was that I wasn't going to be able to get Dr Steen there quickly enough to give me the help or us the help that we needed with Claire. That may have reflected some difficulty contacting Dr Steen or simply here saying perhaps that she was going to be tied up in an important meeting for an hour, hour and a half, and would prefer not to be contacted during that period perhaps. I certainly recall that having been said before by other consultants."

42. Second, it is plain from his evidence that Dr Sands considered there was an urgency about referring Claire to a consultant neurologist that was not standard (T19/10/2012 P78 L20-23).

43. This urgency was expanded upon in the following exchange between Dr Sands and Senior Counsel to the Inquiry:

"Q. Maybe this point might be what underlines some of that concern: your consultant wasn't there, you were conducting the ward rounds for all these patients. Did you feel under any more pressure to complete that work?

A. I take your point. There would have been a certain time constraint. And the other thing too, whilst not wanting to truncate time with Claire or with Claire's mum and dad, I would have felt as well that it was important to not delay getting Dr Webb.

Q. Does that mean that once you'd felt that what you were dealing with is a sick child, then your priority then is trying to get the consultant input?

A. I think that's right…"

Did Dr Sands contact Dr Steen some time on 22nd October 1996?

44. Dr Sands' evidence is that he *did* speak with Dr Steen on the afternoon of 22nd October 1996. He said in evidence (T19/10/2012 P183 L1-9) is that he certainly thought he *would* have tried to speak to Dr Steen before he went to his afternoon clinic at about 2pm, although added that Dr Steen may have phoned him back, if she had been in a meeting when he first called her. But when pressed on the timing, Dr Sands said (T19/10/2012 P183 L16-18):

"My recollection is that it was early in the afternoon, that it wasn't at the end of the afternoon, but I really can't be…I cannot be precise about that, I'm sorry."

45. Dr Sands later added that, whilst he could not remember the words he used to Dr Steen on the telephone, he thinks he would have used *"similar terminology"* to that employed by him in his evidence to the Inquiry, namely that Claire Roberts was *"neurologically very unwell"*.

46. It is submitted that, on the balance of probabilities, Dr Sands *did* have such a conversation with Dr Steen on the afternoon of 22nd October 1996. Given

his heightened state of concern, and the fact that he had already sought the intervention of Dr Webb, it would be a natural thing to do, and surprising if he did not. (It is perfectly possible that when Dr Sands spoke with Dr Steen on the telephone, that he was not actually in Allen Ward, and therefore did not have Claire's notes to hand. It might be thought obvious that many conversations take place between healthcare professionals – and indeed other professionals – without documentary evidence of them, and are only likely to be included within notes if they contribute materially to the management of a patient.)

Was it reasonable for Dr Sands to rely as heavily as he did on the involvement of Dr Webb? What were Dr Sands' expectations of Dr Steen? And were those expectations reasonable?

47. Dr Roderick MacFaul succinctly answered *all* these questions in his oral evidence to the Inquiry (14/11/2012 P75 L8 to P79 L15). He did so economically, and with commendable clarity of expression. The culmination of his evidence on this point came during the following exchange (T14/11/2012 P79 L3-15) between the Chairman and Dr McFaul:
"THE CHAIRMAN: I think the point, doctor, is this: having seen what Dr Sands had to say at the hearing, do you, in broad terms, think that he did what you would have expected him to do as a registrar?
A. Yes.
THE CHAIRMAN: And would you be critical of him for not doing more than that?
A. No. He did ask Dr Webb to see Claire as well and that was a very responsible action. Whether that was following or before Dr Steen's discussion with him on either side, it was a good thing to do. And the expectations that he had of Dr Steen are entirely reasonable."

48. It is, of course, recognised on behalf of Dr Sands that different expert views have been ventilated in relation to some of these issues. For

example, Dr Scott-Jupp has expressed concern that Dr Sands did not discuss the referral to Dr Webb with Dr Steen before making it (although no criticism was made of the *actual referral*). Dr Scott-Jupp was also critical of a lack of clarity having been obtained as to whether Dr Webb was just consulting, or taking over the care of Claire Roberts. So it remains necessary to examine the evidence beyond Dr MacFaul's clear and unequivocal answers to the questions posed under the above sub-heading.

49. The starting point is that, when confronted with Claire's presentation, Dr Sands, an inexperienced registrar, felt he was facing something *"I could not countenance managing myself…not something I had experience of, so therefore it was outside of experience that I'd had prior to this"* (T19/10/2012 P242 L15-18). So what did he do? He went to the most senior person with expertise that he thought relevant, and referred the matter to him. He went on to say (T19/10/2012 P243 L12-20):

    "I think I considered Claire's problems to be neurological and so I felt that Dr Webb was the person to take that fully on board and manage that neurological problem. … I would have felt him capable as well of taking on board Claire's care in the round, if necessary."

50. And of course, whilst Dr Sands had not identified a definite diagnosis, he *"would have believed Dr Webb's impression that she did, in fact, have ongoing seizure activity because he was the consultant neurologist that that seems to be his feeling"* (T19/10/2012 P247 L12-15), adding (a few lines later in the transcript) that *"I don't believe I heard anything that pushed me away from that."*

51. Critically, Dr Sands went on to add (T19/10/2012 P249 L25 to P250 L26):

    "I think [Dr Webb] *was the consultant who was primarily guiding treatment, had attended Claire"* and *"arguably de facto was the consultant who was leading Claire's care."*

52. Dr Sands went on to give colour to his perception in this regard by comparing it to his own practice, as a consultant paediatric cardiologist, 16 years later. He said (T19/10/2012 P124 L21-25):

"Again, I can only…I'm bound to, I suppose, draw comparisons between my own practice and if I'm called to see a child in whom there is a cardiac diagnosis, and that's established, I would seek to manage that child."

53. He went on to say (T19/10/2012 P125 L2-9):

"And yes, I'd want to have a word with the consultant under whom that chid had been admitted, but I would want to manage that child, all of that child, unless there were multiple other organ system disorders that needed other input.

"…

"So I suppose I'm bound to make that comparison in this case."

54. In short, confronted with the severe neurological symptoms, as he perceived them, of Claire Roberts, Dr Sands, a young and inexperienced registrar, went straight to a senior and expert colleague, whom he thought was the *"best person"* to look after her, and whose involvement had the effect of allaying the concerns of Dr Sands. It is difficult to do better in expressing this point very shortly than to adopt the expression of Dr Sands (T19/10/2012 P201 L7-12):

"If a specialist is there who's seen the child, who's prescribed medication, and who's been privy to the same information, if they are not worried and doing something different and anxious, then my anxiety, whilst real enough, would be allayed to some degree by the fact that they seem to be in control."

55. This is, it is submitted, entirely understandable. Just as the very junior member of the Bar might feel himself out of his depth when confronted with a very difficult forensic challenge, and then feels relief that the matter is, at least, under control when experienced Senior Counsel is brought on

board, so it is inevitable that the very junior registrar, when faced with a grave neurological presentation during a ward round, will feel a combination of relief and trust once the highly experienced neurologist involves himself in the patient's management. This is, it is submitted, entirely natural, reasonable, and understandable.

56. As for Dr Sands' *expectations* of Dr Steen once he had spoken to her, it is perhaps helpful to begin with what Dr Sands thinks he would have said during his telephone conversation with her. He said (T19/10/2012 P185 L19-23):

"I think I would have described it…starting with how Claire had been admitted, what her presentation was, and perhaps most importantly what I felt, because I had just examined her on the ward round, and what my specific concerns were."

57. He went on to say (T19/10/2012 P186 L3-6):

"'Neurologically very unwell' is a term that I've used, I think in witness statements, and I think did describe how I felt about Claire, that her problems appeared to me to be neurological and of a serious nature."

58. Immediately after giving the evidence cited in the preceding paragraph, Senior Counsel to the Inquiry and Dr Sands had the following exchange (T19/10/2012 P186 7-14):

"MS ANYADIKE-DANES: What was your expectation that Dr Steen might do as a result of realising her patient was in that condition so far as you saw it at that stage?

A. I'm not sure. I'm not sure at the time what I would have expected Dr Steen to do except to perhaps keep in touch, preferably to talk to Dr Webb if at all possible.

Q. What would you have actually wanted her to do?

A. Ideally, I would have liked her there."

59. It is submitted that, when one looks at matters in the round, these were Dr Sands' genuine expectations of Dr Steen, and they were reasonable.

Was there sufficient clarity over who had overall consultant responsibility for Claire Roberts through the afternoon of 22nd October 1996?

60. Quite simply put, the answer to this question is: no. Dr Sands does not seek to cavil at this reality. Dr Sands said, immediately after making the point in his evidence that arguably Dr Webb was de facto the consultant who was leading the care of Claire Roberts. He then added (T19/10/2012 P250 L4-6):

"But I wouldn't have said Dr Webb was…that he had taken over her care unless I had been told that."

61. He was then asked if he would have expected such a takeover of care to be recorded somewhere. Critically, he answered as follows (T19/10/2012 P250 L10-20):

"Again, this is one of the problems. It often wasn't and, even until very recently, right up to almost the present moment, it's not something that has been well documented in notes. The shared care, as I said earlier, can work well and you can get two consultants or three consultants who manage a patient very well, each talking to each other, and not write anything in the notes about who's doing what. But if there's a problem, it compounds the problem and it leads to ambiguity, and it's something that I think needs to change and arguably should have changed long ago."

62. So the real problem here, it is submitted, was *systemic*, rather than the fault of individuals. And, insofar as fault *might* be laid at the door of any individual, it is submitted that those individuals are the consultants, who had plainly failed to talk to each other (in particular, Dr Steen failing to talk to Dr Webb).

Communication

63. The effectiveness of Dr Sands' communication on 22nd October 1996 is under scrutiny. In particular, his communication with:
    (i) Mr and Mrs Roberts.
    (ii) The nurses and SHOs.

64. It is proposed to deal with these in turn.

65. First, it is necessary to examine the communications between Dr Sands and Mr and Mrs Roberts. The backdrop is that, by the time Dr Sands had a conversation with Mr and Mrs Roberts, he "*thought there was a major neurological problem there that I didn't fully understand, that I didn't perhaps even partially understand, but thought that she was neurologically unwell in a way I couldn't explain*" (T19/10/2012 P130 L23 – P131 L2).

66. But he went on to say (T19/10/2012 P131 L7-12):
    "*I think my own concern, fear if you like, would have been balanced by what I remember as Claire's mum's optimism to…although they recognised Claire wasn't well, they were optimistic that she would soon be well, she would bounce back, she would in a while be herself again.*"

67. This need to exercise judgement about how communication of a child's condition is *pitched* to the parents was echoed by Dr Scott-Jupp, who said (T12/11/2012 P212 L6-23):
    "*Can I just go off on a slight tangent talking about communicating to parents generally in any situation? One has to establish what level they're at, where they're coming from. For example, if a child comes in with a relatively minor problem, they seem to be extremely anxious, then one would emphasise to them that there's nothing to worry about, the child is going to be absolutely fine. This happens very frequently. If on the other hand the child really is quite ill and the parents seem to be somewhat unbothered and blasé about it, you might use*

different language in exactly the same situation to what you would with a parent who was appropriately worried.

"So one assesses their level of anxiety and concern and tries to bring them to what one considers to be appropriate for that situation, either bringing them up or bringing them down, if you see what I mean."

68. Linking the insight of Dr Scott-Jupp back into the evidence of Dr Sands, importantly Dr Sands went on to say (T19/10/2012 P132 L3-22):

"I would have wanted to try and tell Mr and Mrs Roberts that in a way that I hope was sensitive, that didn't completely take away their optimism. I would have said it as a registrar at the time, so I would have had to be pretty careful about what I said and not try and overstate what I knew or thought I knew. And also, try and do it, saying, "Look, I am going to try and talk to someone else, a neurologist, who I think well might be able to help us out more here and whom, I would have hoped, tell you more". And I have to accept as a clinician that we…I…talk to parents, try and give an honest appraisal of how things are and what I think is going on, and acknowledge that I don't always get the message across and what I say isn't always what parents pick up and remember and take on board. I feel that that's probably something that comes with experience as well. I hope I'm more experienced and perhaps better at that now, trying to gauge a parent's understanding of what I've told them, whether I've done a good job or not telling them."

69. Mr and Mrs Roberts have a different recollection of what they thought Dr Sands was conveying to them about the seriousness of their daughter's condition than that *intended* to have been conveyed by Dr Sands. In their evidence, Mr Roberts said (T31/10/2012 P55 L13-21):

"Our impression still was then that Claire was still…back over the picture again…pale, lethargic, vomiting with a tummy bug, and Dr Sands mentioned the words "internal fitting" and he would speak to another doctor about it. That is what was discussed. There was nothing about major neurological problem and

there was nothing about infection and if he did elaborate or explain infection as encephalitis, that was definitely not discussed."

70. So it appears that there was a gap between what Dr Sands was trying, sympathetically, delicately, and in a way which was designed not to crush the parents' hopes, to tell them, and what the parents *thought* they were being told, namely *"That I thought Claire had a major neurological problem, that her consciousness level didn't seem normal to me and to the ward round and, I think, to Claire's mum and dad* (T19/10/2012 P134 L24 – P135 L2).

71. Quite simply, in hindsight, and from a standpoint of vast experience of communicating with parents in the here-and-now (compared with little such experience in 1996), Dr Sands recognises that his pitch must have been insufficient to get the message across. And, whilst it *might* be said that sometimes parents close their ears to that which they do not wish to hear, and take the message they wish to take rather than that intended to be conveyed, it is accepted that the buck stops with the clinician to ensure that what he means to say is understood by the hearer as meaning precisely that.

72. Second, Dr Sands accepts that there may, frankly, have been a *"gap in understanding"* between the nurses and Dr Stevenson and that of Dr Sands about the seriousness of Claire Roberts' condition (T19/10/2012 P239) – although as the Chairman rightly recognised (on the same page, L17), the responsibility to ensure no such gap appeared was surely shared with Dr Webb.

73. Again, therefore, Dr Sands does not cavil at the proposition that his skills in pitching communication were not in 1996 what they are now. It is, however, submitted that any such failings should be viewed realistically and that, if realism is used, they will also be viewed very sympathetically.

An analogy may assist: no one expects pupil barristers to operate at the same standard of excellence as a Silk. And an error that would be unforgivable in a Silk may be entirely understandable if committed by a pupil.

74. There is a more general point of relevance here. The balance of the evidence received by the Inquiry suggests that in paediatrics, parental counselling and communication is largely considered a consultant responsibility, which increases with the complexity of the patient. Dr Sands would have provided provisional counselling to Claire's parents, on the understanding that Dr Webb would soon be attending Claire, and would speak with her parents in greater detail following his neurological assessment.

Note-keeping

75. The clinical notes are what they are, but not what they should be. Dr Sands does not, however, adopt the technique of Dr Steen when she gave her evidence, and accept responsibility in some vicarious and general sense (the "we were all at fault" analysis, which is an approach perhaps designed to give the illusion of having insight into one's own failings, whilst *really* seeking to dilute *personal* self-criticism). Rather, Dr Sands recognises and confronts his *own* shortcomings in this regard. He should, for example, have signed and timed his addition to Dr Stevenson's ward round entry – "*encephalitis / encephalopathy*" (090-022-053). He should have recorded, signed, and timed both the fact and substance of his conversation with Dr Steen. There is nothing further he can do apart from recognise his note-keeping should have been tighter in 1996 than it was. (Dr Sands makes this concession, even allowing for the reality that inevitably more is said between those caring for patients, than can practicably, or even helpfully, be committed to the notes.)

Knowledge of symptomatic hyponatraemia in 1996

76. The backdrop to this issue is that serum electrolyte testing had been carried out at some point on the evening of 21st October 1996 and, in an entry apparently timed some time after midnight, Dr Andrea Volprect has recorded the results. Those include a serum sodium reading of 132 (090-022-052). (There was, in the literature that was current in 1996, some debate over whether a reading of below 135 was hyponatraemic, or whether 130 was the border. Either way, there appears no dispute that 132 is not a reading associated with *symptomatic* hyponatraemia.)

77. In this case there is a range of expert opinions that have been offered as to what the state of knowledge *ought* to have been in 1996 about paediatric hyponatraemia. Wherever, on the scale, the Chairman ultimately determines what *should* have been known is positioned, the *actual* state of knowledge of this issue appears to have been sparse and rudimentary. This is clear from Dr Sands' answer to the question of whether his concerns about Claire Roberts were focussed not on hyponatraemia, but on other issues. He said (T19/10/2012 P106 L5-10):
"I think that's correct. To many doctors at the time, hyponatraemia simply meant literally hyponatraemia, a lower than normal sodium level, without a full appreciation of what it might mean and particularly what symptomatic hyponatraemia…how it might develop, what its implications might be".

78. This, it is submitted, represents a general ignorance of the topic across the board, as opposed to relative ignorance on the part of Dr Sands, for which he should be singled out.

Fluid management

79. Dr Sands believed that repeating the serum electrolytes (including sodium) would have been part of the ward round discussion on the morning of 22nd October 1996 and planned to be carried out (WS-137-1 P8).

Unfortunately this was not done. Nor is there any note to back up Dr Sands' belief that it was discussed. Plainly, this is unsatisfactory. Even more unsatisfactory, it was not *actually* done until much later, in the evening. This is particularly unsatisfactory given that Claire Roberts was not just seen in the morning by Dr Sands, then an inexperienced registrar; she was also seen, apparently three times, by Dr Webb, a senior specialist clinician, during the course of the afternoon.

80. Dr Sands plainly understood the importance of repeating the serum electrolytes, even in 1996, as is borne out by the following portion of his evidence (T19/10/2012 P109 L12 – P110 L13):

"THE CHAIRMAN: Well, in hindsight, let's suppose for the moment that the evidence doesn't really support the suggestion that that was planned. Do you accept, with hindsight, that it should have been planned?

"A. Yes, I think it's something that should have been done during the day. If I may: after hearing of Claire's collapse, I believe it was from Dr Bartholomé, I was surprised to hear that the serum sodium was 121 at 11.30. I was surprised that there wasn't a blood result available before that. Now, I don't put it any more strongly that that I was just surprised to hear that. I've said that in my third witness statement to the inquiry.

"And I have thought about this and asked myself what does that mean, and it was something I wasn't sure whether I should put in because I wasn't sure exactly what it meant to me now. But to me now, it suggests to me that at least I had expected that a blood result or a blood test had been done or had been requested, that it might be due back in the five to six slot when blood results usually come back. Or alternatively, if I or we discovered that it hadn't been done, or the sample had been lost or misplaced or unsuitable for analysis, that we would mention it again at 5 o'clock or 5.30 with a plan to do it shortly thereafter. And that might explain why it surprised me that there wasn't a result available until, you know, much later on in that evening."

81. The position can be summarised shortly. Whether or not Dr Sands had mentioned, or asked for, further serum electrolyte testing, the only entry in the notes referring to such testing, before the tests on the evening of 22nd October 1996, was that apparently made by Dr Volprect that morning (090-022-052). So it was not done through the afternoon of that day, despite the fact that Dr Webb had had three opportunities to pick that failure up, and Dr Sands had had one (when administering the sodium valproate at 5.15pm). Thus it is submitted that *all* the clinicians with responsibility for the care of Claire Roberts on the afternoon of 22nd October 1996 *share* responsibility for that failing. (The appropriate *apportionment* of the blame can be left to the Chairman, if indeed it is deemed necessary at all, without requiring specific submission on the same.)

82. That said, the critical relationship between fluid management – in particular, use of fifth part saline solution – and symptomatic hyponatraemia, does not appear to have been appreciated by staff at the Children's Hospital in 1996. That is the dark side of the story. The bright side of the story is that such knowledge appears to have developed very substantially in the 17 years since. This is borne out by the following passage of Dr Sands' evidence (T19/10/2012 P102 L 22 – P103 L3):
"I suppose I can only compare with the knowledge that I have now, that we have now, and I think our knowledge was limited. My knowledge was limited in terms of how to manage a slightly low serum sodium in an unwell patient. And I think that view has changed, my view has changed, and perhaps the views of many other people have changed."

THE ATTACK ON THE INTEGRITY OF DR SANDS

83. Mr Roberts has questioned both the timing of, and reasoning behind, the addition. The Inquiry may therefore be assisted by a few observations as to the evidence on both these (connected) issues.

84. As to the *timing,* Dr Sands gave unchallenged evidence about this at [T 19/10/12 P 170]. In short, he said he made the addition after speaking to Dr Webb, when he "*came back to Allen Ward and …put that down in the notes.*"

85. This is consistent with the evidence as to Dr Sands' practice at the time. For example, when asked, at [T 6/11/12 P49 L14-16] when the additional notes were added, Dr Stewart said:

"I couldn't say with certainty, but I remember Dr Sands often editing my records of his ward rounds at the time by the bedside. So I would make my notes and Dr Sands would come back and maybe add a word here or there and something I had missed. So whether it happened at the time or later, I can't say, but I do know his normal practice was to add additional notes as he thought necessary at the time."

86. The evidence of Dr Sands on this issue is further corroborated by the *reason* he made the addition.

87. The Chairman already well understands the reason, as articulated by Dr Sands, for his adding the further words in his own handwriting. In the Chairman's own words [T 13/12/12 P 115 L 16 – 22], "*the reason for those two words being in different handwriting is that they were added by him in his own handwriting after he had spoken to Dr Webb and went back to the ward. That explains the different handwriting and it explains them being entered at a different point.*"

88. In assessing this reason it is profitable to consider the *context*.

89. It will be recalled that in October 1996, Dr Sands was a registrar of but a few months' standing. [T 19/10/12 P 5 L17-20] When he spoke with Claire's parents during the ward round, he thinks he would have raised

the possibility of infection causing some of her problems, although *"probably wouldn't have used the word 'encephalitis'"*. [T 19/10/12 P 135 L 12 – 16] In other words, he described what he understood, as a medic, to be encephalitis, but without actually using that word.

90. Dr Stewart corroborates the mention of encephalitis during the ward round (though does not deal with whether the actual *word* was used). [T 6/11/12 P 19 – 20]

91. Dr Sands accepts that Mr and Mrs Roberts do not appear to have understood, as a result of this conversation, just how ill Claire was. He accepts that this denotes a failure of communication and/or comprehension (possibly different sides of the same coin – it behoves the communicator to ensure the hearer understands). Nonetheless, he was self-evidently concerned enough to recognise an urgency about getting a consultant neurologist's input (see [T 19/10/12 P 78 L 20- 23]). Dr Sands went on to say the following at [T 19/10/12 P 120 L 20 – P 121 L 3]:

"I think…my impression was that I was going to speak to Dr Webb and that he, in fact, would come – I hoped soon – and would give us a steer, give us a direction to go down, because it seemed to me quite clear that this child, that Claire, had a major neurological problem that Dr Webb would be able to help with, and that he would guide us in terms of a line of investigation or lines of investigation, rather than me suggesting a number of investigations."

92. In so referring the matter to Dr Webb, Dr Sands acknowledges that he felt, to some extent, out of his depth [T 19/10/12 P 242 L 20 – 25], but felt comforted by Dr Webb's involvement, as the problems were neurological and a consultant neurologist was now on board [T 19/10/12 P 243 L 3 – 20], and had become *"arguably the de facto consultant who was leading Claire's care"* [T 19/10/12 P 250 L 3 – 4].

93. No doubt taking his lead from Dr Webb, what could be more natural than that the inexperienced registrar would add to the note a further differential impression (encephalopathy) as a result of his conversation with the experienced specialist, and add the differential (encephalitis) which he had already discussed, in substance, during the round, but had not already been noted? (See also WS-137/1 Page 10-11.)

94. Dr Sands accepts, of course, that he should have signed, timed and dated the addition. However, turning it on its head, that is precisely the sort of detail that one might expect to be present if the addition *were* a self-serving forgery. So, at worst, what Dr Sands did, by adding to the note in the way he did (even if he had timed, dated and signed it) is leave himself vulnerable to misconceived and unsubstantiated allegations of criminal wrongdoing.

95. Attempts to subject achieve hard scientific exactitude on the point have, to Dr Sands' great disappointment, failed. Thus repeating, or even summarising, the findings of Dr Giles within these Submissions will be unlikely to assist the Chairman.

CONCLUDING COMMENTS

96. On 22nd October 1996 Dr Sands was a junior doctor. Confronted with a child he considered gravely neurologically unwell, he went to a senior specialist, and took comfort from the thought that that specialist would manage the situation expertly. He contacted Dr Steen, and assumed Dr Steen and Dr Webb would communicate appropriately with each other. His note-taking was not, at points, up to the mark. His efforts to communicate his opinion on Claire Roberts' presentation to Mr and Mrs Roberts appears to have failed to get the message across in a way that left

them with the impression he intended to make. His failing here appears to have been to overdo the sensitivity, and wish not to crush optimism, rather than a failing to attempt to communicate the *essential substance* of his message. So, overall, the Inquiry is invited to conclude that on 22nd October 1996, Dr Sands was a conscientious, though very inexperienced, registrar, whose actions were driven by true integrity of purpose, and whose failings were, in fair context, limited.

5th December 2013 **SAM GREEN**