Monday, 24 September 2012

(10.00 am)

(Delay in proceedings)

(10.15 am)

THE CHAIRMAN: Good morning, ladies and gentlemen. The inquiry is now moving on to deal with the death of Claire Roberts in October 1996. For those of you who have not been here before, the inquiry practice is that we normally take a break at around 11.30 or so because the stenographer on my left needs a break for his purposes. We will then continue until about 1 o'clock and then, when we go into the afternoon, we take an afternoon break at about 3.15 or 3.30. That's what we'll do today.

Today's hearing will comprise of the opening of Claire's case on behalf of the inquiry by senior counsel for the inquiry, Ms Anyadike-Danes. We've also been notified that the counsel representing the Roberts family, Mr Quinn QC and Mr Michael McCrea, are going to open the case from the perspective of the Roberts.

I know that there are some other bits of business, some correspondence received late last week, which the parties want to deal with. I'll be happy to deal with that, but I want to get the openings done first and then we'll deal with any other outstanding issues before we

break for today and resume tomorrow morning with the evidence of Dr Steen, which for reasons I understand are known, will be taken in segments on Tuesday, Wednesday and Thursday of this week.

So unless there are any particular points that have to be dealt with now, I will invite Ms Anyadike-Danes to open on behalf of the inquiry.

Opening by MS ANYADIKE-DANES

MS ANYADIKE-DANES: Thank you, Mr Chairman.

Good morning. We have very nearly concluded the evidence in Adam's case and the resumed hearings, which were held at the beginning of this month, brought into sharp relief the issues of learning of lessons and the dissemination of those lessons, and the witnesses, as you know, Mr Chairman, were questioned on those matters and they explained in their evidence to you the reasons for the failure to hold a full investigation into the circumstances of Adam's death, why the statement that was provided to the coroner or the information that was in it was not apparently disseminated to anyone other than the consultant paediatric anaesthetists who had helped to draft it and how the intended seminar was simply forgotten about. And it was hard not to be cognizant of, in effect, the shadow of Claire's death because we now know that almost a year after Adam's last

admission to the Children's Hospital, Claire was to be admitted to that hospital and she was to die there, very nearly four months after his inquest.

So as you know, Mr Chairman, hyponatraemia was a feature in both their deaths, but it was to be some eight years after her death and following enquiries from her parents that they would learn that hyponatraemia was involved in their daughter's death. And the quality of the communications with the Roberts family and the issue of lessons learned formed your principal motivation for exercising your discretion to include Claire's case in the works of the inquiry, and that was explained by you during the public hearing on 30 May 2008. It remains a powerful guide to our investigations. What you said was:

"In broad terms, however, my concern is about the apparent conflict between the initial explanation given to the Roberts family and the subsequent explanation given to them after -- but only after -- they contacted the Royal following the television broadcast. I am also concerned whether more should have been learned from Adam's death and inquest and whether there should therefore have been better fluid management in the Royal for Claire, a relatively short time later."

And as I say, those immediate concerns of yours, the

legal team has had them very much in mind as we have sought to investigate her death and provide to you the evidence for you to complete your report and make your recommendations.

To a large extent, Mr Chairman, those issues involve matters that we have come to term "governance" as opposed to the clinical issues concerning her medical care and treatment. And as you know, there is a separate oral hearing to address those important governance issues. So the clinical issues to be addressed in this oral hearing are set out in a written opening that was provided to interested parties last week. And in that opening, we sought to set out the principal clinical issues in Claire's case in the context of the evidence that we had gathered to date and also in the context of the revised terms of reference and a list of issues, and also to identify the main areas that the legal team consider require further investigation through questioning in an oral hearing.

The issues to be addressed, they arise out of the current list of issues, which has been published early this year, and they fall into five areas for the purposes of this oral hearing. The first is an investigation into the relevance of the medical notes and records from the Ulster Hospital and the

Children's Hospital on Claire Roberts prior to her presentation to the Children's Hospital on the 21st. And that really goes to the relevance of her previous medical history.

Then the investigation into the care and treatment that Claire received on her presentation to the Children's Hospital on the 21st, up until her death on the 23rd. And in particular, in relation to the management and monitoring of fluid and sodium intake and output.

Then there is the investigation into the continuity, coordination and communication of care provided to Claire during admission and the investigation into the quality of the information provided to and received from Claire's next of kin from when she was in hospital in 1996 right until the period of her inquest in 2006.

Then finally there's the accuracy and quality of information provided by the treating clinicians to the hospital pathologists for post-mortem.

So those are the issues. And of course at the heart of the investigation, and not to be forgotten, is a little girl, Claire, who was just 8 years-old when she died in the Children's Hospital.

When I provided the general opening to these oral hearings, Mr Chairman, I said something about each of

the children who are the subject of this inquiry, but that was in February. And I should like to recall now some of those brief facts about Claire.

She was born on 10 January 1987. She was the youngest of three children and the only daughter and she is described by her father as:

"A little girl who had overcome her early setback and was happy, energetic and much loved. She attended school, loved adventure playgrounds and had an active and otherwise normal child's life."

Her parents, as you know, are represented by counsel and they are much better placed than I and perhaps it is more appropriate for them to convey something of Claire and the impact that her death, its manner and its aftermath has had on them and, indeed, the wider family.

So Mr Chairman, the written opening, I hope, is a comprehensive document, and I am grateful for the work of my juniors, in particular Jill Comerton. But the detailed treatment of the issues in that written opening, which I understand is now on the inquiry website, makes it unnecessary for me to provide an extensive oral opening on the clinical issues to be addressed. So I propose to base my comments on a document that we call the timeline that has been provided to try and draw together the main clinical

events and issues. It has already been provided to the interested parties and is published on the inquiry website, I understand, with other documents that have been compiled by the legal team, and to which I would also wish to refer.

I would like to call up that timeline. Reference 310-001-001. As I do so, I should like to thank my junior, David Reid, for his hard work on it.

(Pause).

MR FORTUNE: Sir, I do not have on my timeline, in red, "vomiting indicated by red diamonds". How many timelines are there?

MS ANYADIKE-DANES: There should only be one. I have one with red diamonds. Mr Fortune, do you have a red diamond at 2200 hours on 21 October, literally on the baseline?

MR FORTUNE: No, I do not. I have no red diamonds.

MR GREEN: Nor us.

THE CHAIRMAN: Does the one on your screen have red diamonds as opposed to the hard copy?

MR FORTUNE: I have no hard copy. I'm looking at a document on screen for the first time.

THE CHAIRMAN: Does it have red diamonds?

MR FORTUNE: On screen it does; on the hard copy, no, sir.

MS ANYADIKE-DANES: I'm not quite sure of the explanation

for that. Perhaps we'll provide you with a copy of what you see on screen by the break.

Can I take it that everybody has this document called "Claire Roberts timeline" on screen? And just so that we distinguish it from anything else, that everybody has red diamonds on it.

THE CHAIRMAN: For the record, the hard copy that I have does not have the red diamonds, so I suspect I am in the same position as the other people who have just indicated that fact to you. But the one I have on screen -- let's go by the one on screen because it'll be the one that, as of later today, will be the one that is referred to.

MS ANYADIKE-DANES: I apologise for that.

If I just explain how this document works. What it's intended to do is actually to bring together all the information that we had over the period of her admission until she is transferred to PICU, really. So if you look at the top you can see the clinicians and nurses showing when, in relation to those three days -- 21, 22 and 23 October -- they were either on duty or on call. So the dates and times on along the bottom and the relevant doctors and nurses at the top. The yellow or amber is used to identify those who were on call, whereas the blue is used to identify those who were on

duty.

To help you with that, there are some related documents. All those people are in a document called "List of persons". And the reference for that is 310-003-001. I will just call up very quickly the first page. There you are, you see how it works. They're in the categories of "Family", "Doctors", "Nurses", "Experts", and so forth. That's just the first page to give you an idea. The role is just a brief description. Then there is some information as to what statements they previously have made and what the references for those are and whether, at present, we propose to call them as a witness. That changes sometimes, depending on the evidence that we hear.

So in addition to that, there is a document called "The nomenclature", and in relation to doctors you see it at 300-003-048. If we call that up quickly so you see how that works. There you are. The significance of this is, of course, at the only ward round that we know of, which involved an examination of Claire, you have Dr Sands, who was registrar of about six months, Dr Stevenson, who was an SHO of about one year, and Dr Stewart, who was an SHO of about three months. And the purpose of this is to try and explain what those levels and grades mean.

There is an associated one for nurses at 303-004-051. There we are. A purpose of this is it would seem to be, although it's a matter to be entirely clarified, that the SCN Linsky, State-enrolled Nurse Linsky, was the nurse who accompanied the doctors on that ward round. So you can see there exactly what that means. She's a person trained in that way, is not quite as well trained as a registered nurse, and you can see the details that are set out there. And also, there was a staff nurse who was the ward sister or senior staff nurse, Andrea Pollock, and she seemed to be on duty throughout this and in charge of Allen Ward, but was not present, at least we don't believe so, during that ward round.

So these are the documents to try and help you see the detail of what is set out here. If we just bring back 310-001-001. Just that alone, Mr Chairman, goes to quite a fundamental issue in the case as to the position of Dr Steen, the consultant paediatrician.

If you look along the top there, you can see the period when it appears that she was on call, so that takes you up until 9 o'clock on the 22nd. So she was on call when Claire was admitted. Then you can see the blue when we believe she was actually on duty, so that's the day, really, of Tuesday. And then thereafter, she

doesn't appear to have been either on call or on duty, although she did attend, and there is an unknown consultant paediatrician who appears to be on call. That has been the subject of some correspondence to try and identify who that person was. We haven't been successful so far.

But in any event, Mr Chairman, the significance of all of that is that she was the consultant paediatrician, that is Dr Steen, in whose name Claire was admitted. It seems that Claire was admitted on to Allen Ward at 8 o'clock on the 21st, and she may not actually have seen her until Claire's collapse and transfer to PICU at about 4 o'clock on the morning of the 23rd.

THE CHAIRMAN: Can we just do Monday, Tuesday, Wednesday? Claire comes in on Monday evening, early evening.

MS ANYADIKE-DANES: Yes.

THE CHAIRMAN: She's in hospital overnight, she's there all day Tuesday and then she's transferred to PICU in the early hours of Wednesday morning?

MS ANYADIKE-DANES: That's correct.

THE CHAIRMAN: Instead of 21, 22, 23 -- which is entirely accurate -- let's talk about Monday evening, Tuesday and Wednesday morning.

MS ANYADIKE-DANES: Of course. We can probably amend that

by the time it's printed out to show that.

So then if one stays with who was involved. One can see that, if you look further down, you see:

"Examined by Dr Webb."

You see that at 1400 hours on the Tuesday. Then you see:

"Re-examined."

That happens at 1500 hours. And then you have:

"Re-examined again."

That's happening at 1700 hours. So within a fairly short compass of time, Dr Webb, the consultant paediatric neurologist is examining her. So there is a real issue as to who had the control and direction of Claire's care over the period of her admission. So that's why it has become relevant to identify exactly who was on duty and who was on call.

That's the personnel. Along the left axis is the fluid input. We do have the fluid balance chart, which literally shows you what was identified in terms of Solution No. 18 and the rate at which that was prescribed and when it was reduced. We also have compiled a schedule to try and show what her recorded sodium levels were as they are an issue.

If we go to 310-013-001. If you just think of the terms under the date as Monday, Tuesday and Wednesday,

you can see the times there when we think the blood was taken for the tests. You see when it was received, and then you see the result. This goes to another important issue, which is when her electrolytes were measured. As you can see, Mr Chairman, the bloods are taken for it in the late evening of her admission and received the midnight of her admission. But they're not taken again until very nearly 24 hours later, again in the late evening of the Tuesday, and you can see when they're received. And we will see on this timeline exactly what happened around that time. But you can see from the results that they come in at slightly below the normal range, and it would seem that the bloods were taken before the administration of any fluids. So that was the state of her sodium levels in her blood before any intravenous fluid had been administered.

Then, roughly 24 hours later, they are really way below at 121 and they stay way below until 1 o'clock in the afternoon of the Wednesday, which is past the critical point, if I can put it that way. Then they go into considerably above and in due course you will hear the expert evidence as to how those fluctuations from very low to very high can happen with somebody who is in the state and condition that Claire was at that stage.

So that is a document compiled. Then if we go to the right-hand axis, we see the Glasgow Coma Scale. That is to try and indicate where she was at those times. The record of her attacks are all recorded in her medical notes and records at 090-042-144. But we have also put together something to try and help us understand a little the Glasgow Coma Scale. One sees that at 310-011-001.

There we are. This is a bit of a complicated-looking document; I hope it won't be as one looks through it. Why there is the extra information is because, as Dr Webb has said in his evidence -- and one will hear from the experts -- one treats children slightly differently in terms of how you measure their GCS score. That is because sometimes the child may be too young to be able to respond in a way that an adult might and so you have to evaluate them slightly differently. So there's a modified score. And in fact, there were two, really.

If one looks down at the far left, you see what you are looking for under the adults and how you score that. And if you look under the Paediatric Glasgow Coma Scale down the left again, you see what you're looking for, and they're done under three categories: eye, verbal and motor. Then there's a score. So what you're really

looking for is the total at the bottom of it.

Across the top again we have the times, on what would be the Tuesday, where they were being recorded. They were being recorded roughly every hour, apart from 2 o'clock. That 2 pm or 1400 hours seems to have coincided with the time when Dr Webb was examining her and it may well be that is why there is no record in her chart for that. In any event, Dr Webb did his own estimate or evaluation of where he thought she was.

So you can see along the bottom, the numbers in the brackets are what Dr Webb he says he believes it should be if you make an adjustment for the fact that you are dealing with a child. That will be something upon which the experts will comment as to whether there's an appropriate adjustment, but in any event it is there simply to record it.

You can see that the first time they record her, at 1 o'clock on Tuesday afternoon, she is 9, or 10 if you go by Dr Webb's measurement. The experts will be able to say how they regard a score at that level, but their view is that that is a very serious level for a child to have reached. In fact, if you look and see how it's made up, it's really only with the benefit of the fact that she responds to localising pain that it gets as high as that, if you really see the marks that she has

on the other scales.

Then after that, she goes into 8, or 9, as the case may be and you can see she gradually deteriorates. There was a blip up, so it would appear, at 6 o'clock in the evening of the Tuesday, and then going up slightly again until 8. Then she goes down. And there will be evidence about exactly how to interpret that, but the consensus seems to be, blip or no blip, they were very low scores indeed and a matter of some concern, and of course one is looking at the contemporaneous evidence to try and see what was accounting for those scores. So that's how we can help with the Glasgow Coma Scale.

MR FORTUNE: Sir, forgive me for interrupting my learned friend. My learned friend referred to the first set of figures, "9" and, in brackets, "10". Are they scores of concern, bearing in mind they're in blue?

MS ANYADIKE-DANES: No, it's not supposed to be in blue. The only one that's supposed to be in a different colour is the "8 (9)", and the reason why that's in a different colour is because that is Dr Webb's estimate. All the others are supposed to be in the same colour along the bottom.

MR FORTUNE: Because the scores in blue have not been coloured over by yellow.

MS ANYADIKE-DANES: That's just a failure of technology, if I can put it that way.

MR FORTUNE: I'm sorry, sir, for interrupting.

MS ANYADIKE-DANES: I apologise for that.

So then if we've got the parameters, what's happening in the middle is really to try and draw attention to the information that we have in relation to Claire as to what happened from when she was admitted.

If we go then back to 310-001-001, we can see that, at 1900 hours on the Monday, she was admitted to A&E and she was examined by Dr Puthucheary. Then she comes to Allen Ward at 2000, 8 o'clock in the evening, and the medical note that records the examination that Dr O'Hare took is to be found at 090-022-050. And the points to recall there, when one sees it, is the reference to "viral illness" and "reassess after fluids".

She is admitted and, in fact, she is reassessed, re-examined by Dr O'Hare, and you can see that at midnight. By that time, she has had -- you can see, gradually going up, you see that blue line there, that's her Solution No. 18, and you can see that gradually going in. And the red diamonds that caused so much difficulty to identify, they are instances of vomiting being recorded. So you can see that's what's happened at 10 o'clock in the evening. She's admitted to

Allen Ward and, when re-examined by Dr O'Hare, she notes at 090-022-052 that she is "slightly more responsive", no meningism observed" and to "reassess in the morning". And of course, at that stage, Dr O'Hare has the serum sodium result of 132. And there will be issues, Mr Chairman, as to what more should have happened then, in particular whether at any stage Dr Steen should have been alerted to the fact that a child had just been admitted under her name.

And then as we carry on, you can see it from the blue above that you have, at 9 o'clock on the Tuesday morning, a little block until 1700 hours. That's a time when Dr Steen was on duty. We believe that she actually wasn't supposed to be in the hospital all that time. Her witness statement at 143/1, page 6, indicates that she was only really going to be in the hospital for the morning. That would take her up to 1300 hours, and then the rest of the time she was going to be at a clinic at Culpar Street.

THE CHAIRMAN: Cupar Street, isn't it?

MS ANYADIKE-DANES: Cupar Street. Sorry, that's my pronunciation. 310-012-001. For those who are not familiar with the territory, this is just to give you an idea of where we are talking about. Bottom left, that's the Royal. Up at the top at "A", there's Cupar Street

and the clinic.

If we go back to --

THE CHAIRMAN: In real terms, that's just down the Falls Road from the hospital. It's not far away at all. It wouldn't be a 10-minute drive.

MS ANYADIKE-DANES: Exactly, Mr Chairman.

If we go back to that timeline. That means -- well, she was supposed to be on duty. It's a serious issue to try and identify exactly where Dr Steen was. That's something that we hope that this oral hearing will achieve. But in any event, one thing we do know is that she doesn't appear, or at least we think we know it from the records that she doesn't appear to take the ward round. The ward round is taken by her registrar, Dr Andrew Sands, and you see that identified there.

So far as we can tell, he takes it, he's accompanied by SHOs, Dr Stevenson and Dr Stewart. And I identified for you earlier their level of experience. One year for Stevenson, we think, three months for Stewart. Stevenson appears to be the person who is taking the notes and recording the notes in her notes and records. It also seems that SCN Linsky accompanied them.

What was noted after that was:

"Non-fitting status."

Which is what Stevenson noted. And then thereafter,

that was amended. We had some assistance to produce a document to help with what "non-fitting status" was. I seem to have temporarily mislaid it. In any event, that is what was noted.

It would then appear, Mr Chairman, that Dr Sands discussed matters with Dr Webb because he was concerned about her, and added "encephalitis/encephalopathy", and the plan was to start with rectal diazepam in addition to other things. There will be an issue there, Mr Chairman, as to what should have happened exactly in terms of Dr Steen and the whole approach to their working diagnosis for Claire and what differential diagnoses they should have developed at that time. In any event, that is the ward round and what happens in its immediate aftermath.

Then Dr Webb comes to see Claire at 1400 hours, 2 o'clock in the afternoon. One can see that in the medical notes and records at 090-022-053. There is notation that she "appeared to improve following the rectal diazepam", "acute encephalopathy was most likely postictal in nature", and then he noted that there was no biochemistry profile or normal biochemistry profile and he started her on phenytoin and hourly obs and said that there would be a CT scan tomorrow if she didn't wake up.

Mr Chairman, firstly, those drugs, phenytoin, are set out in the glossary as to what they mean, the medical glossary. So too are the conditions such as encephalopathy and so forth, just to help people. It works in the same way as it did for Adam, but for those who weren't involved, the glossary is to be found at 310-007-001. If we call that up, I will give you an example. Right at the top, you can see "acyclovir", which is an antiviral drug prescribed for Claire. You can also see "antidiuretic hormone", which is an issue. You can see "ataxic", that appears in her notes as well. So does "cefotaxime sodium", or "Claforan" as it sometimes is written as, and also "Cheyne-Stokes respiration".

The main terms that you see in her notes and records and in the expert witnesses' reports and for that matter the clinicians' statements are all set out with an explanation in the glossary.

Thereafter we know, because it's recorded, that he examined or re-examines Claire, but that note, "I note normal biochemistry profile", which is what I think it has finally been interpreted to mean, that is an issue, Mr Chairman, that one has to consider because, arguably at that stage, nobody knew what Claire's biochemistry profile was. They knew what it was the previous evening

when they had a result, but they hadn't taken a more recent test and it would seem that Dr Webb was labouring under the impression that the result that had arrived the previous evening was actually a result from bloods taken that morning. So although it was a little low, he perhaps wasn't so concerned about it. He, I think, has expressed different views had he appreciated it was a result from the previous evening and that there had been no result taken during that day, so that is an issue as to how that could have arisen and what its effects might have been.

Then, on the re-examination, we see that Stevenson is noting that midazolam is administered. If one looks along the top, one can see the drugs that were administered to her. I will maybe turn to these at this stage. You see the rectal diazepam, you see when that was administered. If you drop to the line and the time you can see that. Then the next one, 635 milligrams of phenytoin administered. There is an issue over that. That would seem to be an error by Dr Stevenson. He should have recorded 422 milligrams. Then if we see along the way, the "12 milligrams or 120 milligrams of midazolam" being administered. That's another error on a number of fronts. 12 milligrams is, so the experts would suggest, quite a high dosage in any event, but

120 milligrams is a huge dosage. So there is an issue, how he could have calculated things and written down the figure of 120 milligrams and, for that matter, how nobody seemed to notice that that is what had been written down in her medical notes and records.

It's not entirely clear what was administered because the drug sheet isn't signed, and that is of itself an issue.

THE CHAIRMAN: But it's almost certainly not 120 milligrams which were administered.

MS ANYADIKE-DANES: You'd like to think that it wasn't that. There will be probably more to be taken up with that in governance, how that could have escaped everybody's attention that a junior SHO had made an error like that and how it didn't lead to some sort of a review and to some sort of discussion with him, particularly, as it doesn't appear to have been his only either calculation or recording error.

But in any event, if you go back again and you look at the timeline, you can see at the same time as this medication is being administered, you can see, if one looks at her Glasgow Coma Scale, whether you look at the red, which is the modified one, or you look at the green, which is the one as Dr Webb -- you can see what was happening there, the movement in that, which is

just to translate on to the chart the figures that I had shown you before in the schedule.

Then you can also look at the incidence of episodes, seizures, attacks -- I'm not meaning by any of those terms to be using them in a clinical way, just simply to identify that something was being recorded as happening. You can see how that correlates to other things that were going on. So for example, there's a seizure there indicated at 3 pm and you can see where the Glasgow Coma Scale is there, it's on a downward path. You can see that there is an episode of "teeth tightening slightly", "teeth clenching and groaning", and then by the time you get to where it's at 6 or 7, if it's on the green for Dr Webb, you can see that there is an "episode of screaming and drawing up of arms". She is then described as "sluggish". Then a nurse notes a slight tremor in her right hand that lasts a few seconds, and that is very close to when she goes into respiratory arrest. At that stage, or shortly thereafter, she is transferred to the paediatric intensive care unit and she never recovers.

So if you also look at the same time at the line for the Solution No. 18 and her fluids, which are gradually -- this is a line to show accumulation. The blue shows that, but by the time one gets to 2100 hours,

you can see that there is a slightly higher figure, and that extra amount is brought about by the -- what we think, although nobody's sure because it wasn't recorded -- the fluid that her IV medication was dissolved into. That produces the slightly higher amount.

The significance of that is that if you will see, just a little bit above there, she was being examined by Dr Stewart at 11.30 or thereabouts. Around that time her serum sodium level was 121. That's a very high figure. It would appear that Dr Stewart was sufficiently concerned about her. In fact, her medical note from that is worth bearing in mind. It's 090-022-056. Let's pull that up.

THE CHAIRMAN: I think you said, by mistake, a moment ago that the sodium result of 121 was a very high figure.

MS ANYADIKE-DANES: Sorry, I meant a very low figure.

This is Dr Stewart's note at 11.30 and you can see there, there is the sodium figure of 121. She's noting what the phenytoin levels were. That was something that because she was being administered with phenytoin, the doctors wanted to know what the levels were. In the brackets is what looks like the normal range of 10 to 20 and that was her level at the time, just slightly above that. But for the purposes of this inquiry, you see

that Dr Stewart is querying "hyponatraemia", "fluid overload" and "low-sodium fluids". Then she queries "SIADH", sodium [sic] of inappropriate diuretic hormone. Then she notes:

"Important: ? need to increase sodium content in fluids."

Then the second line looks like:

"D/W" [that I understand means 'discussion with'] the registrar [that would be Dr Bartholome]."

This seems to be her note from that discussion, indicating to reduce the fluids to two-thirds of the present value. And she calculates that as 41 ml per hour, and to send the urine for osmolarity. That's a pretty clear indication of what that junior doctor thought was going on 11.30 and one of the big issues in this is what could or might have happened at that time and what might its consequences have been?

We'll see, Mr Chairman, that she's contacting the senior registrar. There seems to be no indication that Dr Steen was contacted. Dr Steen, of course, would have not been on duty or on call at that time, if one looks back at 310-001-001. That's part of the matter, to try and find out actually who the consultant paediatrician would have been that Dr Bartholome might have contacted, or for that matter that Dr Stewart might have contacted

directly. And that's something else to try and identify.

I was taking you to those fluids and the gradual increase in them. If I take you --

THE CHAIRMAN: Sorry, just to pause for a moment. You have referred there to Dr Stewart and Dr Stevenson; isn't that right?

MS ANYADIKE-DANES: Yes.

THE CHAIRMAN: Neither of them gave evidence at the inquest.

MS ANYADIKE-DANES: I believe that's true, yes.

MR FORTUNE: And Dr Stewart is, in fact, male.

MS ANYADIKE-DANES: I beg your pardon.

If I can take you to 310-015-001. This has been compiled to try and see what actually was happening with her fluid input at around that time. As we know, at 11.30, Dr Stewart's view was that one should consider reducing it and that was Dr Bartholome's direction. There's no indication that Dr Bartholome actually attended, but that was her direction of the guidance she gave Dr Stewart. That was to be reduced to 41 ml an hour, and you know, Mr Chairman, that it was running in or prescribed to be running in at 64 ml an hour. So if we look here, and you see that's the Tuesday and that's the Wednesday, those are the times, then, you can see the Solution No. 18.

So at 10 o'clock on the Tuesday evening at 75; at 11 o'clock, just before this, it's 71. So those in and of themselves are slightly higher than what it was thought they should be running in at. And then you see they do indeed reduce. So by the time you get to midnight, it's 23. There's a zero for one. That is something that we would like to clarify, whether it truly is a zero or somebody just hasn't filled it in on the fluid balance chart. Then at 2 o'clock, it's 33. And then after that there are no records on the sheet. And I suspect that's because there was a respiratory arrest at roughly 2.30 in the morning and then it was a very serious situation, leading her to be transferred to PICU. So I don't think they were filling in that chart.

But if one's trying to get a measure of the total fluids she was getting, if you look along the IV medication -- because all this medication is dissolved so it adds fluid -- so the midazolam doesn't add very much, "2.2", "3", "2.9", and so on. Acyclovir doesn't add a lot, but the phenytoin does, that adds 110 actually. And if you look at the total fluids, so she's quite high for the 10 and 11, certainly higher than the 64 people might have thought she was getting, but over the period, at least over an hour when it would have

been thought that her fluids would have been reduced, she actually hits, at midnight, very nearly 136. It is reduced thereafter, but it will be a matter for the experts to help guide the inquiry as to what is the significance of the fact that although it had been recognised that what really needed to happen was her fluids should have been significantly reduced, that actually one way or another they weren't, for some period of time anyway.

Just while we're at the question of her medication, we did provide a schedule to try and help people on the medication. It's 310-006-001. If we can just pull that up. This is to try and show not only what it is -- let's start with the rectal diazepam, which is probably the easiest. It's a similar approach taken with all the medication. You have the time when it's both prescribed and administered, if we know it. We have the dosage, we have the clinician and nurse involved, the reference so you know where it comes from, witnesses' comments about what they thought they did or what was happening and then the experts' comments.

If one goes over the page, for example, to midazolam, 310-006-004, just by way of example. There we are. Then you can see the prescription. It's not entirely clear when it was prescribed. You can see the

administration. Then the 12-milligrams IV stat followed by 2.88 milligrams-an-hour infusion. Then you can see what -- well, it's recorded as 120 milligrams. It is not initialled as given, although the nursing record notes that the "stat IV Hypnovel", which is the same thing, was given at 3.25, so it's not entirely clear what was given, Mr Chairman. That's something that will have to be investigated during these oral hearings.

But in any event, you see the doctors who were involved. So that's Dr Webb there, directing, and it's Dr Stevenson who is calculating and prescribing and recording, if I can put it that way, and those are the references for it. You can see what the witnesses say about it. Then you can see the experts' comments. For example, at 237-002-014, you have the comment of Dr Aronson, and he states obviously how large it is, very large, what the effect of that would likely be and so forth.

And then he moves on at 237-002-016 to talk about the effects of the drugs, which have a cumulative effect; they are not all to be regarded in isolation from each other. Some of them have a longer tail in the system than others, some are given as boluses, some are given as an infusion. So we will see from his report exactly what he concludes as to the effect of all of

this on Claire as she progressed through the evening into the early morning of the next day.

Then if we go back to the timeline, just to complete that on the drugs, Mr Chairman, if you can see right down at the bottom, one has the IV midazolam infusion. It is done in that way because it happened over a particular period of time, not as boluses. And so you can see it was 2 ml an hour until 2130 and it was increased to 3 ml. And then you can see -- it's a bit small -- the acyclovir IV and the phenytoin IV.

There are some issues about even these drugs, leaving aside the calculation. If one thinks about the acyclovir, it's being directed by Dr Webb during his reexamination of Claire at 17.00, but it seems not to have been written up by Dr Stevenson until 21.30. So there's an issue as to why, if Dr Webb thought that was important for her to have, why she wasn't having it until that time.

The other issue, of course, is that acyclovir is antiviral and since that was one of the original thoughts about the diagnosis for Claire, there's going to be an issue as to why one pursued so long with simply anticonvulsants and didn't introduce the antivirals or the antibacterials for that period of time. And therefore there will be an issue as to what effect might

it have had if one had kept perhaps an open mind -- that may not be entirely the right expression -- but at least had a broader set of differential diagnosis and treated her in a broader spectrum as to what might have been the effect of having done that rather than focusing quite early and consistently on the anticonvulsant therapy.

THE CHAIRMAN: In other words, to put it simply, if you're not sure what is wrong with Claire, you don't treat her for one thing, you treat her for a number of alternatives.

MS ANYADIKE-DANES: That's right. In fact, Mr Chairman, shortly after that ward round, they had three working hypotheses or diagnoses. They had certainty had the non-fitting status epilepticus, and then did have encephalopathy and encephalitis. Also -- and this is an issue to be addressed during the oral hearing -- why didn't you work with all three and treat all three right from the beginning? So that's one of the matters to be explored. It brings into attention something else which I was addressing you about earlier to do with who actually had the control and direction over Claire's care.

It may be that if you had had the involvement of a consultant paediatrician -- I mean the active involvement -- who might have been able to bring

a broader range of differential diagnoses, it may have been that the treatment for Claire would have started off in a slightly different way. In fact, it started off focusing on the neurological aspects, not surprisingly because Dr Sands was worried about those, and he involved a neurological expert and so the neurological expert addressed the neurological issues. That is exactly a point, which is: who really was thinking in the round about Claire's care and treatment?

There are two consultants, as you know, Mr Chairman, who have been involved in the matter. One is, of course, Dr Steen, because she was a named consultant, and the other is Dr Webb, who came in to provide specialist advice. But there has been a tension over the extent to which each thought the other was really taking control of her treatment. We did prepare a schedule to try and assist because it changes a little bit over the statements. If one looks at 310-005-001, it was a very early question that we asked:

"Who was the consultant with responsibility for the management, care and treatment of Claire from approximately 2 o'clock on the Tuesday to the Wednesday?"

And we what we did was we went down and we looked. On the left-hand side is all the doctors whose

statements we interrogated. On the right-hand side, the far right, is the references, and in the middle is what they said about it all.

So for example, the registrar who admitted her said she didn't actually know who was on call on 21 October, and that the consultant in Allen Ward would have been responsible from 9 am on 22 October. Well, that consultant, perhaps not actually in Allen Ward, but the consultant who was on duty, that's Dr Steen. Then there's Dr Steen herself, what she has to say, and immediately after that is what Dr Webb says. So for example, one sees in her witness statement, first witness statement for the inquiry, 143/1, page 32, she says that:

"At approximately 1510 hours on 22 October 1996, the named paediatrician for this case remained [herself] with Dr Webb now managing Claire's neurological condition."

So one needs to explore exactly what that means. Dr Webb himself is of the view, and we see that in his first statement for the inquiry, that Dr Steen was the consultant responsible for Claire's care and treatment between her admission and her death. Then he says very clearly:

"The paediatric neurology team did not at any time

formally take over Claire's care."

I'm not sure that anybody says "formally". And he did not consider himself to have taken over Claire's care from Dr Steen and he was not asked to take over her care. That is his position. It's hard to be clearer than that.

Dr Sands says, in his first witness statement, he doesn't recall:

"[He's] not aware whether Claire's care had been formally taken over by Dr Webb/neurological team, and that such an agreement would usually be between consultants."

So we have to examine whether there is anything that turns on this word "formal". But he says he considered himself under the supervision of Dr Steen and Dr Webb and when Dr Webb saw and examined Claire, he regarded himself as partly under the supervision of Dr Webb and that, following Dr Webb's first attendance, he understood that Claire was being jointly cared for by the medical and neurological team.

THE CHAIRMAN: Of course, there could be nothing possibly wrong with the paediatric team asking the neurology team for some assistance because that is what you would expect to happen if the different specialties in the Children's Hospital worked together. But aren't we

rather short of any evidence of direct contact between Drs Steen and Webb until the Wednesday morning?

MS ANYADIKE-DANES: We are, that's the other thing. That may be affected by who they thought was actually in charge of matters. It gets a little more complicated still if you look at what Dr Sands says, three lines up from the bottom of that box:

"However, Dr Sands believed that by 17.15 [that's the Tuesday, Mr Chairman, so that's that last re-examination] that Dr Webb's team was primarily responsible for Claire's case as all of Claire's direct consultant care had been given by the paediatric neurologist on duty, but the medical team on Allen Ward were also assisting with that care."

So the inquiry's experts consider that it is most unfortunate that there should be any lack of clarity as to who was primarily in charge and who junior doctors and nurses should look to if they wanted consultant assistance and guidance. And particularly that that somehow was not clarified, if we go back to the timeline, at the end of Dr Webb's last re-examination, which would be 5 o'clock or so on the Tuesday, going into the evening, and that people should not know exactly who was the consultant with primary responsibility, directing primarily the treatment and

guiding those junior doctors. That's an issue to be explored in these oral hearings, particularly for Dr Steen, because she's then going to go off duty, not on call in that evening, and that that matter could be left in some way so that the junior doctors seem not to be entirely clear about it is an issue to be explored.

In fact, Mr Chairman, that whole issue of communication is something that is a recurring theme through the evidence that we have sought to put to you. It is not just the communication between the doctors and nurses, whether the nurses should have been alerting doctors more about the deterioration in Claire's case as they were observing her and recording her Glasgow Coma Scale, but also between the junior doctors and the more senior ones, the registrars, and also of the consultants, and then, of course, from the point of view of the family, the worst failing in communication is the communication with them.

As one sees this chart and sees exactly what was going on, it'll be, I'm sure, a matter that the family's counsel are going to deal with, but that they should have felt all that time that their daughter was not particularly seriously ill and that they could go home and did go home, and yet now we see all that flowed on and all the concerns when one looks at the witness

statements that the doctors had about her condition and about the potential for deterioration. That is a matter to be explored, not just in these oral hearings, Mr Chairman, but also those in governance when one deals from a slightly different direction with communication with the family.

THE CHAIRMAN: Just to put it on the record, Mr and Mrs Roberts have a major concern that when they went home at about 9.30 on the Tuesday evening, they had no idea at all that Claire was in real trouble.

MS ANYADIKE-DANES: That's right.

THE CHAIRMAN: And had they known that, of course, they wouldn't have gone home.

MS ANYADIKE-DANES: Well, I think, had you known your child was so ill, I think it's fair to say that you don't just leave them.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: I have found the document that I had wanted to pull up to try and explain some of these difficulties about differential diagnoses. If we can pull up 310-014-001. It's a highly stylised and simplistic diagram, I admit, but it's really done to try and demonstrate the interrelationships between these things with the hope that the experts can better explain the consequences of taking too narrow an approach when

you have a child coming in, whose presentation could actually result from any number of things.

If we start at the bottom, in the middle:

"Status epilepticus (non-convulsive/non-fitting)."

That was the first take that Dr Stevenson wrote in his note of the ward round at 11 o'clock. From this diagram, one can see that that can result from, to the left, encephalitis, with, for example, viral or bacterial encephalitis or meningitis. Then encephalopathy and that can result from toxins, metabolic disorders, infection, very high, acutely high temperatures. So it can be a thing on its own, but it can also be brought about by either of those things. And we know that by the time Dr Sands, some time after that ward round -- or at least so it appears, we don't know other than what's recorded, so it appears from the documents -- had spoken to Dr Webb, that he is the person who then had those two, encephalopathy and encephalitis, added to the note. So that is where they were starting off in the note in the midday, let's say, on the Tuesday.

As one looks at that, Mr Chairman, the experts of the inquiry have posed the question:

"If you had identified encephalopathy as something that could be responsible for Claire's condition and if

you know that encephalopathy can be produced by toxins, poisoning, a metabolic disorder, what were the tests that were carried out to eliminate that? What was the full blood screen that was ordered and reviewed to satisfy yourself that the child didn't actually have any toxins in her system, or for that matter have a metabolic disorder?"

And that is a matter that will be explored. But that's the sort of thing that is at issue here.

Then if one sees, on the far left, the encephalitis. If you think that's what's happening, then what was the treatment that was being considered and administered, if you thought it was encephalitis, and if you know that encephalitis can be produced by viral or bacterial infection? Because looking at that timeline, one sees that the medication for viral or bacterial infection doesn't actually start until some time later on, towards the close of play of the Tuesday. Then those conditions lead up to brain swelling, which, as it progresses, can lead to cerebral oedema. And then to complicate matters more, the brain swelling itself can produce, as an incidence of it, SIADH, and that is something that Dr Stewart had identified at 11.30 on the Tuesday.

That can lead to the retention of free water and if you, at the same time, are administering hypotonic

fluids, for example Solution No. 18, as you may recall from the case of Adam and the evidence given by Dr Haynes, Dr Coulthard and Professor Gross, that also can lead to the retention of free water. And why is that important? Because the sodium levels are being diluted in the body and one reaches the hyponatraemia, and the hyponatraemia in itself can lead to and exacerbate cerebral oedema. So there's a bit of a vicious cycle going on there.

That is a simple flow chart to try and indicate that, if you started off with those differential diagnoses, then one wishes to see during this oral hearing how people were actually addressing that and whether they were doing that in a timely fashion and whether, if they had had the benefit of an experienced general paediatrician, they might have been more likely to keep in mind the treatment for these other diagnoses.

Then just finally to say, Mr Chairman, Claire's condition ultimately deteriorated so far that she coned, which is something that we have heard about in the case of Adam Strain, and ultimately ventilatory support was withdrawn from her and she died. There are many issues surrounding whether she was an appropriate case to have been referred to the coroner; the information that was included on her death certificate; even if she wasn't

going to be a case to be referred to the coroner, whether she should have had the benefit of a full post-mortem to understand what was happening. And there is much evidence from the clinicians, particularly Dr Steen, as to why it was that she discussed matters with the family in terms of a brain-only post-mortem. And that will be explored having regard to what is in her medical notes and records as to what people thought might have been happening.

All that leads to a slight difference amongst the experts and the clinicians as to the cause of her death. I have set it out in the opening, I don't propose to go through it, but there is a little handy reckoner, if I can put it that way, for people to look at. Not necessarily to be pulled up, but one can find that at 310-009-001. Maybe pull up the first page so you can see. That sets out under "Cause and death and reasoning" along the left-hand side, the experts, their views. Of course, Professor Harding has given us some additional views for us.

Going over to the next page, there we start to see the inquiry experts, and it's very simple. It's set up just to put what they thought what the cause of death is and the explanation for it as we have distilled it from their statements and their reports. So that is how that

works. But it would seem that just about everybody has had hyponatraemia featuring to some degree, and ultimately the hospital did, which is why the case is here, from their point of view.

One final document that I don't think I did mention is the chronology of events. I think I did mention the chronology. If I didn't mention it, I apologise. It's at 310-004-001, and it literally goes from the Friday the 18th, which is the earliest record that we have relevant to her admission, right through to the end page, which is on 023, 1900 hours, the discussion that is recorded in relation to whether there would or would not be a need for an inquest. So it follows the same scheme as the reference and the events and the source of those comments.

So Mr Chairman, I hope I haven't taken it through too quickly, but it is in some detail in the written opening and, really, what I was trying to do is to help people see the landscape, if I can put it that way, of the areas that we will be covering, why we are, how they arise and where are some of the compiled documents that can help them see the information that we have distilled from the evidence we have received.

I should say, though, I am not entirely sure that we have received all the evidence that we may ultimately

receive in relation to Claire, but we will try and deal with that as it comes in.

THE CHAIRMAN: Well, let's tease that point out. That is, at least in some way, because, although Claire died in 1996, there was no inquest. Mr and Mrs Roberts have said in their statements that they were left unhappy and unclear about why Claire died and that it was only when they contacted the Royal after the Ulster Television documentary in about November 2004 that Claire's case was re-opened -- or in Mr and Mrs Roberts' eyes, perhaps not re-opened, but perhaps maybe looked into properly for the first time -- and at that time there was a reference to the coroner and then an inquest. So there are eight years from 1996 to 2004 when documents could be, as it happened, mislaid, as documents inevitably are in big organisations, and it becomes harder to piece everything together if there's a delay of eight years.

MS ANYADIKE-DANES: Yes, Mr Chairman, that's the case.

THE CHAIRMAN: With the best will in the world, it is very difficult to put together documents eight years after an event.

MS ANYADIKE-DANES: That is so.

THE CHAIRMAN: Okay. Thank you very much, Ms Anyadike-Danes.

As everyone here will understand, the long,

comprehensive inquiry team opening was circulated last week so that this morning Ms Anyadike-Danes could focus on some specific points and highlight some general areas. I am grateful to her for doing that. We will take a break now for 15 minutes and then, Mr Quinn, you and Mr McCrea will open on behalf of the Roberts family. Thank you.

(11.30 am)

(A short break)

(12.08 pm)

THE CHAIRMAN: Sorry to have kept you waiting for a few minutes. I understand there have been some discussions going on about various issues. Mr Quinn.

Opening by MR QUINN

MR QUINN: Yes, Mr Chairman.

First of all, I want to thank Ms Anyadike-Danes for a very thorough, well-organised opening, that opened the issues in a logical and concise way dealing with the clinical issues, the science of the treatment, the very important issue of the fluid and the detailed analysis of the precise treatment that Claire had when she was in hospital between 21 and 23 October 1996.

I would like to deal more with the human side of the matters involved and put the concerns raised by the family. What I want to do is tell the inquiry about the

family's evidence, really to get their story before the inquiry and deal with general issues. The issues that we want to deal with, that the Roberts family want to deal with, are issues that the general public would be concerned about. They are approached, we hope from a commonsense point of view, as a layman would approach the huge wealth of material that has been generated in relation to Claire's treatment, her death and the aftermath of her death. What we want to do is highlight certain issues that can be teased out, mostly without recourse to a battery of experts, the science of it -- and we will leave all of these elements of the science to the experts called by the inquiry. The family are very aware, fully aware, that the governance issues will be dealt with in a separate issue, but make the point that it is often difficult to separate the two issues.

Doing the best we can, we have dealt mostly with the general issues and how they affect Claire, her family and, most importantly, how they will affect other children who find themselves in a similar position it Claire and her family. The family trust the inquiry legal team and the chairman to explore all of the relevant points and to deal comprehensively with all of the clinical and scientific issues.

THE CHAIRMAN: Can I just say, Mr Quinn, that I share your

view that the clinical issues and governance overlap. It has been a recurring problem for our experts to distinguish -- there are some issues which are specifically easily identifiable as clinical, there are other areas which might be easily identified as governance, but there's a big grey area in between and it's clear from the expert reports that one leads into the other. That's why some of the reports end up covering both.

MR QUINN: So forgive us if we do stray into governance on some issues that we are going to cover this morning. Mr McCrea of counsel, who is assisting me with this matter, has prepared a brief statement dealing concisely with how the issues have affected Mr and Mrs Roberts and the immediate family circle. I intend to deal with more general issues and highlight those matters the family think require further investigation and, hopefully, when all of the evidence has been heard and evaluated, the inquiry can provide some answers.

I want to give a background for the family and for Claire. Claire was born on 10 January 1987 and died on 23 October 1996. Her birth was joyous for the family; her death was totally avoidable and a disaster for the family. We know the death was avoidable, we know she was failed by the medical profession and the system

in the Royal Belfast Hospital for Sick Children.

We know this because all of the experts' reports that we've read have told us so. I know this because, for the past year or so, the parents have been telling me precisely how she was failed by the Children's Hospital and they want to get this across this morning. Her father and mother have been fighting a long and desperate fight to get to the truth and, hopefully, the truth will not be denied to them again. The truth was denied on a number of occasions. We will briefly state that. When Claire died in October 1996, were the family told that she died of an overload of fluid? No. Where the family told that they should have an inquest into her death? No. Was hyponatraemia ever mentioned to the family? Again no. Did they get to the truth? Obviously, that's a no. Were they treated fairly and with respect? They say not. The truth only came out when Mr and Mrs Roberts watched a film documentary on hyponatraemia-related deaths that was shown as part of the Insight programme on Ulster Television on 21 October 2004. This was just two days short of the 8th anniversary of Claire's death. It was only after that programme was broadcast that the parents followed up with the hospital staff and an inquest was held in 2006, ten years after Claire died.

They behaved like any responsible, respectful and grieving parents would behave: they trusted the staff at the Children's Hospital, they trusted that the system would not let them down and they placed their faith in the medical profession. You will hear from Mr and Mrs Roberts, who will give evidence before this inquiry -- they're scheduled for the second week -- and they will tell you, Mr Chairman, how precisely they were treated. They will tell you how a catalogue of errors caused a catastrophe that put them into an enormous, cavernous hole of grief, a grief that could not give closure because of the constant niggling doubt that they still have in their minds in relation to Claire's death. Not only her death, but the aftermath of her death.

The information they were given by doctors in the weeks and months immediately after her death and, to make things worse, the information they got after the UTV programme was shown and the evidence given by the doctors at the inquest before Her Majesty's Coroner in Belfast. They attended that inquest and they will give evidence about what they heard at the inquest.

This was an inquest that was delayed by 10 years and which still produced no closure for Mr and Mrs Roberts and the extended family. They are now relieved that they will get a chance to speak, that they will get fair

and balanced forum to express their views and that their views are now supported by proper documentary discovery and that an abundance or a plethora of experts who will give evidence on each and every medical discipline that requires proper investigation and expert opinion.

But let's look at the background and what occurred. Her birth on 10 January 1987 was a dream come true for the family. They had a beautiful little girl to complement the family after having two sons, who were Stuart, who was nearly two, and Gareth, who was four. She was a much loved daughter of her parents and granddaughter of grandparents, Billy and Lily Roberts and Margaret and Alister Magill. She had a special character. She had an impact on everyone who knew her and she was a happy, loving, vibrant and active child. She enjoyed all sorts of outdoor activities, running about adventure playgrounds. She would tackle any leisure activity or adventure activity that her brothers encouraged her into. To give you a flavour of her attitude to life and also her ability, as opposed to what has been alleged to be her disability, she could climb a slide and use a slide without assistance, she could play with her family on a see-saw, she could bounce very ably on a trampoline and ride her motorised bicycle with full coordination on the steering. She

could also go out for meals with her family and behave as a normal child. I say this because, later in this address, you will hear that the family do not want her described as a disabled child.

She could also go out for meals with her family and behave as a normal child. As the only girl on the Roberts side of the family, she was the centre of attention. She loved her grandparents, she loved and enjoyed visiting them and they love spending time with her. She had a wide-ranging circle of family and friends, her brothers and cousins -- seven in total -- and very many close friends.

Clearly, her death had a devastating effect on her parents, siblings and the entire extended family and friendship group. Of course, the sense of loss has been exacerbated by the lengthy and protracted process that her parents and family have had to go through in their attempt to establish the truth and get to the bottom of what caused her death and, perhaps just as importantly, to discover why they had to jump through a great number of hoops to get to this stage.

Why could they not get at the truth? In fact, the recent revelations about the Hillsborough tragedy, where 96 Liverpool supporters died in a football stadium Sheffield, brought it home to the Roberts family. They

understand and empathise with those families in England who may also now have sort of some closure on the life and death of a family member. They are looking for closure. The families touched by the Hillsborough disaster are looking for closure. The Roberts family are looking for closure. The family, particularly the two boys, can relate to this disaster and they fully understand why the people involved in the Hillsborough tragedy want to remember, but still need closure.

Anyway, I digress because I want to tell the inquiry about Claire. One of the important issues is that, at the age of six months, Claire did have a setback in her childhood when she suffered from seizures. This condition was a bit of a mystery and it would seem that there was never a positive cause established to explain this condition. The seizures were assessed, monitored and controlled with medication and she was on Epilim to control her condition. Over the next 12 months, Claire had fewer and fewer seizures, her medication was reduced. She was in the Ulster Hospital for a while as a baby. She then was in the Royal Victoria Hospital in or around September 1987. The parents' recall of this -- and I stress this is their recall of it -- is that from in and around July to September 1987, Claire was stabilised. The seizures were concentrated within

this three-month period. Eventually, she was tapered off Epilim. She was gradually tapered down and was off Epilim for at least 18 months prior to admission to the Children's Hospital in October 1996. She had been seizure-free for over 4 years before admission and had only had one or two seizures after her condition was controlled at around 18 months after birth. Her parents will say that she had one or two convulsions between 18 months perhaps and four years old and thereafter she had none, four years old being the cut-off point. The last recorded seizure that was witnessed by anyone was when she had a seizure in September 1991 when she was at school. The family also want to make it clear that these seizures were not what you would think typical of an epileptic-type seizure, in that she didn't lock her muscles or go into any type of spasm. Instead, she seemed to go into a trance-like state and her muscles went rather floppy. There was no locking or stiffening and there certainly was no spasm of muscles. She certainly didn't have any convulsions or seizures in the period immediately before the admission to hospital in October 1996. So any medical record or note -- and I stress this -- any medical record or note that records that she did have a seizure or convulsion before admission is totally wrong. I make this point because

Mrs Jennifer Roberts witnessed the seizure at 3.25 on 22 October 1996 and this will become a very relevant point during the course of this inquiry. I will also go back to it during this address.

Mrs Roberts will say that the seizure that Claire had at 3.25 on 22nd was different from anything that she had witnessed before. When she had a seizure in the Children's Hospital at 3.25, it was more like an epileptic-type of seizure, or what Mrs Roberts would consider to be an epileptic-type of seizure, in that there was a stiffening and distorting of the body. It was a more intense type of locking and stiffening.

To finish the story of Claire's development, you will hear from her parents that although they didn't have any seizures for a number of years before admission and she was off all medication for at least 18 months prior to admission, this early infancy setback did result in Claire having a learning difficulty. She was not mentally handicapped. I stress that the family want me to ensure that the inquiry is aware that Claire was not mentally handicapped. Somehow, this is another error in the notes that is totally wrong according to the family.

Another indication of how Claire was failed: her parents will tell you that her learning difficulty will

have been moderate. She was delayed in her milestones in that she walked and talked late and she was a slow learner. She attended school, first of all, at Castlereagh Primary. Therefore, she was in mainstream schooling during her nursery period. She then went to Longstone Primary and then to Torbank where her needs were better catered for.

THE CHAIRMAN: When you are saying this, are Mr and Mrs Roberts distinguishing between their daughter, who had a learning difficulty which was comparatively mild but far short of what anyone would regard as mentally handicapped? Is this a question of degree?

MR QUINN: Yes, it's a question of degree.

THE CHAIRMAN: But they say there's a huge degree of difference between having a learning difficulty and being mentally handicapped.

MR QUINN: Yes, they say that. And I'll explain more as we go through this address.

So the admission to hospital. Claire was admitted to the Royal Belfast Hospital for Sick Children on the evening of 21 October 1996. She came in through the A&E department and they refer to document number 090-012-014, which is the A&E note. This was a Monday evening at around 7. The history was that she had been unwell from around lunchtime on Monday 21st, but it is

worth noting that she had been at school at Torbank Primary School. She had attended swimming lessons. We know this from her homework diary and the note reads that she went swimming, she had a light lunch -- she had a sausage -- and then the teacher noted that she was lethargic. There is no note about vomiting or diarrhoea. When she came home, she was able to speak to her gran on the telephone and told her gran that she wasn't feeling well. She vomited a few times and, when Mr Roberts came home from work, her parents decided to phone the doctor. At 6 pm, the general practitioner called at the home and advised that she should go to hospital. So the evidence from her parents will be that Claire was ill for around 5 or 6 hours before she attended hospital and this seems to be supported by the A&E note, which I'll refer to later. I will come to this later when I ask you to look at the autopsy request form, which is document 090-054-183.

The doctor in A&E examined Claire and informed the parents that she had a viral illness, or so she thought. The parents were concerned about other serious illnesses and, in fact, they asked about illnesses, as any parents would, such as meningitis, and they were told that Claire didn't have meningitis. The parents thought she was suffering from a tummy bug. The doctor in A&E

reassured them and said that there was no neck stiffness, no rash or temperature, and that therefore was unlikely to be meningitis going through the symptoms, as it were, for meningitis. The doctor in A&E advised that, as Claire was continuing to vomit, she would be admitted for overnight observation. Everything seemed normal. Claire was not exhibiting any signs of a severe illness and her parents continued to assume that she had a tummy bug.

Mr and Mrs Roberts stayed with Claire until about 10 pm that evening. She was settled for the night, she was asleep when they left hospital, there were no concerns expressed by any of the medical staff on duty. They expected Claire to have an uneventful night.

The Roberts came back to hospital at around 9 am on Tuesday the 22nd. They recall that they were advised by the nursing staff that Claire was much more alert and had had a comfortable night. But when she saw Claire in bed, they both expressed concern to the nursing staff that Claire did not appear to be herself. She was pale, lethargic and was not responsive as she normally would have been. I make this point because on this disabled child/learning difficulty thing, the parents will make the point throughout this hearing that Claire was a responsive child. She was not mentally handicapped,

she had learning difficulties. She was normally bright and energetic, a child that would interact with both children and adults without any hint of shyness. The parents now express some concerns about the information they got at the Royal Victoria Hospital in relation to how comfortable Claire was because, when one looks at the notes and particularly looks at the timeline that my learned friend put up on the screen earlier, we can see that, in fact, Claire vomited a numbered of times, the timeline identifies it as six diamonds during the note. So to advise the parents that Claire had a comfortable night was clearly wrong.

They recall that they were there when the ward round commenced at around 11. They were present when the ward round reached Claire's bed and they had a conversation with the doctor carrying out and supervising the round, who they now believe from the ward notes to be Dr Sands. This was a short conversation, no more than five -- perhaps ten minutes at most -- and they confirm that this was the only communication that either parent had with Dr Sands through Tuesday, 22 October. The parents expressed their concern to Dr Sands in that they had expected to see improvement in Claire's condition from the previous evening and were very concerned that there was no improvement. In fact, she seemed to have got

worse. She seemed more lethargic than she was the day before and she was certainly off colour. She was not her usual energetic itself. She demonstrated very little movement and her parents would comment -- they said to each other -- that she just couldn't be bothered.

During the discussion with Dr Sands, he seemed -- that is Dr Sands -- to be gathering information about Claire's character and her past history. The parents stressed that this behaviour was very unlike Claire as she was usually very active, alert and bright. The parents recall that they explained to Dr Sands that Claire had early infant seizures, but that she had no seizures for perhaps four years and was off all anti-epileptic medicine for nearly two years. That is their clear recollection of their instructions to Dr Sands. The extent of this conversation with Dr Sands was minimal and the parents were not really concerned about Claire's well-being. There were no alarm bells ringing in their head. Dr Sands advised the parents that he thought Claire had a viral illness and that she may be experiencing some type of internal fitting. They felt that she would be over this in a matter of days. They clearly recall the words "internal fitting" being used. At that time, their understanding was -- and they

discussed this among themselves -- that the viral illness that Dr Sands was referring to was nothing more than a stomach bug.

The parents discussed Claire's approaching puberty as a possible cause because Mrs Roberts had been to a series of talks at the school advising the parents about this possibility and the parents certainly discussed it at the time. I stress the parents were not concerned about Claire's condition. The internal fitting was not discussed or explained in any detail by Dr Sands and both parents assumed that it was not serious and that it related to the tummy bug. They recall Dr Sands advising them that he would speak to another doctor and Dr Sands didn't express any concerns regarding Claire's condition during the ward round. Most importantly, "non-fitting status" or "non-convulsive status epilepticus", entries that now appear in the notes at 096-025-257, entries we are going to hear a lot about during this inquiry, was not raised.

This entry or diagnosis was not mentioned or discussed with the parents by Dr Sands when he spoke to them during the ward round. Nor were the parents informed that there was any possibility -- any possibility -- of infection in the brain or encephalitis. Neither did Dr Sands discuss with or

inform the parents of any medication that he was going to recommend, the type of medication, the dose of medication, or any effect that it would have on Claire. They were certainly not informed during this ward round or throughout any time on the 22nd by Dr Sands or any other doctor or nurse in attendance that Claire was being treated for a possible virus of the brain or encephalitis.

Their understanding throughout Tuesday the 22nd was that Claire had a tummy bug. That was the height of the information they received. Dr Sands did not inform or discuss with the parents that he had added "encephalitis/encephalopathy" to the ward round note or that he thought it likely that Claire was admitted to hospital with meningoencephalitis. The parents never heard these words spoken by the medical staff. I use the word "added" very carefully in relation to this note as we can see the different writing and what looks to be a different pen and we know what Dr Sands has said about this. If that could be brought up, 096-025-257.

We can see there, Mr Chairman, it's page 53 of the medical notes, about ten lines down, "non-fitting status". And then the different pen, and it looks like different writing at the end of that line.

We can see the different writing and what looks like

a different pen. The family await with interest to hear from the staff of the Children's Hospital in relation to their records and how this came to appear in the records, and most importantly, when it appeared. All four of Claire's grandparents visited the ward at around 1 pm. They stayed with her while Mr and Mrs Roberts went to Belfast to pick up some personal items for Claire, have lunch, and thereafter returned to the hospital shortly after 2.

Mr Roberts left the hospital at about 2.45 to collect their sons from school and, when he returned to hospital with the two boys at around 6.30, he was informed at that stage by his wife that Claire had a seizure around 3.30. That's what she told Mr Roberts at that time. Claire was sleeping when the family arrived back.

Let's go back a stage and look at the period over lunchtime of 22 October. The grandparents informed the Roberts that a doctor had been to see Claire and they now believe this doctor was Dr Webb. The grandparents were relieved that Dr Webb informed them that any serious illness such as meningitis had been ruled out. Of course, grandparents, being of that generation, see meningitis as the great killer of their time, and they were extremely relieved to hear that this had been

excluded from the diagnosis.

Mrs Roberts also recalled that her mother, Margaret, told her that Dr Webb had handed Claire a pen to try and evoke some interest in her. He was told that he should give her a piece of paper and she was given a piece of packaging paper off one of the medical packages, which she did respond to. The grandparents recall this incident as Claire took her grandad Billy's hand and pulled herself up on the bed. It is therefore clear that she was awake and alert between 1 and 2 pm on Tuesday the 22nd, and was responsive -- and I stress "responsive" -- at that time. What is now important at this stage is that Mrs Roberts clearly recalls that, at 3.25, she was with Claire when she had a seizure.

She clearly recalls this, as she informed one of the nursing staff, who asked her to note the seizure on the hospital record sheet. Her clear recall is that she would never have touched the notes, any of the notes, without the nurse specifically telling her and instructing her that she could do so. That is why she put an entry into the record sheet. And it is clearly recorded on that sheet and I want this to be brought up, if I may, Mr Chairman, at 090-042-144.

What we see there is the first line. It's dated "22/10, 3.10" at the very top of the page. If that

could be highlighted. What Mrs Roberts will say is that all of that piece inside the yellow, apart from the two columns, the date and the time, is in her hand. So she wrote:

"Lasted frequently strong seizure at 3.25."

She wrote that. And she wrote:

"Duration 5 minutes, sleepy."

And signed it "mum". So that is her writing.

Mrs Roberts was concerned about this seizure as it was unlike any seizure that Claire had ever suffered before, and I repeat, as I previously described, the seizure was a type of stiffening and distorting of the body and there was a more intense locking reaction of the muscles. It was not like the seizures she had had on a regular basis up until about 12 months old. In fact, Mrs Roberts makes the point that she went to a nurse because she hadn't seen this type of seizure activity before. That's why she decided to highlight it and stress it.

Also, it lasted much longer than the previous seizures and she recorded the five minutes. Claire slept after the seizure. This seizure definitely occurred at 3.25 on the 22nd and it is important that this evidence is absolutely clear and certain.

We're going to hear evidence about what drugs were

administered around that time and this issue will become crucially important because of the administration of those drugs.

At about 4.15 pm, Mrs Roberts went to the hospital shop for a coffee and when she returned at about 4.30, she was informed by another parent at another bed that a doctor had been to see Claire. At around 5 pm, Dr Webb arrived on the ward. Mrs Roberts had not seen him before and she had discussions with Dr Webb. In a brief conversation lasting no more than around 10 minutes, during which she gave Dr Webb a general overview of Claire's history and health and expressed serious concerns that Claire had a seizure at 3.25 that afternoon.

On witness statement WS138/1 at page 20. Dr Webb states, at the top of the page:

"Following my discussions with Claire's mother, I felt it more certain that Claire had experienced focal seizures affecting her right side on the day of admission to hospital."

This is another serious fault in the record keeping. She did not have a seizure on the day of her admission to hospital. She had a seizure the day after she was admitted to hospital. She had a seizure on the day that Dr Webb came to see Mrs Roberts, that day. She had

a seizure at 3.25 on the 22nd according to Mrs Roberts' own handwritten record. We can see from the record that it is timed precisely at 3.25. Mrs Roberts is absolutely clear that she did not inform Dr Webb that Claire had experienced any type of seizure or seizure activity on the day of admission and that she was under the supervision of adults during Monday the 21st. She was at school. There was no indication that she had any seizure and where this information came from is a total mystery to the family.

Claire had no seizures at school, she had no seizures whilst returning from school, she had no seizures at home on the 21st, and it is contrary to what Dr Webb states in his witness statement at page 66 that she had any seizures the day before. For clarity, I refer to questions 45 and 45B on this point.

Mrs Roberts does not agree with his witness statement. She never provided this information and has no idea how Dr Webb came to hold this view, which she will say is clearly wrong. There are further mistakes in the factual history and I would like to run through those.

There is no history of diarrhoea or any continuous bowel movement. Mrs Roberts told Dr Webb that Claire had "smelly poo", but there was no sign or no indication

of any diarrhoea. It is clear that the issues surrounding the bowel movements have been exaggerated, but it would seem clear that Mrs Roberts had got it right, referring to the A&E note wherein it states:

"No diarrhoea."

So when she went to A&E, it is clear that they recorded at A&E that there was no diarrhoea.

Somehow or other, Dr Webb in his witness statement states that Claire's symptoms had included loose bowel motions and vomiting over the two days prior to admission. There were no loose bowel movements. There was no vomiting for two days. She vomited for five or six hours before admission.

Claire was at church on Sunday, school on Monday. We know this. Her parents were with her at church, she was fully supervised at school. We know from the notes in her homework diary what happened at school, so we have a record of this. Her parents certainly wouldn't have taken her to church on Sunday if she was ill and they never would have sent her to school on Monday if she was ill. This mistake about diarrhoea and vomiting is repeated throughout the case history. It appears in the autopsy request form, 090-054-183, where Dr Steen also records:

"She had a few loose stools and then, 4 hours prior

to admission, started to vomit."

That is wrong. The autopsy report, 090-054-193, also carries this information. And if you look at the first three lines of the clinical summary, which starts off, "She was well until 72 hours before admission", that would seem to infer that she was ill for three days before admission. That's wrong. It's totally and absolutely wrong:

"She had visited her cousin [it goes on to say] who had vomiting and diarrhoea. She had similar symptoms and, 24 hours prior to admission, started to vomit."

Again, totally wrong. Her cousin had a tummy bug, but there was though mention of vomiting or diarrhoea. She was not ill until the day of admission. There was no suggestion that she was ill for 72 hours before admission. None whatsoever. Once again, this gives the wrong impression in relation to a viral infection, and I stress, this gives the wrong impression in relation to a viral infection of the brain.

She did not have symptoms of vomiting and diarrhoea. She had no diarrhoea at all and I refer for proof of this to the A&E note. The admission note carries that clear record. She didn't have similar symptoms to her cousin and she certainly was not vomiting for 24 hours prior to admission. She was vomiting for 5 or 6 hours

before admission.

While we are on this point of the autopsy report which we have before us, let's look at the drugs that are reported, although I will come to this point later. It states four lines down:

"She was treated with rectal diazepam, intravenous phenytoin and intravenous valproate."

She also had acyclovir and cefotaxime. There is no mention of the drug midazolam. Now, why not? She actually had so much midazolam that she had an overdose, and I will deal with this in an moment. This has already been mentioned in the opening by Ms Anyadike-Danes, but I feel that we have to stress it in our opening.

This point in relation to loose bowel movements, diarrhoea, is repeated throughout the case and, in fact, the parents received a letter from Dr Webb, dated 21 March 1997, 090-001-001. If that could be pulled up, please. It summarises the post-mortem results and in that letter it refers to the clinical history. Three lines from the bottom:

"The clinical history of diarrhoea and vomiting would be in keeping with that."

There was no clinical history of diarrhoea and vomiting. This, of course, is because a viral cause has

been given for the brain swelling. And Mr and Mrs Roberts will say that this was something that was pushed by the medical staff throughout the investigation into Claire's death.

So there was no vomiting over two days prior to admission or, as one report says, 72 hours, three days. There was vomiting for five or six hours prior to admission. Let's go on to the last paragraph to make it absolutely clear. Mrs Roberts will say she discussed with Dr Webb Claire's medical history. She recalls discussing Epilim, but she has no recollection whatsoever of him discussing with her any type of medication that he had given or proposed to give to Claire, such as phenytoin, midazolam or sodium valproate. Nor did Dr Webb express any concerns regarding Claire's clinical condition to Mrs Roberts, nothing such as encephalitis, meningoencephalitis, or non-convulsive status. None of these were mentioned. There was certainly no mention -- and I stress at this point -- of hyponatraemia or of any fluid problems.

The parents will say that Mr Roberts arrived back at about 6.30 with the boys. Mrs Roberts told Mr Roberts about the seizure that afternoon, she told him a doctor had been at around 5 and that he prescribed medication, but she had no idea what was given and she had never

been told.

The nursing care from about 6.30 to 9.30 from the notes and all that we have before us, was general and without alarm or concern. That is also the recollection of the parents. They say nothing of any concern was raised with them at all. The nursing staff did not discuss or mention any sort of condition that would give the parents any concern. There was no mention of any of those conditions that now appear in the medical records. There was no meaningful contact with staff and Claire slept that evening. We now, of course, realise that she was probably unconscious. There was no suggestion or information given to the parents that there was any possibility at that stage of any infection in the brain or encephalitis. Nothing was given to them. In fact, they recall leaving the hospital at 9.30 without any concern at all. And this is a point you raised, Mr Chairman: no parent would go and leave the hospital if there was any concern. They went to the nurses' station to report Claire was settled and that they would return next morning, and their only concern -- Mrs Roberts raised this -- was that the sides of the bed were secure in case Claire would waken up and try to get out of bed. The staff didn't raise any concerns whatsoever and the parents went home thinking she would

be released from hospital within a day or two.

The Roberts family were not worried at all. They were taking the boys home to finish their homework and get ready for school the next morning. At 3.45 am on Wednesday the 23rd, Mr Roberts received a call from the Children's Hospital, stating Claire was having breathing difficulties -- the call was from Dr Bartholome -- and they should make their way to the hospital. At 4.30 am, the parents met Doctors Steen and Webb in the paediatric intensive care unit. The doctors, Dr Steen and Webb, informed them there was a build-up of fluid around Claire's brain and pressure was being applied to her brainstem. She was being sent for a CT scan to confirm this -- and remember no CT scan had been carried out at that stage -- and the parents were brought to the intensive care unit to be with Claire. They were told by Doctors Steen and Webb that everything possible had been done for Claire and that nothing more could be done.

Mr Roberts has a clear recall about asking about trying to relieve the pressure on the brain by somehow draining the fluid. He might have even mentioned drilling at that stage. He didn't fully understand the process, but was hopeful of some sort of result in relation to alleviating the pressure. However, the

doctors stressed that everything possible that could be done had been done and that nothing more could be done. Following the CT scan at around 6 in the morning, they met with Doctors Steen and Webb in a room next to the intensive care unit and it was there that Dr Steen explained -- and this is their take on this -- that the virus from Claire's stomach had spread and travelled into Claire's brain and caused a build-up of fluid. Pressure was being applied to Claire's brainstem and this was cutting off her essential body function.

Remember, the parents left the hospital at 9.30 the night before and there was absolutely no emergency. At 4.30 am, a matter of seven hours later, Claire was gone. It was too late to do anything. However, the parents again have asked if everything was being done. They asked the doctors again if anything more could be done. They couldn't fully understand and it is just beyond explanation. Dr Steen replied that everything possible had been done and there was nothing more they could do.

They never questioned the accuracy of the diagnosis, the quality of the treatment, the accuracy of the records or the efficiency of the system. They trusted the doctors, staff and the system, a trust they would soon learn to question.

Dr Steen advised that Claire was brain-dead and she

was being kept alive by the life support equipment and the brainstem tests would be carried out and repeated again in 12 hours and that the parents would be fully informed. Claire was then moved to a small side room beside the intensive care unit where the family could be in around her bed and she remained on life support until 1845 hours. At 7 pm on 23 October, Dr Steen brought the parents into a small office and told them that Claire was dead. She expressed her sympathy for their loss and explained that there would be a post-mortem.

She explained that they would carry out a brain-only post-mortem to try and identify the virus responsible for the brain swelling, that is the swelling that caused Claire's death, and that there would be no need for an inquest. They clearly recall that. They clearly recall this even though they were in great distress.

In particular, Alan Roberts clearly recalls Dr Steen told them that there would be a brain-only post-mortem and hopefully this would identify the virus and that the virus had caused the brain swelling. There was no mention of hyponatraemia; there was no mention of excess fluids; there was no mention of fluid overload. There was no mention or reference to sodium levels and there was certainly no mention that the sodium had dropped from 132 to 121.

All of this must be set aside the fact that the paediatric intensive care notes at 090-055-203 -- if they could be brought up please. 23 October 1996. They show there were brainstem tests, two of them, and it was clear from the PICU notes that hyponatraemia was recorded.

THE CHAIRMAN: I'm not sure your reference is correct.

MR QUINN: I will just check that. It's 090-055-203. I've got the document before me here.

(Pause).

THE CHAIRMAN: Is that from the inquest file that you have?

MR QUINN: Mr Chairman, I only received it about ten days ago.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: It's the PICU documents that came rather late and were put at the back. So it may be that they haven't quite got into the system properly.

MR QUINN: I will move on, Mr Chairman, and come back to that point. It is mentioned again.

In fact, I want to stress this: not only is "hyponatraemia" recorded, so is "hypernatraemic" and "hypokalaemia". So there are three definite indicators here that hyponatraemia was brought out and it was recorded in the PICU notes. None of this information was given to the parents. None.

During their time in the PICU, the only reason given relating to Claire's condition by Dr Steen and Dr Webb was that there was a virus causing a fluid build-up. There were no discussions about hyponatraemia, sodium levels or fluid management. We now know that all of those, of course, are extremely relevant issues.

What happened then is a series of events that requires the fullest and most careful investigation. There is, perhaps, some overlap with the governance issues and I apologise for this, but the family want this matter mentioned at the opening. Mr and Mrs Roberts had a meeting with Dr Steen on 3 March 1997. This was to discuss the post-mortem results. However, let me first refer you to the autopsy request form, 090-054-183. If that could be brought up, please.

It's difficult to interpret because the writing is very light. I have a paper copy, which is slightly better.

THE CHAIRMAN: You have quoted the bit you want in your text, haven't you?

MR QUINN: Yes. But I want to go through this. Firstly, the clinical presentation:

"Nine-and-a-half year-old girl with a history of mental handicap admitted with increasing drowsiness and vomiting."

This is wrong and inaccurate. One, Claire didn't have a mental handicap; she had learning difficulties. Two, the history given is that she was well until 72 hours before admission:

"History of present illness: well until 72 hours before admission."

That's totally inaccurate. She was at school that day. She had been for swimming lessons. She was not ill until noon on Monday, the same day as admission. So she was ill for five or six hours, not 72 hours, three days.

Three:

"Her cousin had vomiting and diarrhoea."

That's not correct. Mrs Roberts mentioned that the cousin had some tummy upset. There was no mention of vomiting and diarrhoea.

Next phrase:

"She had a few loose stools."

That's a matter of interpretation, Mr Chairman. Mrs Roberts did tell the staff that she had "smelly poo" and once again, we stress that she didn't have any diarrhoea or loose motions.

Then:

"24 hours prior to admission, she started to vomit."

This is totally incorrect. The first vomiting

occurred at around 3 pm to 3.30 pm when Claire came home from school. In fact, again, I cross-refer to the A&E note, where they have put a circle before diarrhoea, meaning "no diarrhoea". Therefore, it must be questionable as to whether or not Dr Steen ever read the A&E note if she can then put this in this history of present illness.

Number 6:

"Treated with rectal diazepam, IV phenytoin, IV valproate."

Yes, she was treated with those drugs, but why is there no mention of midazolam, which is something I am going to take you to in a moment? Let's keep in mind that there is no mention of midazolam in that history. But as you will see, Claire had an overdose of midazolam and also, it is quite clear, an overdose of phenytoin. Her serum sodium, Na, dropped. 121 at 2300 on the 22nd. That's correct. But there's no proper reflection of the fact that it fell from a reading of 132 in just over 23 hours. That is, and I can make it clear, from 132 at 10.30 on Monday the 21st to 121 at 9.30 on Tuesday.

I will not deal with this in any depth and move on. The experts will deal with this. What I want to mention is the interpretation of the notes and the blood tests that were carried out:

"Inappropriate ADH secretion."

And I stress, this is from the family's point of view. ADH is antidiuretic hormone and it's part of the body's defence system to release this if there is a danger of dehydration. In basic terms, the body is instructing the kidneys to retain fluid. The experts will discuss this and I will not deal with it other than to give an overview.

That is as the family see this point. They see this as hyponatraemia, needs fluids. Hyponatraemia feeds off fluids. It's probably accurate to say that Claire did retain fluids due to ADH, but what is also abundantly clear is that she needed fluid input to get an overload. So why was the overload not mentioned? Why was the hyponatraemia not mentioned to the parents? Why did Dr Steen not refer to the PICU notes? The clinical notes also mention hyponatraemia on two separate occasions. In fact, it's written in the notes by Dr Stewart, the SHO, and Dr Wells, and I refer to pages 56 and 57.

This very important point was never mentioned to the parents. We must remember that Claire died in the ICU and one would have thought that the consultant who was explaining the death to the parents would have seen fit to mention that there were three entries in the ICU

notes, "hyponatraemia, hypernatraemia, and hypokalaemia", in the clinical notes as well.

Then we come to the entry: "Fluids restricted". You'll see that on the same ... Yes, there is an entry in the clinical notes, this was dealt with earlier, saying that the fluids should be restricted by two-thirds. My learned friend dealt with this point very well.

This entry is at 2330 hours on 22 October and was signed off by Dr Stewart, senior house officer. He actually got the procedures right in relation to the note taking in that he timed and signed his note, including his rank in the hospital. You will see as the notes are examined throughout these hearings, that even the most senior doctors have not followed hospital protocol and their training in relation to timing and signing of the extremely important clinical notes referring to this child.

But let's get back to the fluids. If anything, the fluids weren't decreased, they were actually increased. They did decrease the Solution No. 18 infusion from 64 to 41 millilitres, but then they give her normal saline. What we didn't see in the timeline chart was in the bottom right-hand corner of the timeline, it shows the infusion of fluids that were carrying drugs. Mr Roberts

and Mrs Roberts will say that when one looks at that and extrapolates that purple line on the bottom right-hand side on to the main chart, it shows that there's a spike in fluids. I will not deal with it in any depth and hopefully this can be put up on the fluid timeline when the chart is fully explained.

We then come to the entry dealing with past medical history including drug therapy. And what does it say in this section?

"Mental handicap. Seizures from six months to four years."

That's totally wrong. She had seizures from six to 18 months. In fact, Claire had seizures, the most intense of which were from when she was around six or seven months to nine or ten months, and then she had a few thereafter. After nine or ten months, her problem had been brought under control by the Epilim.

Let's go to the autopsy report. Turning to the autopsy report at 090-054-193, first let's look at the third line under "anatomical summary":

"History of epileptic seizures since 10 months of age."

Then look at the last sentence on the page:

"In her past history she had iatrogenic epilepsy since 10 months and mental handicap."

Where did that information come from? The parents want an answer to this. Referring to the comments section of the autopsy report, which is the same reference, but at page 195, 090-054-195, I take you to the middle of that section that reads:

"With the clinical history of diarrhoea and vomiting, this is a possibility, though a metabolic cause cannot be entirely excluded."

Of course, we will say that all of this was put in to explain the section that immediately precedes it, which is:

"The reaction in the meninges and cortex is suggestive of a viral aetiology, though some viral studies were negative during life and in post-mortem CSF."

Why was such an extensive history given in relation to vomiting and diarrhoea? It starts to make sense. We now know the history is not correct, therefore the parents are forced to conclude, as any layperson would, that this was all done to arrive at a result that Claire's demise was caused by a virus -- you can see now how it's put together -- and there were no other problems. The parents want this to be fully investigated, Mr Chairman. Everything was slanted towards a virus by the doctors, who were explaining

a reason for the death to the parents, but they totally failed to explain the problems, the problems with fluid, or that there was a drug overdose.

THE CHAIRMAN: So their concern is that if you put in wrong or incomplete information, you are then fed out the wrong result?

MR QUINN: Exactly. That's exactly what happens. What goes in affects what comes out.

I don't want to pre-empt or predict or comment upon with any weight any of the evidence to be given by the experts. That's not what this address is about and they're listed as witnesses in the weeks to come. Instead, I refer to the witnesses that have already reported on this point, in particular Dr Harding. I don't propose to read through the quotes of this -- I don't think it's useful for this opening -- other than to have it recorded that there are various views given in this result, and what I want to do is highlight paragraph 3 on page 27.

The views given by Dr Evans and Dr Harding are supported by another report for the PSNI, a report from Dr Gupta, consultant paediatric neurologist, who states:

"I believe that cerebral oedema was the cause of Claire's death. I believe that the most likely cause for her cerebral oedema was hyponatraemia."

He went on to say:

"During her admission to hospital from 21 October 1996, it was felt that Claire may have non-convulsive status epilepticus. Although this is possible, there was no clear evidence for this and I believe this was unlikely."

And the parents want those reports given their full weight.

Now I want to turn to the clinical notes, the drug sheets and the drugs that were prescribed, dealing mainly with midazolam and phenytoin.

The clinical records -- I don't intend to dwell on the subject for any great length of time; there will be days and days of evidence given about this. I want to look at and explain the family's reaction after careful examination of the records, what they say is wrong.

Of course, I've already made the point that not all of the notes are timed and signed, but I make it again, as it is such a simple thing to correct, yet nothing seems to have been done about it. There are entries where the author of the note can only be identified by the handwriting. If we look at 090-022-052, we get a perfect example of that in relation to the note at the bottom of that page of 22 October 1996. That's page 52. Commencing with the ward round of Dr Sands, then the

note:

"Admitted? Viral illness."

If we refer to the next page, 090-022-053, if they could be put up together, you will see that the note is not timed, nor is it signed. We only know that Dr Stevenson probably wrote it as the note on page 054 is in the same handwriting and we know that Dr Stevenson made that note.

It is also abundantly clear, 12 lines from the top of page 053, with different writing -- and it's absolutely important that this is highlighted as this seems to be the diagnosis. So what we have is "non-fitting status" and then, in different pen, we have "encephalitis encephalopathy", and we now know that this was written by Dr Sands, but he didn't sign it or time it or date it at the time. We know this from his witness statement, WS137/2.

Of course, it's only after extensive investigation that we found out why the note was made in that form. There are just so many problems here that it becomes confusing to highlight them all, Mr Chairman. Non-fitting status, so far as we know from the experts, is a form of internal seizure activity. But of course, as you will hear from the experts, to have a proper diagnosis an EEG is required. The parents want to know,

why was there no EEG if that was in fact a diagnosis? Then go to the next entry halfway down the page, 22/10/96 at 4 pm, where it states:

"9 year-old girl with known learning difficulties."

At least that note is correct in that it describes Claire as having learning difficulties and there was no suggestion that she was mentally handicapped. Further, the note is timed, though we now know that this timing is probably wrong because the grandparents were there and it would seem that Dr Webb now admits that his timing of that as 4 pm is probably wrong.

If we look at the next page, 054, we can see that this note is signed by Dr Webb. We say this is where a critical error is made. A critical error. Halfway down that page, 054, you will see a note at line 15, which states "N [for normal] biochemistry profile".

THE CHAIRMAN: If you go to the second block, the fourth line down.

MR QUINN: "I note N [for normal] biochemistry profile."

It would seem that Dr Webb has looked back in the notes and he sees the sodium levels on page 53 of 132 and he assumes that this is a new blood reading, whereas it seems that the doctor who didn't sign the notes has taken that blood reading from the previous day when the blood reports came in at around midnight, and they're

recorded on page 52. The real problem is that Claire's sodium levels were not normal, they were dropping rapidly, but because of this erroneous assumption, Claire dies; her sodium level drops.

So at midnight on 21/22 October, the sodium is dropping at 132. At 132 it's already at a level that should cause concern. We also see that the white cell count is rising at 16.5, which is high. That blood result at midnight indicates that Claire was already hyponatraemic on admission to hospital and thereafter she received 1,550 millilitres of number 18 IV fluids within 24 and a half hours.

We know that number 18 IV fluid is a dilute solution and, when administered to children with a high ADH level, the result is dilutional hyponatraemia, followed by cerebral oedema. Therefore, there was a likelihood of damage, particularly when there was a large change in the serum sodium concentration rapidly occurring. Claire's sodium level fell acutely from 132 to 121 within 23 hours while she was receiving Solution No. 18.

This is probably what sealed Claire's fate. In fact, Dr Webb admits this error and it has already been covered at paragraph 188 of the clinical opening for the inquiry that we've already heard, and it's in the printed document. He admits that on the day he saw

Claire, he erroneously understood her serum sodium level to be 132 on that day. And I stress, on that day. He thought that the results that were recorded on the clinical notes were from a sample that was taken that morning, not a sample that was taken the previous day at around midnight. He will also state that he may have misinterpreted the note which is recorded, "12MN", for midnight, as being 12 noon. How that could be will be something the family will expect to be fully explored by this inquiry.

Why did no one order further blood tests, is another question. We know that the mistake in relation to the serum sodium level of 132 was a serious omission in her clinical care. It had serious knock-on effects in relation to how the clinicians dealt with the case, and the importance of this point cannot be overemphasised. From a layman's point of view -- and this is where the Roberts are coming from -- it is something that needs explanation in easily understood terms, and the parents are still concerned about what steps the hospital have taken to ensure that this sort of error never happens again.

The problems are then further compounded by the drugs that were administered. Let me go to phenytoin. When you look at the record of 090-022-054, that's

page 54 of the clinical notes, you will see that phenytoin seems to be prescribed by Dr Webb about halfway down the page. You can see the prescription being written up, third paragraph down, just below where it starts -- below the highlighter, the third paragraph on the page.

He prescribes it and it's then administered by someone else who signed the record a couple of lines from the bottom. The signature is pretty illegible but we now know it to be Dr Stevenson. So let's do it the mathematics of the phenytoin, and I want you to look at this very carefully, and if that section could be highlighted where it starts "24KG phenytoin".

So let's do the mathematics. This is a loading dose of 18 milligrams per kilo of body weight. Claire was 24 kilos, we know that. So 18 multiplied by 24 should be 432. But we can see clearly from the clinical note that in fact the calculation arrived at was 632.

A grave and serious mistake. Claire got an overdose. Unfortunately, we also know from the prescription sheet at 090-026-075 -- if that could be pulled up along with the highlighted sheet. Rather than even getting the miscalculated overdose, she actually got 635. If you look at the phenytoin, it looks as though she got 635, signed off, signature, and "as given".

So we can therefore say from the records that she got nearly 50 per cent too much. This is a massive overdose. To make matters worse, she also possibly, according to the experts, got even more phenytoin at 2130 hours, as again the prescription sheet is ticked at 21.30, which would indicate she got another dose. Now, how can this sort of error occur? Well, we know there was a simple mistake in the mathematics. We also know that someone has extrapolated the wrong information from the clinical records under the prescription sheet. The family expect a full investigation into this miscalculation and the very substantial overdose.

Dr Aronson, an inquiry expert, states that toxic concentrations of phenytoin can be associated with seizures and that it is certainly a possibility that the seizure at 15.25 -- that's the one witnessed by Mrs Roberts -- may have been due to or contributed to by the phenytoin overdose. Once again we have something that could cause great confusion in relation to the diagnosis and ongoing treatment. And I just want to add there that it's something that can also cause confusion for the clinicians who are trying to diagnose Claire. It creates confusion.

Let's then turn to midazolam, another drug that we know Claire had. It is essential that we see the

prescription record for this, and in fact it is up on the right side of the screen. We know from the clinical notes that Claire was prescribed 12 milligrams of midazolam. But it would seem, if you read the prescription sheet just below the highlighted area -- if you look at that sheet, it would seem she was given not 12 milligrams, but 120 milligrams, and that that was given at 3.25 pm on the 22nd.

Now, we know that that's the same time as Claire's mother witnessed the seizure. To clarify this, the experts have commented upon this and I leave it to the experts to say whether the dose that was given was 12 or 120. There is a lot of doubt in this area. But is it a coincidence, the Roberts want to know, that Mrs Roberts witnessed a seizure at 3.25? In a nutshell, the experts have said that 120 is a massive dose. It seems unlikely she was given that. But do we know, do we know what caused the seizure? This is the seizure that is misinterpreted by Dr Webb, but it is the seizure that certainly was evident to Mrs Roberts. You can also see that the prescription record is signed off, but the identity of the person who gave the prescription is not signed off. This is another grave error. Who was keeping these notes?

Let's look at what the inquiry expert, again

Dr Aronson, the expert pharmacologist, says about this on page 14 of his report. He is asked to comment on the effects that a dose of 120 milligrams of midazolam would have on Claire, and he answers that question. I am quoting from Dr Aronson:

"I have noted above that it is not clear what dose of midazolam Claire was actually given. Midazolam 120 milligrams, even if given over 24 hours, is a very large dose and would have cause major anaesthesia, coma, severe respiratory depression and possible death, as has been reported in adults."

He goes on to add:

"Midazolam would have supplemented the sedative effects of diazepam and phenytoin."

So I would ask on behalf of the family, if a parent were looking at that record, what would they conclude? What would the layman conclude and how are the records to be interpreted? I would suggest they would conclude that Claire was given ten times the prescribed dose. But then let's go back and examine that. If there's a doubt that she got 120, let's look at what she may have got. Let's look at what dose was actually prescribed.

Dr Webb states that the loading dose of midazolam should have been calculated at 0.15 milligrams per

kilogram, and he is not aware of how a dose of 0.15 milligrams per kilogram was charted. Dr Webb's calculation means that a loading dose should have been 3.6 milligrams, not the 12 milligrams that appears on page 55 of the clinical records. That's 090-022-055.

We can see, on the top right-hand corner, the dosage. So remember, what she should have got, according to Dr Webb, was 0.15 milligrams per kilo. But we can see, where it says "Midazolam" in the third line, that she actually got 0.5 milligrams per kilo. That is then multiplied by 24 for her body weight, 24 kilos, and they arrive on this chart, this note, at 12 milligrams.

So no matter what way you look at it, there's an overdose going on here. Dr Webb recommended a loading dose of 3.6 milligrams. That is to explain, 0.15 multiplied by 24 kilos, 3.6 milligrams. The clinical notes seem to demonstrate she got a dose of at least 12 milligrams, which is 300 per cent more than she was prescribed. But if the prescription sheet shows, and it's accurate, that she got 120 milligrams, that doesn't bear thinking about.

Could the dose of midazolam have caused a seizure, the seizure that was witnessed by Mrs Roberts, which was unlike any other she had witnessed in the previous years. And remember, she was free of seizures for four

years.

The next issue is in relation to the rate of administration of midazolam. The first point we make is that there are no notes about this. The inquiry has engaged an expert pharmacologist, Dr Aronson, who will give evidence on the point and we wait to hear from Dr Aronson. The parents want to hear this expert evidence on all the concerns they have in relation to the drug therapy, particularly as Dr Aronson has agreed that there has been an overdose of phenytoin by about 50 per cent. There is also no doubt that she had an overdose of midazolam. There would seem to be little dispute that she had at least 300 per cent more than was prescribed by Dr Webb. And in fact, she may have had a massive overdose of 120 milligrams, which is more than 30 times more than prescribed. The overdoses of the two drugs may not have had any effect on the ADH secretion or the overall picture in relation to fluids that were given, but it would certainly make it extremely difficult for any examining clinician to assess her progress. I don't want to deal with this point in any further detail, but we say it is another area where Claire was failed by the system. Even with Dr Aronson's examination of the records, he is still not sure what dose of midazolam Claire was actually given and he

concedes that if Claire was actually given 120 milligrams of midazolam, this was a very large dose and would have caused major anaesthesia, coma, severe respiratory depression and, possibly, death. So whilst the drugs that were given may not have had an impact on her serum sodium levels and the brain swelling, they certainly could have confused the clinicians that were treating Claire.

The Roberts family make the point that the drug charts that are available online for this medication -- and this is what all parents are doing, they all want to look online -- would recommend a bolus dose for Claire's weight as 0.1 milligram per kilo, whereas Claire got the drug at a dose of 0.5 milligram per kilo. We remind the inquiry that Dr Webb has stated in his statement that the dose should be 0.15 per kilo, so even on his recommended prescription, it is substantially over the proper dose of administration and we require that to be investigated.

We have to remember that this is an inquiry into hyponatraemia-related deaths. It could be said that this inquiry is all about the administration of fluids. But we have to stand back and remind ourselves that not only was Claire getting Solution No. 18 fluids, which we'll hear discussed in great depth and detail in the

inquiry, she was also getting fluids by way of infusion of drugs. That is, fluids that were carrying drugs, and I'm grateful for my learned friend opening this earlier.

We say that she was probably also getting too much midazolam by intravenous infusion, and she was certainly getting fluids that she did not need by intravenous infusion. It is clear that the inquiry will investigate this matter with great rigour and the parents look forward to getting some answers.

In fact, we have to ask the question as to why midazolam was prescribed at all. Professor Neville, another expert to the inquiry, will say that the giving of midazolam was inappropriate because there was no confirmation of the diagnosis by way of an earlier EEG. This drug would certainly have had a sedative effect and could have contributed to a fall in her Glasgow Coma Scale. The parents want to know why midazolam was prescribed.

To conclude, what on earth was going on when Claire was on the Allen Ward? The analysis that I've gone through in relation to the records would demonstrate that she had an overdose of phenytoin and an overdose of midazolam. We know that midazolam could cause sedation. Dr Aronson has told us, and you will hear from him in this inquiry, about the effects of an overdose of

midazolam. We know for a fact, from Mrs Roberts, that Claire had a seizure and we know that her Glasgow Coma Scale was dropping. Fact.

We will also hear that the evidence about the Glasgow Coma Scale and the central nervous system observation chart is also questionable. If those original readings for the Glasgow Coma Scale are correct, then Claire may have had a Glasgow Coma Scale of 6 as opposed to the recorded score of 9. Was that another failing, the parents want to know? So did the midazolam overdose simply compound the incorrect type and volume of fluids? Was Claire failed on every front?

She was given too much fluid. We know that's the main problem in the case, but was she also given an overdose of drugs? We say, on the above calculations, there seems to be no doubt that this occurred. One point is totally clear: there is no arguing with the written and signed prescription records showing a dose of 120 milligrams of midazolam administered at 3.25 on 22 October. Clearly, the parents need answers on this point.

What about the phenytoin? We know that she got an overdose of at least 50 per cent and we will hear that phenytoin affects the central nervous system and can

cause slurred speech, decreased coordination, mental confusion and drowsiness. All of these things seem to have been observed when Claire was in hospital. Her parents will tell the inquiry that's what they saw.

What we will say and what the parents want emphasised is that the administration of an overdose of those two drugs could give the clinicians another problem in that it would more difficult -- much more difficult, we say -- to assess Claire's condition and ongoing problems. The family will say that Claire never woke up after she had the seizure at 3.25 on the 22nd.

I then go on to a list of issues, and I don't intend reading through all the issues. They're recorded. I will just read out the first page. Issues to be investigated. So what do the Roberts family want out of this? The simple answer is they want to ensure that this never happens again. That's the main thing. They want to ensure that no other child of a family goes into hospital suffering from a tummy bug and, due to the failure of the staff and the system at the Royal Belfast Hospital for Sick Children, never comes out of hospital. A child goes in, tummy bug; never goes out.

There are a great number of issues to be investigated by this inquiry and the family want me to submit to the inquiry a list of issues that they want

investigated. At all times, the family want to assist this inquiry. What they don't want and what they are certain will never happen again because of this inquiry is for nothing to happen. That's what has happened so far.

It would seem that nothing happened after the death of Adam and therefore the inquiry will realise the importance of the Adam Strain case. The very fact that there were ongoing investigations into Adam's death in the months before Claire died and that there was an overlap of certain personnel. Mr Chairman, you have already made the point for me.

They have posed a number of questions and they have compiled a list, with our help, of another 28 issues. And what I want to do is finish by simply summing up page 43 of this opening. The parents want me to stress point 27:

"What lessons are learned from Adam Strain's death and the coroner's inquest into his death at the same hospital?"

Mr Chairman, you have made already it clear this morning that Adam's inquest was only a matter of months before Claire's death. It took place in June 1996 and Claire died in October 1996. There are a number of members of staff involved in Adam's case that were also

involved in Claire's case, so why were changes not made? It's no use to answer "mea culpa". The question that they want answered and what is even more vexing for the family is the lack of progress at the hospital in relation to this type of case.

So even though it is extremely difficult, the death of a child can never be accepted when it is unavoidable. When everything that could possibly be done has been done and the family, at the end, are told the truth, the whole truth, and nothing but the truth and nothing has been left out, then this family may get closure.

If time permits, Mr McCrea has a short address in relation to the effect on the Roberts family. It'll probably take 10 or 12 months.

THE CHAIRMAN: That's okay. Let's hear from Mr McCrea.

Opening by MR McCREA

MR McCREA: Mr Chairman, the purpose, I think, of my address to the inquiry is to highlight, if you like, the parents' perspective on what Mr Quinn has just set out in very graphic detail.

Between Claire's admission to the Royal Belfast Hospital for Sick Children on 21 October 1996 -- that's Monday evening -- up until 4 am or thereabouts on 23 October -- that's Wednesday, the early hours of Wednesday morning -- between those two periods of time,

Claire's mother and father spent, at most, 20 minutes in total communicating with the doctors in relation to Claire's condition.

The first recorded conversation that Mr and Mrs Roberts had with any doctor providing any treatment to Claire was around 11 am on the Tuesday morning. That was a conversation with Dr Sands, who was the registrar. This conversation, in their recall, lasted no more than five to ten minutes. This was the only communication at all -- the only communication at all -- Mr Roberts had with any doctor throughout Tuesday 22 October 1996.

The second discussion that took place between the doctors was with Dr Webb and Claire's mother, Jennifer, at approximately 5 pm on Tuesday afternoon. This was a conversation again of similar length that Dr Sands had had earlier that morning and, in both instances, the parents painted a background picture of Claire's health, previous epileptic picture and history relating to the medication received since infancy.

Whilst all the doctors who have treated Claire between Monday and Wednesday stated in their various statements and evidence on previous hearings that Claire was very unwell, at no time were the parents ever advised about this or picked up, even, the seriousness of Claire's perceived condition. Diagnoses such as

encephalitis and encephalopathy, meningoencephalitis, were never mentioned to Claire's parents at all at any time.

Claire's mother and father were always of the view, as Mr Quinn has pointed out, that Claire had some type of tummy bug, and whilst unwell, was in good hands, was being properly looked after and, hopefully, during the course of the afternoon of 22 October, had turned a corner and would probably be much better on Wednesday 23 October. Had anyone -- anyone at all -- advised the parents, informed them, communicated to them the fact that their daughter was suffering from anything more than a 24 to 48-hour tummy bug, they would never have left the ward.

The fact that they did and the fact that, in the next few hours, their daughter's health deteriorated to such an extent that the next time they saw their daughter she was brain-dead has -- and continues to -- filled them, not only with distress but guilt. Like any parent, had anyone told them what the situation was facing their child, they would never have left their daughter's bedside. And it was because of this absence of communication, they were never given this opportunity, and it's something that will haunt them for the rest of their lives.

As already has been outlined in great detail, Claire's condition continued to deteriorate to such an extent that by the time the blood test taken at 9.30 pm on Tuesday evening was received, Claire was suffering from acute hyponatraemia. Her health deteriorated further, she suffered a cardiac arrest and, at around 3 am or thereabouts, was subsequently diagnosed as being brain-dead.

Between 9.45 on Tuesday evening and 3.45 in the early hours of Wednesday morning, there was no communication whatsoever between the Allen Ward, the Royal Victoria Hospital, and Claire's parents. It wasn't until 3.45 am or thereabouts that Mr Roberts received a telephone call from the hospital stating Claire was having breathing difficulties and could they attend as soon as possible. As events turned out, by this stage Claire was already brain-dead. In real terms, there was nothing further that could be done.

Whilst this in itself, Mr Chairman, would be hard for any parent to cope with, what happened afterwards and in the immediate aftermath led Claire's parents almost to breaking point. What they wanted to know, as Mr Quinn has addressed the inquiry, Mr Chairman, is what happened to their daughter and why? Two very simple questions. They have never received answers to these

questions. They had meetings with Dr Sands and Dr Webb when they arrived at the hospital, they were advised that the CT scan was going to be performed and they were told by Dr Steen and Dr Webb that everything possible had been done for Claire and nothing more could have been done.

It was the following meeting with Claire's parents after the CT scan -- and this promise, if you like, was reiterated to them, the undertaking that everything possible had been done for Claire that could possibly have been done. Mr and Mrs Roberts accepted the accuracy of the diagnosis given to them and the quality of treatment that Claire had been provided. They accepted without question the explanation as to why their daughter was brain-dead. There was another meeting just shortly after the ventilation, life support system, was turned off, and again Dr Steen advised them that everything possible had been done for their daughter and that the hospital would carry out a brain-only post-mortem and would identify that virus that was responsible for the brain swelling and their daughter's death.

The only explanation that Claire's parents ever received for what had happened to Claire was that there was a virus. No mention about sodium levels, fluid,

hyponatraemia, fluid management, nothing. Nothing at all. There was another meeting on 11 November 1996, when Claire's parents turned up at the ward, again looking for an explanation. Dr Sands spoke to them on that occasion and advised them that much more would be known when the autopsy was carried out.

There was a meeting with Dr Steen on 3 March 1997 at the hospital. Firstly, Mr Chairman, Mr And Mrs Roberts were never given a copy of the post-mortem results. Secondly, Dr Steen informed them that the post-mortem had identified a viral infection responsible for Claire's brain swelling, but the virus itself could not be identified. Dr Steen went on to explain how that virus would have caused the build-up and the brain swelling, and that is what has happened in Claire's case.

Mrs Roberts asked some questions about the treatment Claire received and if Claire had actually suffered. Dr Steen reassured them again that everything possible had been done for Claire and nothing more could have been done. At no stage during the course of this meeting was any mention made again of Claire's management, fluid management, hyponatraemia or the like.

Subsequently, Mr and Mrs Roberts received a letter from Dr Webb, which again has already been referred to,

but significantly, Mr Chairman, there was no mention in that letter again of hyponatraemia, metabolic causes or any other reason or explanation for Claire's death other than a viral cause.

Mr and Mrs Roberts would like this inquiry to investigate why these explanations were given to them, why it was that they were advised a brain-only post-mortem was required and why there was no need for an inquest and why it was that a full and proper explanation of the contents of that post-mortem result were never provided to them, and why it was that Dr Webb made no mention of any metabolic cause for Claire's death. Why was that? That's the question they asked at that time.

However, in the intervening years, Mr and Mrs Roberts were simply left to wonder what it was that caused their daughter's death. Then there was the UTV Insight programme, broadcast in October 2004. Consequently, Mr Roberts contacted the hospital and asked to enquire if Claire's death was in any way attributable to fluid management, sodium levels and the use of IV fluids. That was his very specific query. That's what he wanted to know, Mr Chairman. The hospital arranged a meeting with Dr Sands, Dr Steen and now Professor Young, who had been engaged to review

Claire's papers.

However, despite the years that lapsed between Claire's death and this meeting, and despite whatever lessons had been learned in the intervening period in relation to the use of hypotonic fluids, Dr Steen continued to stick to her original explanation for the cause of Claire's death, namely it was viral. Dr Steen never changed her position. Mr and Mrs Roberts recall Dr Steen advising them that new procedures were in place at the Royal Hospital and that they should consider what would be gained by taking Claire's case further.

Mr and Mrs Roberts' perception of the discussion, and in particular the responses given by Dr Steen, was an attempt by her to dissuade them from taking Claire's case any further. Following on from that meeting, Claire's parents raised a series of questions and they received a response. However, that response essentially reemphasised Dr Steen's view that Claire's symptoms were viral, and that had been confirmed at post-mortem. Additionally, Claire's condition had not been underestimated and that medication was important. Without it, Claire's condition could have deteriorated more rapidly, and that hyponatraemia was not thought, at that time, to be a major contributor to Claire's condition, and that the reason the coroner had not been

informed at the time was because it was believed the cause of Claire's death was viral.

Ultimately, the matter was referred to the coroner and an inquest was held in early May 2006, almost 10 years after Claire's death. Dr Steen's position at that inquest remained unchanged. In summary, therefore, despite all of the advances that have been made between Claire's death in 1996 and 2006, none of the doctors treating Claire resiled from the view that Claire's death was viral in nature and Dr Steen, in particular, did not attribute hyponatraemia as playing any cause in Claire's death.

Following on from that, this inquest commenced its work and Mr and Mrs Roberts attended the majority of the hearing into Adam Strain's death. They were, and these are their words, angered and shocked to learn what the Royal Victoria Hospital was saying publicly in relation to lessons learned from Adam Strain's death, yet privately there was, in fact, no meaningful investigation carried out.

It appeared to Mr and Mrs Roberts that the Royal Victoria Hospital learned no lessons from Adam Strain's death and, had any form of investigation or inquiry been held into his death, how he died and in particular the role of hyponatraemia in his death, then the outcome in

Claire's case could have been very different. Mr and Mrs Roberts believe that had an investigation been carried out into Adam Strain's death, Claire could be alive with them today.

What Mr and Mrs Roberts would like from this inquiry has already been emphasised by Mr Quinn. They would like the doctors and nurses who treat patients, in particular children, are aware of hyponatraemia. Where a mistake or error is made, that a proper, transparent, complete, full and independent inquiry by proper people is carried out to identify what happened and that such an investigation is open. Thirdly, they hope that any such investigation is carried out promptly and without any undue delay so that no parent will have to wait almost 16 years to find out answers to two simple questions: what happened and why?

THE CHAIRMAN: Thank you very much, Mr McCrea.

Ladies and gentlemen, that brings to an end the opening submissions which we had invited and which we had been alerted to. It is now 1.40. If there are any other matters which we can deal with quite quickly, I'm happy to sit on and do that and see if we can let people away fairly quickly today. The next step would be that we start tomorrow morning with the evidence of Dr Steen and then going into the evidence of Dr Sands. Is there

anybody who wants to raise any issue which hasn't been raised so far this morning?

MR SEPHTON: My name is Mr Sephton, I represent Dr Webb. I raise at this stage to express concern at the fact that Dr Webb and those who represent him have received very, very late in the day a number of important documents. The difficulty is that you, sir, will probably know that because Dr Webb is presently very unwell, it's going to prove very difficult for me to obtain instructions from Dr Webb. What is done is done, and if a problem arises, I'll make the inquiry aware of the fact that I've had difficulties. But I would ask for the future that, if documents are to be generated and to be relied upon, they should be released as soon as possible so that we can deal with them.

THE CHAIRMAN: I understand. Thank you.

Mr Fortune?

MR FORTUNE: Sir, without going into great detail in public at the moment, my learned friend and myself have been having a number of discussions, about which you are aware. I don't know whether those matters which will be clarified shortly between us may or will detain you this afternoon or may involve others.

THE CHAIRMAN: Well, I'm available for the rest of the afternoon. However, I'm reluctant to keep people here

in Banbridge if this hearing can be completed, partly because there's a public cost to keeping people here in Banbridge, as you'll understand. I think when you referred to "my learned friend", you're having some discussions with Ms Anyadike-Danes; is that right?

MR FORTUNE: Yes, about which you know.

THE CHAIRMAN: I think I know something. I'm not sure how much I know and I'm not sure frankly at this stage how much I want to know. Give me one moment.

Does anyone else have any other point to raise now?

MR QUINN: Mr and Mrs Roberts wanted to raise one point about documents that arrived very late in the day. I got documents Thursday and Friday. We just want to know: are there any more documents coming?

THE CHAIRMAN: I think the documents you got on Thursday and Friday are from the Brangam Bagnall exercise.

MR QUINN: Yes.

THE CHAIRMAN: There have been lengthy discussions between the inquiry and the Belfast Trust through the Directorate of Legal Services since the inspection took place in early July. Some documents were released, there have been some further debates as a result of which more documents have been released, but we're now at a stage -- I think all the documents have been released other than those for which the Trust claims

privilege. Isn't that right? I have agreed that there are some documents which I don't need to have and I don't believe anybody else needs to have for the hearing of this inquiry because they're simply not relevant. They're so peripheral and we already have plenty of information. There are some other documents for which the Trust claims privilege. That has been reconsidered. The documents which you received towards the end of last week were documents for which privilege had already been claimed, which is now -- I don't think it ever arose, frankly. I don't think an e-mail exchange between Mr Trevor Bernie of UTV is ever a privileged document. But there are other documents, a list of which are specifically between individuals within the Royal and members of Brangam Bagnall, which appear, on the face of a list, to be privileged.

I think what I should do for you and for the others is to -- I can't release all the correspondence to you without redaction because there are other individuals referred to who should not be referred to in public because they're quite irrelevant to this inquiry. If you'll accept this in a summarised form, which excludes the references to other people, I can show you where we have reached in relation to the claim for privilege and you can tell us over the next few days whether you

want to pursue any issues further.

MR QUINN: I am obliged.

THE CHAIRMAN: Beyond that, I will let Mr Fortune and Ms Anyadike-Danes continue with such discussions as they're having. I will ask everyone, if you wouldn't mind waiting for another 15 or 20 minutes, to see if they require me to intervene or do anything. I'll stop now. I may not need to sit again today, but if I do, I hope to sit by 2.15 at the latest so that people can leave if they want and we will resume tomorrow morning at 10 o'clock. Thank you.

(1.50 pm)

(Adjournment)

(3.45 pm)

Discussion

THE CHAIRMAN: I'm very sorry everyone's been kept waiting, but I understand that an issue has arisen, which needs to be sorted out this afternoon. Ms Anyadike-Danes, could you explain to everybody what that issue is?

MS ANYADIKE-DANES: It does, and I am also sorry for the time.

It is an issue, I think, that's going to start with Mr Fortune, counsel for Dr Steen, informing you, Mr Chairman, and the others in the chamber, about a matter to do with documents and information. Then

I think Mr Simpson for the Trust and the Department will respond. It may be that I can assist by saying some few things after that. I think that might be the more helpful order.

THE CHAIRMAN: Okay. Mr Fortune.

MR FORTUNE: Sir, as you know, amongst the issues to be raised in respect of Dr Steen are two very important matters. Firstly, whether Dr Steen was in fact in the hospital on that Tuesday morning and, secondly, whether at any time during the whole of Tuesday, Dr Steen was contactable by any member either of the medical staff or the nursing staff.

My instructing solicitor took possession on Wednesday of last week of certain documents which were unsolicited and handed to her by Dr Steen. We have made those documents, which are in a redacted form, available to my learned friend, counsel for the inquiry.

THE CHAIRMAN: Just for confirmation, I have not seen any of these documents; okay? Continue.

MR FORTUNE: We have had a frank discussion with my learned friend Ms Anyadike-Danes and her instructing solicitor, and then, later, we have had a further frank discussion with those and also my learned friends Mr Simpson and Mr McAlinden. We have explained how we came to be in possession of those documents. As I say, they are

unsolicited and it is clear that an enquiry will have to be made, firstly as to how they came to be obtained, and secondly as to the content.

If, on one reading, it is apparent -- and I put it no higher than that -- that Dr Steen was on the ward or in the hospital on that Tuesday morning, then clearly Dr Steen would wish to refer or be able to mention, by reference to the document, just that matter. Likewise, to refer to any document that may indicate that she was contactable at some time during that day.

Clearly, these are important issues.

THE CHAIRMAN: Yes.

MR FORTUNE: And in the circumstances, we anticipate that certainly both counsel for the hospital and counsel for the inquiry will want to investigate this matter further because it affects not just Dr Steen but, of course, other witnesses. That's all I need say at this stage. I anticipate my learned friend Mr Simpson will respond in a particular way.

THE CHAIRMAN: Before he does, Mr Fortune, until the end of July, when the inquiry notified a number of people in writing, including your client, that they were interested parties, your client was receiving some level of advice and assistance from the Directorate of Legal Services; isn't that right?

MR FORTUNE: That is correct.
THE CHAIRMAN: In the sense that we were being contacted by DLS to say that they were assisting and they were helping her to prepare her response to the witness statement and there was some toing and froing between them; right?
MR FORTUNE: That is correct.
THE CHAIRMAN: It must have been evident to Dr Steen that an issue was where she was on the Tuesday.
MR FORTUNE: That is correct.
THE CHAIRMAN: Okay. Did she make enquiries or did she ask DLS and the Trust to make enquiries when she was preparing her response to the witness statement to see if there was any documentation? The reason I ask is this: we asked for the ward diary for the Allen Ward, the inquiry asked for it, and the ward diary, as I understand it, gives a list of who the patients are in the ward at a particular time and gives the names of the doctors who see the patients.

We were informed that the ward diary had been disposed of, consistent with the Trust's document disposal policy. And we heard about that policy during the course of Adam's case. It was a practice -- and there's certainly a question in Adam's case about the extent to which it might glorify it to call it a policy.

But Dr Steen would surely have known that if a ward diary wasn't available, what other efforts might be made to track down details of where she was or who she might have seen, et cetera. Did she make any of those efforts before the time that she obtained separate representation?

MR FORTUNE: I do not have an answer to that question. I can take instructions immediately if you would wish.

The point is this, sir: Dr Steen recognised the importance of the questions, "Where were you on that Tuesday?", and, "Were you contactable?" And certainly Dr Steen would wish to say, and can say: well, I asked where the ward diary was because I asked those of my colleagues, could they assist to tell me where the ward diary is or was, because that would or might indicate who I was seeing or who was on the ward on that Tuesday morning.

Dr Steen learnt that the ward diary no longer existed. Dr Steen also made an enquiry of the community team at Cupar Street, along similar lines, and was given information that there was nothing available that would assist her.

THE CHAIRMAN: Are you saying that she made these enquiries and got these responses at the time that she was preparing her witness statement? Or are you saying that

this is something which was done more recently?
MR FORTUNE: My understanding is that this has not been just recent -- you know, as soon as the issue was raised, she asked, but I can take specific instructions.
THE CHAIRMAN: The issue was raised in her witness statement.
MR FORTUNE: Yes.
THE CHAIRMAN: Right.
MR FORTUNE: And it would have been perfectly natural, sir, for Dr Steen to have said, in those circumstances, even when represented by the Trust, well, surely there must be something --
THE CHAIRMAN: Yes.
MR FORTUNE: -- for instance, the ward diary.
THE CHAIRMAN: Yes. Rather more than the Trust's legal advisers, the people who will really be able to help her are the Trust employees, the Trust record keepers, managers, other doctors and nurses. They know better than lawyers do what documents exist, so if the ward diary isn't available, what is route B?
MR FORTUNE: Well, route B is the problem here, sir, because there is no ward diary. There is no equivalent at Cupar Street.
THE CHAIRMAN: But you have indicated that there are now some unsolicited redacted documents, which do throw some

light on this issue. So there is a route B.

MR FORTUNE: There is a route B and it was discovered, we understand, by accident. I see my learned friend looking at me.

THE CHAIRMAN: Be careful.

MR FORTUNE: I'll be careful.

THE CHAIRMAN: It sounds to me like a remarkable accident.

MR FORTUNE: I'll retrace my steps. Route B was discovered, whether by accident or otherwise, and I see my learned friend nods in agreement as to the use of those words, whereby the Trust computer can be interrogated to find out who was admitted on a particular date. It does not say where that patient was placed because, of course, although there were so-many beds in Allen Ward, it was possible at sometimes for patients to be placed elsewhere in the Children's Hospital, albeit in the name of a consultant who would normally admit to Allen Ward.

THE CHAIRMAN: For instance, there could be a computer file which shows that, say, John O'Hara was admitted on 21 October and that then allows you to go and look up John O'Hara's file to see who treated him that night and on the following days?

MR FORTUNE: The information on the computer would go a little further, sir, and say that John O'Hara was admitted under the care of ... And then the consultant

would be named, and thereafter the file could be retrieved.

THE CHAIRMAN: Sorry, and the file which can be retrieved --

MR FORTUNE: Is the file containing the medical records, which would include the nursing records.

THE CHAIRMAN: But I thought that we had the nursing records and the medical records, which don't refer to Dr Steen being contacted. Sorry, we have them for Claire, right. But these are other people's records, which will show, for instance, that a four-year-old boy was seen by Dr Steen or whoever.

MR FORTUNE: Or Dr Steen may have been contacted at some time on that Tuesday in respect of, as you put it, that four year-old boy.

THE CHAIRMAN: Yes. Okay. Do I take it then, and do other people who haven't seen these documents, take it then that these unsolicited, redacted documents are the fruit of some level of search along those lines through a computer?

MR FORTUNE: As a result of the computer being interrogated.

THE CHAIRMAN: Okay. And they were made available to you last Wednesday?

MR FORTUNE: The redacted documents were made available to my instructing solicitor last Wednesday in the evening.

THE CHAIRMAN: I want to get this in sequence. Mr and

Mrs Roberts have waited until 2012 for a full inquiry into Claire's death. She was admitted in October 1996. They went back to the Royal in October/November 2004. There was an inquest in 2006. One of the issues which has been repeatedly highlighted and questioned is the role of the consultant paediatrician who was on duty for at least part of, if not all of, Tuesday 22 October. The ward diary, we were told, had been disposed of. And now at this exceptionally late stage, 16 years later, I'm being given information to indicate that it is possible to show that even if Dr Steen wasn't there, there was some level of contact with her from the Allen Ward.

MR FORTUNE: Or that she may have been on the ward, sir.

THE CHAIRMAN: Either she was there or that she was contactable at some points.

MR FORTUNE: That is correct.

THE CHAIRMAN: Right.

MR FORTUNE: Sir, may I make this quite plain because you're aware when those who instruct me came into this inquiry. Clearly, that's important to bear in mind. This information came to me as counsel in hard copy today and my instructing solicitor and I disclosed the existence of this material today.

THE CHAIRMAN: What I'm currently at a loss to understand is

how this information was not made available or prised out of the system at the very least when Dr Steen was preparing her response to the witness statement.

MR FORTUNE: When represented by the Trust?

THE CHAIRMAN: Yes.

MR FORTUNE: I cannot answer that now, sir. I have no specific instructions. I can take instructions.

THE CHAIRMAN: When Dr Steen comes to give evidence, I will be asking her that point. I want to know what efforts she made or what suggestions she made about other enquiries that should be carried out.

Okay. Mr Simpson or Mr McAlinden.

MR SIMPSON: Sir, just dealing with that, we haven't had an opportunity to carry out any investigations as you might appreciate in relation to what was shown to us today. The unredacted records relate to patients other than Claire Roberts.

THE CHAIRMAN: Yes.

MR SIMPSON: Someone has accessed patient records and photocopied patient records. How that has been done -- sorry? I appreciate they're redacted, but in order to be redacted, they have to be photocopied somewhere along the line.

THE CHAIRMAN: So someone has got the original.

MR SIMPSON: Someone has gained access to the files.

What we are being asked for at this stage, as I understand it, from both my learned friends following our discussion is for a list of the patients. My learned friend says that the computer can be interrogated. We didn't, as counsel, know that. We asked some time ago for that and were told that wasn't the case. We will make enquiries about it. What is being sought at the end of the day is a list of the patients who were in Allen Ward or on any overspill part of Allen Ward on that date, with a view, as I understand it, to accessing those patients' records.

Two points arise immediately before we go any further. The first is, all of those patients, those patients who are still alive, will be adult patients. All of them will have to be contacted at some stage to be asked whether they agree to anyone accessing their records. But a more fundamental point occurs even before that. Even in the act of passing on the information about the fact that they were children in hospital for a period of time may itself involve data protection issues, which I would need to take instructions on. I know very little about data protection legislation and it may be that the Information Commissioner would have to be involved at an early stage before even the names could be released.

That will, of course, be the first stage before each of these individuals is asked whether he or she agrees to his or her records being made available, even in a redacted form, because there may be extremely personal data therein contained. How quickly that list of names could be provided to the inquiry will depend upon what the Information Commissioner tells us and thereafter I don't know what will happen and how long it will take.

But the first matter which we have to attend to, sir, is to see if we can access a list of the names in Allen Ward or any overspill area on that day.

THE CHAIRMAN: Mr Simpson, I don't have the slightest difficulty in accepting that you and Mr McAlinden and your team don't know how to access or didn't know that it could be accessed. If it turns out that the records can be interrogated to see if it discloses Dr Steen treating somebody else, I would be very surprised if there were not people within the Trust who have known that all the time.

MR SIMPSON: We will be making enquiries into that, of course, sir.

THE CHAIRMAN: In essence, what you're saying is, this isn't something that can be done overnight?

MR SIMPSON: No. Even if the computer could be interrogated and I had a list of names in my possession today, there

are still issues which will have to be dealt with about patient privacy for all of us. It is not just the Trust, it's a matter for the tribunal as well.

THE CHAIRMAN: Okay, thank you.

Mr Quinn, you might have something --

MR QUINN: No.

THE CHAIRMAN: Ms Anyadike-Danes?

MS ANYADIKE-DANES: Thank you very much, Mr Chairman.

Well, Mr Chairman, I am concerned, as I'm sure others are, as to how the information was accessed in the first place, concerned about how it has been provided, but for my duties as senior counsel of this inquiry, what I'm really concerned about is how it bears on the issues that I wish to deal with and help you deal with in this oral hearing. My concern is that, prima facie, it would seem that these documents are relevant, and they're relevant to a very important issue or twin issues.

Firstly, where was Dr Steen? And wherever she was, how contactable or how accessible was she to her junior team? Those are issues which I wish to deal with in this oral hearing. They are matters which have, to a certain extent, been flagged up in witness statements, and we have people's evidence in relation to that, but not in a way that is entirely satisfactory.

So if they go to that issue, they are obviously very important. I would imagine from what Mr Fortune has said, that his client would wish to rely on any interpretation of such documents that can be placed on them to suggest that she was not only there, but she was accessible to her junior team. From the point of view of Dr Sands and the other members of her junior team, that is an issue, obviously, in which they're interested, because the extent to which their consultant was available to them and they did not avail of her expertise and experience is going to be an issue for them.

If, on the other hand, she was about, but it was absolutely clear that she was not available to them, that is an issue as well. Either way, those junior doctors, particularly Dr Sands, are going to want to know what the answer is. It also has some effect on the nurses because some of these documents, as I understand it, involve nurses taking notes and being able to give some evidence as to Dr Steen's movements, if I can put it that way.

So that is the very unhappy situation we're in. Had I known about those documents earlier, then I would have asked for further investigation, assuming that I had received them in an orthodox fashion, if I can put it

that way. I would have asked for further investigation. I would have raised witness statement requests, certainly of Dr Steen, of Dr Sands, possibly of Dr Stevenson, and from some of the nurses. And that's the difficulty that we now face. We don't have that opportunity, but one can't ignore that it goes to a very important point. In fact, in some respects, as I took you through the schedule dealing with people's understanding of who was in control of Claire's care, one sees how central is the role, the potential role anyway, of Dr Steen.

So that's the difficulty that we have. It's a matter for you how it is resolved, but I would ask that we have the time to be able to identify properly who was there, particularly in relation to Dr Steen, how available and accessible she was to her junior team, and how much she had made that clear to them.

I just want to deal with one other question that you had touched on, Mr Chairman and that is the whole issue of the ward round diary, just so we're clear on it. On 1 June, the assistant solicitor to the inquiry wrote to the DLS and asked in relation to a witness statement from Angela Pollock, whose movements are also not entirely clear for that day. Angela Pollock had said in her witness statement 225/1 at page 5 in answer to

a question 12:

"The medical staff would document findings of clinical examination of the patient at the time of the ward round in the clinical notes, and if particular tests were required following the ward round, this would be documented in the ward round diary. Under the Belfast Health and Social Care Trust policy for disposal of records, this diary would now be disposed of."

So the question was:

"I would be grateful if the Trust could now confirm on what date the ward round diary of 22 October for Allen Ward was destroyed or disposed of, under what policy. And, if there was no policy governing the destruction, under what local practice this was destroyed."

We did get an answer to that which isn't relevant to the issues of today. That answer was dated 23 August.

But it would have been clear to everybody how much the inquiry legal team wanted to be able to pinpoint who was where, not just Dr Steen, but others, including the missing consultant paediatrician who was on call and on duty maybe even, on the evening of the 22nd. We didn't get any further than to be told that the ward round diary, which might have helped us, was no longer available. And that is as much as we knew about it.

Although, as I say, the issue we were getting at was pretty clear. So if there had been an alternative way of furnishing that information to us other than the ward round diary, I think the legal team would have been expected to be told about that. And then we could have carried on with the investigation in the normal way.

MR FORTUNE: There is clearly more than one issue. Firstly, as to how these documents came to be found, and, secondly, what use, if any, can be made of them at this time. Insofar as the second issue is concerned, as you know, Mr Uberoi and myself appear regularly in front of fitness-to-practise panels at the General Medical Council. But you now have the advantage of having in front of you my learned friend Mr Sephton, who appears for the Council from time to time, and he will no doubt be in a position to confirm that, from time to time, the General Medical Council comes into possession of medical records for which consent is not forthcoming, which are redacted and then used in inquiries.

If I'm wrong about that, my learned friend Mr Sephton will correct me, but clearly in some instances it is not always possible to obtain consent for one reason or another. But that doesn't, of course, get over my learned friend Ms Anyadike-Danes' bigger concern of how these records come now to be found,

bearing in mind the length of time this inquiry has been up and running.

THE CHAIRMAN: The inquiry isn't going to be adjourned. The starting point for every part of this debate from now on is that the inquiry is not going to be adjourned.

Mr and Mrs Roberts have waited for too long, the Fergusons are waiting behind them, and Debra Slavin, most of whose evidence has been heard, is ultimately waiting for a report. So we're not stopping the inquiry. The only question to be sorted out overnight is how quickly and how best to advance it.

One issue does concern me generally -- and I'm raising this, Mr Simpson, Mr McAlinden, because within the last couple of weeks we received a governance statement in Claire's case from Mr Peter Walby. In that statement, he referred for the first time that we'd seen to an inquest file and to a media file. Those might not be the exact terms that he used, but in effect that's what he referred to, and he quoted from their contents.

MR SIMPSON: This matter has already been raised with me, sir, I'm dealing with it.

THE CHAIRMAN: The reason why I am raising it now is this. I know that the DLS legal team, as lawyers, know what we look for when we ask for all of the documents which are relevant to the inquiry. What increasingly concerns me

is the people to whom these requests are forwarded may not realise what they're being asked for. They may not realise the scope of the inquiry. It is remarkable that Mr Walby refers in his witness statement to documents which are in files, which we had never been made aware of, and I'm just taking that, not particularly to hit Mr Walby with, but as a general point that we need some reassurance that when the Trust says, through you and Mr McAlinden, we don't have the documents, that the people in the Trust who are giving that information actually understand what it is that they're being asked for. Because this arose a number of times in Adam's case and if the ward diary is an example of it, then we don't have the ward diary, so we'll write back to the inquiry and say, "We don't have the ward diary". That's not the end of the exercise.

MR SIMPSON: We understand that, sir. We have made that clear. We'll keep banging that drum as much as we can.

THE CHAIRMAN: Thank you very much.

Mr Fortune, you made a reference a moment ago to Mr Sephton, and I will ask him about this in a moment. You said that the consent of various people had not necessarily been sought. Now, was that meaning that their consent could not be obtained or somebody had short-circuited it and not bothered to obtain consent

and a document was produced to the General Medical Council?

MR FORTUNE: It could be for more than one reason. For instance, the person could not be found. The last known address is, in fact, no longer a valid address.

THE CHAIRMAN: Yes.

MR FORTUNE: I'm not saying that efforts are not made. Clearly, those at the GMC do their best to obtain the up-to-date details of patients with a view to obtaining consent. But sometimes it's impossible because the patient has moved on or, indeed, the patient has died, or there is no further information.

THE CHAIRMAN: But that comes at the end of a process in which the patient can be identified from the information which is available, but steps are taken unsuccessfully to track down that person to ask for consent. The scenario which is being raised here seems to be slightly different. It is that nobody has sought to trace those patients or nobody has sought to obtain their consent, but that certain information has been provided to Dr Steen, which you're in possession of and which has contents which are potentially of some relevance to Dr Steen, to the inquiry and to various other doctors too.

MR FORTUNE: That's correct.

THE CHAIRMAN: Okay. Mr Sephton, can you help us with a steer on anything along these lines?

MR SEPHTON: Sir, the General Medical Council has powers under section 35(a) of the Medical Act to require documents to be produced. Section 35(a)(iv) says that:

"... nothing in the section shall require or permit the disclosure of information which is prohibited by any enactment."

But subsection (iv) says that if you can redact matters, so the name is no longer present, then the prohibition doesn't apply. So it's a provision that's particular to the General Medical Council.

THE CHAIRMAN: I see. Okay.

MS ANYADIKE-DANES: Sir, I wonder if I might refer to another matter to be clear about it? That is, obviously, we don't know the full details as to how these files were searched for and these particular documents were provided, but I think it's not too much of a stretch of the imagination to suppose that whoever was doing it was doing it to try and see if there was anything that could assist Dr Steen. So we have some documents from some files, we have absolutely no idea if there might be other documents, either in those same files or other files of children admitted, which might actually paint a slightly different picture. We have no

idea about that at all and we should have an idea because if there are documents out there, that, for example, go a little further than these to suggest that maybe she was there or maybe she actually wasn't there or it may have been by phone call, or if she was there, that she was very difficult to contact. Anything like that may be relevant. Equally, of course, if they do go further and they confirm not only her presence, but her availability, that is also relevant. We are just in a halfway house with partial documents that have been provided on behalf of somebody who, if I put it this way, has the best interests of Dr Steen at heart. That's not my interest. My interest is to get the fullest documentation to you.

THE CHAIRMAN: Okay.

MR GREEN: Sir, I appear on behalf of Andrew Sands. He is due to give evidence tomorrow. I recognise and he will have heard and taken on board the fact that you're not going to adjourn. My interest at this stage is purely to ensure that, in his attempts to assist the inquiry, he is treated fairly. And therefore, I would like first to see the documents that are in the possession of your learned counsel overnight so that I can take instructions on them, and second, so that I can consider whether there are any further avenues of enquiry which

the current documentation in the possession of my learned friend Mr Fortune and my learned friend Ms Anyadike-Danes generates.

So the question really from the point of view of Dr Sands and those who represent him is where we go from here overnight so there's no delay in the morning and so that he can get on with giving his evidence and so the inquiry maintains the momentum which has already been built up today and which you are anxious to progress.

THE CHAIRMAN: What I am inclined to do, unless there's any strong view to the contrary is this: I'm inclined to adjourn until tomorrow morning at 11 o'clock. Dr Steen should assume that is that she's going to give evidence tomorrow morning from 11 and Dr Sands should assume that he's then going to follow. I'm going to start late to give everyone an opportunity to consider the positions overnight, look at Freedom of Information provisions, and see if there's any way in which the evidence can start tomorrow, even if we may have to come back to some issues at a later point.

We may have some time on Wednesday. Dr O'Hare, who was due to give evidence by Skype on Wednesday, has now indicated she wants to be here rather than do that, and since Skype is a really unsatisfactory way to take a witness's evidence, we're going to try to accommodate

that so we might have a bit of room that if we start late tomorrow or delay tomorrow, we might be able to fit in evidence on Wednesday if there is a gap from Dr O'Hare. But for the moment, my inclination is that we start tomorrow morning at 11.00. Does anybody have any objection to the document which has been shared between inquiry counsel, Dr Steen's counsel and the Trust counsel being shared with others?

MR GREEN: On the contrary, I'm inviting that.

MR SIMPSON: All I can say is this: clearly, on the face of it, it was a wholly unauthorised access and one would need to be very, very careful. There may be information in it which would identify the person, whether the person's name is in it or not. Just as a matter of prudence, I would object. I think it must be me who has the locus standi to object because they are prima facie a Trust document, which has been accessed in an unauthorised way. I would be very wary about any further dissemination.

THE CHAIRMAN: That means that I will have to look at the document now to see if it has been redacted sufficiently or if it could be redacted any more to ensure that whatever child is involved is not identified.

MR SIMPSON: I'm registering our view.

THE CHAIRMAN: I understand. Okay.

Mr Green, I understand why you're asking for it and I assume you'll understand that I similarly recognise why Mr Simpson is bound to object. I will rise for a few minutes, look at the documentation, whatever it is, and come back as soon as I can with a decision on that point.

MR GREEN: Thank you very much indeed.

(4.24 pm)

(A short break)

(4.30 pm)

THE CHAIRMAN: I have considered what the way forward might be and reconsidered what I said just before I rose a few moments ago. I can see that I need more time to consider whether I should even look at this document. If it turns out that this document has been unlawfully obtained in a way which means I should never see it, then I cannot poison the well by looking at it this evening and deciding whether it should be redacted so that Mr Green or anybody else should look at it.

What I'll do is this -- and this is unfortunately getting more complicated -- I'm going to put tomorrow back to 2 o'clock instead of 11 o'clock. I would like Dr Steen to be available because we may need some questions to be answered by Dr Steen about what efforts she made to deal with this issue in her witness

statement and what information she sought. The other witnesses -- I'm afraid, Dr Sands is going to have to be put back until Wednesday. I'm sorry, Mr Green, I don't have any option but to do this. You'll understand why I am determined --

MR GREEN: I completely understand, sir, and I follow all the difficulties which you very carefully, if I may say so, and properly identified. Just from Dr Sands' point of view, if there is other information out there, which potentially is going to affect an important aspect of his evidence on matters, then he's entitled to know about it and have time to consider it.

THE CHAIRMAN: I agree. At the moment, one interpretation of the evidence to date is that he didn't have Dr Steen available to him and that may be why, for instance, he contacted Dr Webb. One of the issues which I raised this morning was the lack of evidence of contact between Drs Steen and Webb. And if it turns out that she was available, then that reinforces that issue. There are many aspects to it, some of which are for your client and some of which are against him.

MR GREEN: I agree.

THE CHAIRMAN: It's more fundamental than whether they're for or against you; they're all part of the inquiry.

MR GREEN: Absolutely, I understand that from your point of

view, but you equally, I'm sure, understand it from Dr Sands'.

THE CHAIRMAN: I do. And I think, ladies and gentlemen, we cannot determine this now, but it may be that the only way we keep up with our timetable this week is to run into Friday. Tomorrow at 2 o'clock, I would like some assistance with what you believe my powers are. We, of course, will be looking at that overnight. And I would like a number of the issues which have been raised in the exchanges to be considered by Trust counsel, by Dr Steen's counsel, inquiry counsel and by anybody else who wants to make a contribution. So tomorrow at 2 pm. Thank you very much.

MR FORTUNE: Sir, before we rise, can I just ask one question as a matter of logistics? It's a case of obviously having conferences. Will this building be open tomorrow morning?

THE CHAIRMAN: Yes. We can arrange for it to be open tomorrow morning. Thank you very much.

(4.35 pm)

(The hearing adjourned until 2.00 pm the following day)

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