Friday, 19 October 2012

(9.30 am)

THE CHAIRMAN: Good morning. Just before Dr Sands starts: Mr Sephton, after Tuesday afternoon's exchange about Dr Stevenson, we haven't heard anything from your end about any more points; is that correct?

MR SEPHTON: That's correct. We have been in contact with our client, Dr Webb. We have impressed upon him the urgency of the situation. He has e-mailed us, late last night, something which is a start, but I'm afraid it's not yet in a position where I'm able to disclose it.

I'm very conscious that the inquiry wants a document as soon as possible and I have impressed that upon Dr Webb. I hope by the end of today I will have such a document, but I can't put one before the panel now.

THE CHAIRMAN: More importantly for Dr Sands giving evidence, I don't want any surprises today coming from Dr Webb like we had for Dr Stevenson on Tuesday afternoon when Dr Stevenson was giving evidence.

MR SEPHTON: I can tell the inquiry that my concern with Dr Webb is around the issues of who was the consultant responsible. I don't think there are going to be any surprises there.

THE CHAIRMAN: That's an issue which has already been developed, I think, substantially. Okay. Dr Sands

knows the lines of questioning which are going to come from the inquiry, he has his representatives here.

MR SEPHTON: There are no factual matters I intend to raise with Dr Sands of which he hasn't had notice.

THE CHAIRMAN: Thank you. Dr Sands, please.

DR ANDREW SANDS (called)

Questions from MS ANYADIKE-DANES

MS ANYADIKE-DANES: Good morning, Dr Sands. Do you have a copy of your curriculum vitae there?

A. I do.

Q. You've made two statements for the inquiry, that's correct, isn't it?

A. Three now, I think.

Q. Sorry, two in relation to clinical issues, I should say.

A. That's correct.

Q. And did you make any previous statements for anyone else in relation to this case?

A. To the coroner for the inquest.

Q. Yes. You didn't make any in terms of any inquiry that there might have been in relation to the hospital?

A. No, I didn't.

Q. So if I ask you about your inquiry witness statements -- for the record, they're at 137/1, and that is dated 23 December 2011, and 137/2, and that's dated 18 June 2012.

A. That's correct.
Q. Do you adopt those witness statements as your evidence subject to anything that you might say to the inquiry during your evidence here?
A. Yes, I do. Maybe I should just point out one thing that has come to light quite recently, I suppose. The rota has been made available to me, the on-call rota for junior doctors from the evening and night of the 22nd into 23 October 1996. That probably affects, to some degree, my -- clarifies some of my answers in relation to who was on call and what the roles were on the evening of the 22nd, the night of the 23rd.
Q. At this stage, are you able to assist with how that clarifies what you might have said?
A. Just in terms of the personnel and their individual roles at that time, because I didn't have the rota, which I've now seen in the last 10 days or so.
Q. Does that mean that you're now aware of the individuals' names where before you would only have been aware that there would have been a registrar or there would have been an SHO, now you know the actual persons that you're talking about?
A. And perhaps actually the number of SHOs.
Q. I understand.
MR GREEN: I can give Ms Anyadike-Danes a reference now, or

if she wishes to have it later she can have it then.

MS ANYADIKE-DANES: Perhaps now would be convenient.

MR GREEN: 302-031-004.

MS ANYADIKE-DANES: Thank you very much indeed.

While I was questioning you before about your inquiry witness statements, you said you had made a statement at the inquest. So that we're clear, you had made a statement which was to be provided to the coroner; that's correct, isn't it? And I think that we have that, 6 July 2005. That's a fairly short, two-page statement.

A. That's correct.

Q. In fact, the reference for that, for the record, is 090-051-157. Then there is your actual deposition --

A. That's correct.

Q. -- which, at the bottom of it, will be some manuscript writing, some further things that were added while you were actually giving evidence to the coroner; that's correct, isn't it?

A. That's correct.

Q. And that is dated 4 May 2006. The reference for that is 091-009-055. The new part, because your earlier statement is in fact just incorporated into that, starts at 091-009-059. And those are all the statements that you've made in relation to Claire's case; would that be

correct?

A. That's correct. If I could mention maybe while we're on the subject, in my deposition to the coroner, I think there's a transcription error, as I read my statement out to the coroner, in terms of my position at the time. I think I'm recorded as being a paediatric cardiology registrar. I think that appears in the deposition to the coroner.

THE CHAIRMAN: Yes, you said:

"I had commenced my first substantive post as a paediatric registrar in paediatric cardiology."

A. Which is actually slightly different, Mr Chairman, from my statement to the coroner. So I think that was just a transcription error taken as I read out my statement to the inquest.

MS ANYADIKE-DANES: So what should it be?

A. It should have been that my first substantive post was as a paediatric registrar in Allen Ward on 7 August 1996. Prior to that I had been a locum registrar in paediatric cardiology for four months.

Q. In fact, that --

THE CHAIRMAN: Sorry, just for the record, we're looking at 091-009-055. Just to make sure, doctor, that we're looking at the right thing. This will be brought up in a moment. There we are. Ten lines down:

"I had commenced my first substantive post as a paediatric registrar in paediatric cardiology."

A. Which is not quite correct, and that's not as in my statement to the coroner.

MS ANYADIKE-DANES: If we pull up your CV, which I can take you to, it's at 311-001-001, but for these purposes, if we could pull up 004 of that document. Does that more accurately set out your previous engagements?

A. It does.

Q. So then I think the point you were making is that you can see that you were the locum registrar in paediatric cardiology and that's what you were from 1 April to 6 August of 1996.

A. That's correct.

Q. And then you were the registrar, specialist registrar in paediatrics, and that's where you were from 7 August 1996 to 5 August 1997. And that's what you were actually when Claire was admitted; is that correct?

A. That's correct.

Q. So just while we're at that, does that mean that was really your first substantive registrar posting?

A. That's correct.

Q. And you'd been about two-and-a-half months into that or thereabouts?

A. That's also right, yes.

Q. It was only something like about six months earlier when you were an SHO yourself?
A. That's true.
Q. Just so that we have it correctly, the hierarchy of clinicians, because the terminology has changed, and we have a document that seeks to assist us with that. But from your point of view, was it JHO, SHO, registrar and then consultant in 1996?
A. I think there would have been a distinction made between registrar and senior registrar. That largely disappeared with the adoption of the specialist registrar terminology, in which case you would be a specialist registrar in year 1, 2, 3, 4 or 5, rather than be a senior registrar in perhaps four or five of your training.
Q. In fact, I think when we were looking at that file 150, and we saw a letter between Dr Livingstone at Cupar Street and Dr Bartholome, Dr Livingstone was a specialist registrar.
A. I think she may have been a senior registrar.
Q. I beg your pardon, senior registrar, yes. That's to be distinguished from your position, as you weren't a senior rather at the time of Claire's admission.
A. That's right.
Q. I would now like to ask you just in general terms about

your knowledge of the Adam Strain case. As you may be aware, Adam Strain was admitted for paediatric renal transplant in 1995 and died in November 1995. Then he had an inquest into his death in the summer of 1996. So just a few months really before Claire was admitted and, in fact, just before you would have started your position as registrar. You would have been at the hospital at the time when that inquest happened and, in fact, I don't think you were at the hospital when he was actually admitted for his surgery. Just from looking at this, you would have been there when the inquest took place.

Dr Bartholome yesterday said that she -- it's at page 4 of yesterday's transcript, line 9, but not to be pulled up. This is what she said about it:

"I cannot definitely say whether in October 1996 I had read the full result [that's the full result of the inquest], but the whole events surrounding this inquest have been known to me and to most of the doctors in the Children's Hospital."

Would you agree with that?

A. I don't think I would, but that's based on my lack of knowledge about the Adam Strain case.

Q. Were you aware of it at all?

A. To the very best of my recollection, no.

Q. Can you recall when you became aware of it?
A. I don't think I became aware of the Adam Strain case until after, in fact, the television documentary was shown. The name in fact would have meant, I think, very little to me. Perhaps nothing at all until somebody told me about it after that television programme was aired. So I wasn't aware, knew nothing about the case.
Q. So if there was general discussion about it, it's not a discussion that would have moved so widely as to have included those perhaps not involved on the nephrology programme, not involved on Musgrave Ward and not you?
A. I think that's probably correct. I did move then into cardiology and away from the general paediatric side of things and indeed away from, I suppose, much of what went on in Musgrave Ward and so on, and indeed they may well have had a good background of Adam and his history, whereas I wouldn't have.
Q. Did cardiology involve surgery in those days?
A. Yes, the cardiology ward is a mixed medical and surgical ward, although the patients don't actually have their surgery within the Children's Hospital. They have their cardiac surgery over in the adult hospital, the Royal Victoria Hospital.
Q. What about the anaesthetist for any paediatric cardiology surgery, would those anaesthetists be from

the Children's Hospital?

A. No, at that time they were a separate group. Currently there's quite a bit of crossover, but at that time and indeed until very recently, the cardiac anaesthetists were a separate group working on a separate site, that is in the Royal Victoria Hospital rather than the Children's Hospital.

Q. So although the paediatric anaesthetists who worked on the renal transplants came from the Children's Hospital, the anaesthetist who worked in cardiac surgery did not, they came from the main hospital, the adult hospital?

A. That's correct.

Q. When you moved into that, did you have any exchanges, did you have much communication with your colleagues at the main hospital, if I can put it that way, when you moved into cardiology?

A. I would have been over visiting patients in the cardiac surgical intensive care unit.

Q. The reason I'm asking you this is because one of the things to have come out of Adam's inquest was a recognition that, for children going into major surgery with the potential for electrolyte imbalance, particular care needed to be taken of their fluid management, in particular, the testing. And that went on into ensuring that there was ready access to

laboratory results because there was such a concern that that was an area which had been deficient in Adam's surgery, if I can put it that way.

So there would be an issue if major surgery was identified as the area of concern. Obviously, cardiac surgery in children is major surgery. I say "obviously"; is that correct?

A. That's correct.

Q. Yes. So if there was going to be that sort of concern and people ought to be alive to that, what I'm trying to explore with you is whether that had, in any way, transmitted itself to the paediatricians dealing with the cardiac matters for children in 1996.

A. I think that's very difficult for me to say. I'm not aware that Adam's case did cause a change of care amongst the anaesthetists, particularly who were looking after the cardiac theatres and the post-operative cardiac surgical intensive care. It may have done, but I don't believe it was discussed with me or was something that was discussed generally within our team.

Q. So if I understand you rightly, although that might be something that the paediatric anaesthetists in relation to renal transplant may have been alive to -- because he obviously was a renal transplant case -- you're not aware of that message having got to the adult

anaesthetists who are providing anaesthetic care to paediatric cardiology patients?

A. I'm not aware of that.

Q. If it had transmitted itself, that message, in that way, is that something that you would expect to have at some stage become alive to?

A. I would have expected my senior colleagues to be aware of it, perhaps first of all, and to transmit that to the whole team as we were all -- I mean, as a trainee, as a specialist registrar in paediatric cardiology, I would have expected to hear about it from other colleagues.

Q. Is it something you would have wanted to know about?

A. Yes.

Q. Thank you. Just if we stay there, what was your own awareness of hyponatraemia at that time? Leaving aside anything that may have or should have filtered down to you in relation to Adam's case, what was your own awareness of hyponatraemia?

A. In 1996?

Q. Yes. Round about the time of Claire's admission, if you can put it in that way.

A. I think amongst clinicians at the time, including me, I think we would have first and foremost regarded hyponatraemia as a descriptive term of a low serum sodium, not so much as a diagnosis or an entity of

itself.

Q. Well, would you have been aware of how a child might reach such a condition or situation, if I can put it that way?

A. I would have had theoretical knowledge, at least, of that. I had studied for my MRCP examination and passed that in 1995, the summer of 1995. I'm not sure I would have had the appreciation of acute, that is sudden, hyponatraemia versus more chronic hyponatraemia, which I do remember seeing in adult patients as a houseman. I can recall adult patients coming in with low serum sodiums maybe before having surgery, and been aware that they were clearly hyponatraemic, perhaps because of drug therapy or other causes. As to whether I'd seen it particularly in the paediatric setting, perhaps not much at that stage.

Q. Well, were you aware of what we have called rather loosely the Arieff article in 1992?

A. I don't think I was.

Q. In terms of how it might develop, if I can put it that way, I wonder if I could -- it's slightly out of turn, but now that we are talking about hyponatraemia and your state of knowledge, it might help to do it now. 090-022-056. This is part of Claire's clinical notes and records, which I'm sure you have seen. If you look

at the second paragraph starting "hyponatraemia". So that is hyponatraemia and, as you've described it, hyponatraemia is effectively to say that the serum sodium is low. Would you agree that the 121 falls into that classification of hyponatraemia?

A. Certainly.

Q. 135 to 145 being the sort of normal range, so 121 is pretty low.

A. Certainly.

Q. And sufficiently low to be of concern?

A. Yes.

Q. And therefore classified, not just technically as hyponatraemic, but hyponatraemia that you have to do something about?

A. Yes.

Q. So this is Dr Stewart's note, and this is a note that he's making at 11.30, so he has those results and he has hyponatraemia, so he has that as how to classify it. Then he's querying the causes. One is fluid overloads and low-sodium fluids. That's one pathway, if I can put it that way, towards hyponatraemia. The other is SIADH. Would you have been aware of that yourself in 1996?

A. Of those as causes of hyponatraemia?

Q. Yes.

A. I would have certainly been aware of this syndrome of

inappropriate ADH, again probably more from a theoretical point of view rather than having practically dealt with it on a frequent basis. In terms of fluid overload with low-sodium fluids, I think at the time I would have been aware of that as a potential problem.

Q. So although you may not have seen many instances of it yourself in your paediatric career at that stage, you certainly were aware that that was a means by which hyponatraemia could develop?

A. Yes.

Q. And they might have different ways of addressing them, depending on which cause it was?

A. Yes.

Q. We had prepared a little flow chart to see how these things might interact with one or other of your differential diagnoses, but since we're talking about it now, it might be as well to have it. I think it's 310-014-001.

There we are. It's a simplistic graphic representation of what I'm quite sure is a complex situation. But this is just to try and see where the interrelationships might be. Would you say, broadly, that, leaving aside the three at the bottom, you can get a sort of cyclical relationship, as is described above,

with the greens feeding into the cerebral oedema, the cerebral oedema feeding into the SIADH, and an alternative route to getting to the retention of free water and the hyponatraemia being the one that you've just identified, which is the hypotonic fluids? So overadministration or too rapid a rate of administration of the low sodium fluids could lead to a retention of free water or an excessive retention of free water, that lowering the serum sodium level could produce hyponatraemia, which could lead to cerebral oedema, and the cerebral oedema could produce the SIADH in and of itself and you could just get into that awful cycle.

Although you might not have stood on the ward and drawn that out yourself, but if you had been asked, would you have appreciated that there were those interrelationships?

A. I'm not sure in 1996 whether I would have understood it in those quite clear terms as they're laid out there, because I think this does reflect the understanding now that, if you have even some elevation in ADH levels and you provide a source of free water, that you can then retain free water, that you can then see hyponatraemia. So I don't think I would have understood it in this sort of clarity at that stage.

Q. But from what you had said before and looking at

Dr Stewart's own note, you would have understood, would you not, that an overadministration of low sodium fluid could lead to a retention, an excessive retention, of essentially free water, and that would necessarily produce a low serum sodium, which is hyponatraemia; you'd have understood that?

A. Yes, but probably just in those fairly simple terms, and had you asked me to draw this diagram in 1996, I probably wouldn't have been able to.

Q. But if we stick with that fairly simple relationship, and once you'd got to hyponatraemia, might you have appreciated that hyponatraemia, left unchecked, could produce cerebral oedema?

A. Yes.

Q. Thank you. And that's one of the reasons you would have appreciated then why it is dangerous and it needs to be addressed.

A. Hyponatraemia, yes.

Q. Thank you. Before we go into the day and work our way through the day, which I'm going to try and do with you, because it's less confusing than jumping about the issues, I wonder if you could help with this: what were your teaching responsibilities at that time?

A. Again, I'd have to say that my recollection is not complete on that matter, but typically during the

university terms, we would have had medical students to teach and would have taught them on a regular basis. That would have probably involved consultants and registrars taking them in tutorial groups for fixed sessions. We probably had some teaching responsibility as well towards SHOs within a ward group meeting setting, and that probably occurred on a weekly basis.

Q. If we stick with the SHO element of it, apart from a sort of more formal teaching session, is that something that was really ongoing, that you would use ward rounds, if you were conducting them, as a learning point, if I can put it that way, particular conditions of patients as a learning point or outcomes of their treatment; is that something that you were expected to carry on through the day with your SHOs?

A. I think that is the model that was usually employed. I have to say that is somewhat time dependent and depends just on what else is happening and whether there's time to do that. I think that in a teaching hospital particularly, that's how things ought to be and that's what you would aim for.

Q. And the Children's Hospital was a teaching hospital?

A. Yes.

Q. So that was the intention, not exactly mentoring, but you would be bringing along these SHOs and taking the

opportunity to teach them. What do they call it, ward-based learning perhaps?

A. Yes, and I think a lot of learning was ward based. I think if one was taking a ward round, one would feel the onus was on the registrar, me as an individual, to firstly and foremost try and address the patient's needs. Teaching would probably have been of secondary importance and would have been subject to having time to maybe take people aside and talk to them and explain why you were doing something and why a particular course of action might be appropriate.

Q. Is it part of your role to, apart from inculcating good practices, which you're trying to do there, but also try and prevent or avoid poor practices developing amongst the SHOs?

A. Yes, as a general rule, and I think if one had a concern about poor practice, one would have felt obliged at that stage to tell a senior doctor, that maybe there was -- if it was a small problem, if it was something that could be corrected or if you could encourage somebody to do something a slightly different way, I think one would have tried to do that. If there was a major issue, then I think one would have tried to talk to a senior doctor about it.

Q. Leaving aside the major issues, just making sure that

they're coming along in the way you would wish them to because these are going to be the future doctors standing in your shoes at some point, you hope. For example, record keeping. You're presumably looking at the medical notes of patients all the time as you go through your working day, and if you identify poor record keeping, is that something that you think -- leaving aside what the consultant might do -- that you might have a word with whichever was the SHO involved to draw that to their attention?

A. Yes.

Q. And you would consider that part of your responsibility?

A. Yes.

Q. And did you do that sort of thing in 1996?

A. I think we did. I seem to remember that we did have discussions of that sort. I don't remember exactly in relation to record keeping, but other things, about how a ward should be run and how things should be done. It partly depends. Obviously, you take a lead from your consultant, you also provide a lead by thinking what is, in your own mind, best practice and then you try and encourage others to try and follow both of those examples, and I think we did have discussions of that sort as a team. As well, when we came to Allen Ward, we received some instruction from consultants about these

matters as well.

Q. I understand that it's quite difficult to go back 16 years and tease out what you think you were told then and what you might have developed along the way, but given that you had perhaps not been in Allen Ward that long yourself, were you aware of having any sort of discussions to assist you in what the relevant consultants' expectations were of you, what their own standards were, how they wanted to have things done, if I can put it that way?

A. I don't have very many direct recollections. I can tell you of one though that I do remember.

Q. Yes.

A. I assume it was actually quite early after starting at the Children's Hospital -- it was possible it was my very first attachment to the Children's Hospital, so it may have been a little before I was a reg in Allen Ward. I remember Dr Steen sitting some of us down and telling us how we should avoid doing blood tests out of hours if possible, do them within hours, try and avoid doing a so-called full admission profile on admission just for the sake of it, that tests should be focused, well-organised and done within lab hours if possible. And that's just something that has stuck in my mind from way back. As I say, it may pre-date October 1996 by

a little bit, in fact it may relate to my very first attachment to the Children's Hospital.

Q. And that was why? That was because out-of-hours put a burden on the laboratory and the other resources to do it?

A. I believe so, and also, I think it was to make people think exactly what they were asking for, why they were asking for it, what they hoped to find from it.

Q. To be more focused in your thinking about what might be the diagnosis that would require any given test being carried out?

A. Yes. I think other individual consultants, I'm quite sure, had their specific things that they were concerned about. For example, Dr Redmond would have had very definite views about what she did or didn't want done with other her cystic fibrosis patients as a more specialist doctor. And I feel Dr Hill as well would have had probably particular things about her own group of patients with neurodevelopmental disorder, that she felt should be done or how things should be done and she would have emphasised those points I believe as well.

Q. Without getting to actual specifics, but in the way that you have given that generally for those two consultants, were you aware of anything like that in relation to Dr Steen?

A. Other than what I've mentioned, because I do believe it was Dr Steen who did discuss about the investigations, I have no other specific recollection about how she particularly wanted things done.

Q. Do you recall any discussion as to the circumstances in which any of those consultants, but obviously specifically Dr Steen, would have wanted to be contacted by you in relation to any of their patients? Did you have those sorts of discussions?

A. I'm not sure how explicit that would have been. I think we would have all been aware of what the consultants' expectations were, but it may not have been explicit. I would say that as a junior doctor, time and time again -- and I still repeat this today -- we were told that if we were in any doubt about a patient that we should seek senior advice and not hesitate, not delay, in doing that.

The other thing that was emphasised is that we should encourage people to be able to spot the sick child because we see lots of children, many of whom can appear quite sick, but sometimes when their temperature comes down, miraculously, they look so much better straightaway. But being able to spot a sick child and to seek senior advice, get senior advice and don't be afraid to ask for that.

Q. Speaking of getting senior advice, were you -- I think you probably were here when Dr Steen was giving her evidence, and she indicated that she was contactable in a variety of ways. She had a bleeper, like many I'm sure, she had a mobile phone, not so much like many, she had a secretary who maintained her diary and, at any given time, the clinicians would have known how to reach her; would you accept that?

A. I'm not sure I would have known of all of those routes of contact with Dr Steen.

Q. Which do you think you wouldn't have known about?

A. I can't say. I think, though, I would have usually known her whereabouts and --

THE CHAIRMAN: Did you have a bleeper?

A. I had a pager, yes.

THE CHAIRMAN: Did all the doctors have pagers?

A. I'm not sure that all the doctors had pagers and carried them all the time. Within the hospital, I think all of the junior doctors had pagers. I'm not sure all of the consultants had pagers all the time. I'm not sure all the consultants had mobile phones all the time.

MS ANYADIKE-DANES: You just added a bit to it: even if they had them, you're not sure they had them with them all the time?

A. That's right.

Q. Thank you. Just finally on this general part of what I'm asking you, I've asked you about your teaching responsibilities and you went through what you did during term time with the medical students and then what you tried to do on the ward with the junior doctors. Did you have clinics yourself?

A. As in a registrar-run clinic?

Q. Yes.

A. I think there was probably one registrar-run clinic.

Q. Can you help us with when that might have been?

A. I have asked a lot of people about this. I think there was a registrar-run clinic, which was a review clinic, I think on a Thursday morning. That's the best advice I can get, having asked people about it.

Q. The reason I'm asking you this is because Dr Stevenson is not clear in his own mind exactly where you were on the afternoon of Tuesday. Well, where you were in the hospital. And he did wonder whether you might have been attending a clinic or a lecture or something of that sort. Can you assist?

A. This has been an issue for me too in trying to recall this, trying to find out about where I was during that afternoon. Because my own recollection of it is that I was out of the ward for much of that afternoon for what seems like a finite period. That's my own

independent recollection of it.

When I first asked people about it, they said, no, there wasn't a clinic on the Tuesday afternoon. So I thought, well, maybe I was teaching or doing other clinic duties, maybe I was still seeing patients in other parts of the hospital. More recently, when I asked again about it, because it still bothered me that I couldn't pin it down, I asked Dr Anne Armstrong, who currently does a clinic on Tuesday afternoon on the fourth Tuesday afternoon of the month, which is a medical review clinic.

I asked her then, was that inherited from Nan Hill, whom she had taken over part of the responsibilities from, when Nan Hill had retired. She said, yes, it was. I phoned Nan Hill and I asked her because I still wasn't sure. I asked her: did you do a medical review clinic on that Tuesday afternoon, the fourth Tuesday afternoon of the month? She said she did. And I asked her, I said, "Please don't let me put words into your mouth, but would you have expected a registrar from Allen Ward to be with you doing that clinic or even instead of you doing that clinic?", and she said she would have expected registrar help at that clinic.

Q. So that's where you could have been?

A. That's where I could have been. I don't remember,

I don't have a clear recollection of where exactly I was on the afternoon, but my independent recollection is that I was out of the ward for a period of time, a finite period of time, during that afternoon. I may have been able to briefly call back into the ward at some stage, but ...

Q. If you were attending that clinic, do you know where that would have taken place?

A. As I understand it, in the surgical outpatient area of the old part of the Children's Hospital, because the rest of the Tuesday afternoons -- as I understand it, Dr Hill did a joint surgical clinic with, I think, maybe Mr Boston, initially and then, maybe more recently, Mr Bailey. That really related to patients with spina bifida.

Q. And I'm going to try and see if I can pull up one of the site maps. Let's try 300-003-003. There. It's actually on the hospital complex, do you think?

A. Yes.

Q. If we perhaps blow that up then. Can you help us with where you think it might have been if you orientate yourself?

A. It was actually -- it was adjacent to the old A&E department, which faced on to the Falls Road.

Q. Can you point the pointer? Are we going to the right of

where that is?

A. Yes, just to the right and down a little bit.

Q. Just about there?

A. Yes. Perhaps slightly to the left, because as far as I'm aware, the surgical outpatients occupied just two or three rooms down from the casualty cubicles.

Q. Somewhere roughly where that is marked?

A. I think so.

Q. And if you were going to get there from where Allen Ward is, which we can see identified there, roughly how long would that take you?

A. Five minutes. Less. Maybe four minutes.

Q. If you were going to do something like this, I know you say you can't remember if you were doing it, but if you were going to do something like that, is that something that you would know in advance that you were going to do that?

A. Well, usually, although if a consultant perhaps said that they couldn't do all of the clinic, couldn't maybe do any of the clinic, then you might have found yourself doing rather more than you'd anticipated.

Q. If that's the fourth Tuesday in every month, that might have been only the second or so one you'd done; would that be right? But it would be, I understood you to say, an established practice, not necessarily that the

registrar is doing it, but certainly that there is a clinic like that?

A. That's my understanding. I wouldn't have known that had I not gone through that process, and I did ask the Trust recently to see if they could clarify that at all.

Q. But that would be known on the ward that there was a clinic like that that registrars may, from time to time, have to attend and may, from time to time, have to take?

A. I believe so.

Q. And if that's established and known in that way, what sort of arrangements are made for cover for you?

A. Well, I would still have been contactable with my pager. People would have known where I was. I don't think I would have had direct registrar cover for my absence if I was doing a clinic such as that, insofar as I think then the ward staff, senior house officers, really would have been working away without my presence actually there and then.

Q. And so in terms of senior house officer cover for Claire on that day, that is Dr Stevenson certainly and Dr Stewart; is that right?

A. I think I think so, yes.

Q. So that would just be the two of them?

A. Yes.

Q. And if you had been attending that clinic, what time would it start, or more particularly, when would you be expected to turn up for it?
A. At a guess, perhaps around 1.30, quarter to two.
Q. I'm just trying to establish your whereabouts. I hadn't entirely realised we would go down this direction, but let's pursue it seeing as we are talking about your whereabouts. Dr Webb thinks that some time, lunchtime, you and he had perhaps attended some sort of lecture and that that is when you and he had the conversation about Claire. Do you remember anything like that at all?
A. I don't think I met Dr Webb to speak with Claire at that lunchtime meeting. I am aware that there is and was a Tuesday lunchtime meeting in the Children's Hospital that ran most Tuesday lunchtimes from 1 to 2 o'clock.
Q. What is it for, the Tuesday lunchtime meeting?
A. It's usually a senior doctor and his or her team will present a case or cases, and then -- so it gives some clinical information followed by some discussion about a particularly interesting aspect of patient care.
Q. Is it something that you would normally attend?
A. Yes. As far as I was able to, yes.
Q. I am just trying to see if we can pull up that reference from Dr Webb for you. WS138/1, page 5. I think it's 2(a) and (b).

THE CHAIRMAN: It's the bottom two lines.

MS ANYADIKE-DANES: Yes:

"I cannot recall when Dr Sands contacted me about Claire, but I believe this was in the corridor at lunchtime on 22 October. I cannot recall the exact details ..."

I was am trying to place where you were. That comes in (b):

"I believe Dr Sands contacted me in person at lunchtime on 22 October. This may have been after a hospital clinical meeting that we had both attended."

So as I understand it, there probably was a hospital clinical meeting, you're just not sure whether you attended it?

A. I think it would have been finished at 2 o'clock, so that would have suggested that I talked to Dr Webb after 2 o'clock. And I don't think that's how I contacted Dr Webb.

Q. Do you have any actual recollection? You do? We'll come to in that a minute then. That would have meant, if you had attended that, you would have been at the lunchtime meeting, and if you had gone on to the clinic, you're pretty much going directly to the clinic if that had happened?

A. Yes.

Q. Which, absent being contacted through your pager to attend back at Allen Ward, would have had you away for most of the afternoon if that had happened.
A. Yes.
Q. Okay. And I think you were saying that if you were going to a clinic like that, it would be known ahead of time that you were and it would be known that you could be contacted, at least, through your pager.
A. Yes.
Q. And if for any reason that didn't work, did people actually know where that clinic was being conducted to physically ask somebody to go and get you?
A. I think they would. I think nursing staff and, I believe, junior medical staff would have known, yes.
THE CHAIRMAN: Why do you think that it's not likely that Dr Webb is right that you spoke to him at about 2 o'clock?
A. My memory is that I left the ward round after we'd seen Claire and that I went to find Dr Webb at that point. I would have probably gone first to Paul Ward because that's where Dr Webb's ward base was. I don't think that's where I found him; I think I found him elsewhere in the hospital at that stage. So I think it took me a little time to find him, but not so very long. I think while there, my memory is that I described

briefly Claire's findings to him and asked him if it was okay that we give a dose of rectal diazepam because that's what we had suggested on the ward round. But I think it wasn't actually given or prescribed until 12.15. So I believe I checked with him that he was comfortable with that before it was given and it was given around about or shortly after 12.15.

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

A. Perhaps around 12-ish, yes.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: I think we can see the reference for when the rectal diazepam is given. I think it's 090-026-075. If one goes right down to the bottom, just so that we understand how this works, this is the once-only prescription and the rectal diazepam, 5 milligrams, was once only. Time of administration, 12.15, and whose signature is that?

A. I think it's --

Q. It looks like Dr Stewart's signature prescribing it. And Nurse Linsky, it looks like her signature signing off as having actually given it?

A. That's my impression too.

Q. So what you're saying is -- in fairness to you, I think

that's what you said in your witness statement at 137/1, page 11. Right down at the bottom in relation to (i):

"I left the ward round to speak to Dr Webb and asked for his advice, and raised the question of an urgent CT scan. The ward round discussion had suggested a trial of rectal diazepam."

And we can see that from the notes:

"I believe that I checked that Dr Webb was in agreement with this before administration."

So if you piece the plan, if I can put it that way, in her medical notes and records following the ward round, with the administration of the rectal diazepam in the prescription sheet, and you saying that you didn't do that before you confirmed that with Dr Webb, then that assists in placing when you were discussing with Dr Webb. Is that how you would categorise it?

A. That's right.

Q. Is there any way that you might have had a further discussion with Dr Webb, slightly later on in accordance with what he recalls in his evidence, that you might have, after all of that, nonetheless gone to the lunchtime meeting and nonetheless raised the case of Claire, about whom you might have had concerns? Is that possible?

A. It's possible, but I don't remember that.

Q. But it could have happened?
THE CHAIRMAN: It's possible.
MS ANYADIKE-DANES: Thank you.
If you'd been concerned about a patient's condition, would you have gone to the clinic?
A. I think I still would have felt an obligation to go to the clinic, but I wouldn't have gone there without having tried to put in place a plan or at least feel that somebody was going to be looking at the patient whom we're concerned about, somebody who was going to try and help manage things. I would have felt uneasy about doing that unless I felt that was going to happen.
Q. And who would that person be if you're starting the clinic at 2?
A. I think in this case I felt that Dr Webb was going to come and see Claire quite soon. Perhaps I felt he would see her even maybe sooner than he did. I suppose I went to him feeling that he might even be able to come right away.
Q. Staying as we have with that part of your witness statement there, are you saying that when you had raised Claire with him, whenever it was, before 12.15, it was your impression, understanding, hope, that he would actually come quite soon to see Claire?
A. That's right.

Q. And certainly before you had to leave to go to that clinic?
A. That was my hope.
Q. Can you recall whether he had actually come to see Claire before you left for the clinic?
A. My recollection is that I wasn't there when he came to see Claire, so I wasn't actually in Allen Ward when he came to see Claire. I remember being, I suppose, frustrated at having asked Dr Webb to come, that I had been unable to be there when he was there.
Q. So did that mean, then, that you left for the clinic without actually being sure when Dr Webb was going to see Claire?
A. Yes, I knew he was coming, he assured me he was coming. I would have anticipated his arrival soon, but I may have had to go before he came to Allen Ward.
Q. So if you were speaking to Dr Webb, let's say 12-ish, to enable you to have had that conversation, got back, told them, "Yes, administer the rectal diazepam", and that's all signed up for 12.15. So let's say you were speaking to him at about 12-ish, would that be a reasonable time?
A. Yes.
Q. So in two hours, you haven't seen him, and you're sufficiently concerned to have gone to see him in the first place and had wanted him to see her earlier. Did

it not trouble you that you were leaving Claire, a patient who you had been concerned about, to go to this clinic when you weren't entirely sure when Dr Webb was going to come and see her?

A. I think that would have caused me concern. I don't remember exactly how I felt at the time, but indeed that may have the time when I also tried to contact Dr Steen to let her know that I'd spoken to Dr Webb. So when I say I had spoken to Dr Steen in the afternoon, it may have been in the early afternoon.

Q. I understand. I will come to that in a minute. I'm sorry to be taking you out of turn, but it is just that we were talking about where you were and what you were doing in more general terms so I thought I'd take the opportunity to do that. Just so we close that off, not entirely being sure when Dr Webb is coming but believing he will come, those then in charge of any deterioration in her condition or managing her until Dr Webb finally does come and making any decisions that might need to be made, should he delay even further coming, that was left to Dr Stevenson and Dr Stewart?

A. Yes. Again, I would hope that if they had additional worries over and above those that had been voiced at the ward round or thought there's still no sign of Dr Webb, that they would have called me and told me that perhaps

there's no sign of Dr Webb yet, what do you want us to do, are there other things we should be doing.

Q. Because they wouldn't have been present, either of them, would they, when you had your conversation with Dr Webb?

A. That's right.

Q. Could it have been in some way that they thought that, registrar to consultant, it had been sorted out and we're just holding the fort, as it were, until Dr Webb turns up?

A. I take the point. I still would have hoped that they would have known me well enough to give me a call if they weren't happy and felt able to do so.

Q. Just so that we're clear: how ill would Claire have had to appear to you for you not to have gone to that clinic?

A. I think she would have needed to appear very unwell and perhaps on a ... My impression of Claire on the ward round really related to her neurology and her being neurologically very unwell. If her other vital signs had been impaired or changing rapidly, I think I would have felt very uneasy about going to that clinic and I would have perhaps had to cancel or pull out of that clinic if possible.

Q. Her Glasgow Coma Scale at that stage had fallen.

THE CHAIRMAN: At which stage?

MS ANYADIKE-DANES: At the stage he's going to the clinic, which is 2 o'clock. The first record taken of her Glasgow Coma Scale is at 1 o'clock. In fact, if we just pull up this compendium document that we have just been looking at, 310-001-001.

A. I may have had to be at the clinic rather before 2 o'clock, perhaps 1.30 or 1.45.

THE CHAIRMAN: Yes, I think you said early it would be about 1.30.

MS ANYADIKE-DANES: So you would have had to leave at about 1.30? So all that you would have known is the first result, which is, I think, 9. You wouldn't have known about anything after that?

A. I may not.

Q. Can I then ask you to try and take it chronologically in what was going on during your day? When did you actually come on to the ward to take over, as it were?

A. Again, I don't remember precisely from the 22nd October 1996, but usually just a little before 9 o'clock.

Q. Dr Steen had said if she was doing a ward round, she would be arriving at about 8.45 or so to have a talk to people, perhaps have a quick look at notes, maybe talk to the nurses, that sort of thing. Would that accord with the sort of time that you'd expect to get there?

A. I think, on occasion, Dr Steen would even be there earlier than me.
Q. But you would be there at about quarter to or there or thereabouts?
A. Thereabouts.
Q. Do you have any independent recollection of the 22nd?
A. I do.
Q. Thank you. As I ask you, will you tell me when we get to a point which is no longer your independent recollection, but is a reconstruction from the documents, if I can put it that way?
Dr O'Hare was the doctor who was covering that night on call during the night shift, and we have had her evidence yesterday. I don't know if you heard any of that evidence.
A. I've seen the transcript.
Q. So you know -- and maybe you have been in that position yourself -- how many beds you're taking care of and you know what the pressures might be. In any event, she writes up her examination, she sees Claire twice.
A. Yes.
Q. She sees her at 8 o'clock and then again about midnight. Would you have looked at those notes before the ward round?
A. Not necessarily, unless they were pointed out to me and

said: here, you'd better have a look at this chart or there's something in here that you should read beforehand.

Q. Would you have expected to have had any kind of handover at all between you and Dr O'Hare?

A. I would have hoped for a handover, albeit a limited, perhaps brief handover. I think that was the practice and was the practice for some lengthy period of time. My impression is that the morning handover may have been somewhat more limited than the evening handover, I suppose, because you're handing over to somebody who's covering a greater number of patients.

Q. Mm-hm.

A. So the morning handover may have been less formal and more limited.

THE CHAIRMAN: You'll have seen her point yesterday that if she was doing a handover to each of the wards that she covered overnight, and it was 10 minutes each, that could be an hour's work. She thought in those days it was less likely that there would have been even an informal handover unless there was a patient of real concern. And the ward that she continued to work on after 9 am was Musgrave, not Allen Ward.

A. That's right. I think that's right. It might have to be a patient or patients whom one was particularly

concerned about in order to prompt a handover.

THE CHAIRMAN: Yes. Okay. In any event, you don't remember a handover from 22 October?

A. I don't remember specifically that morning, no.

MS ANYADIKE-DANES: But I think you said that you might have been expected to have been told something, however briefly and informally?

A. That I'm constructing really from looking back at Claire's admission note and thinking, you know, that Claire, as she appeared in A&E, and to Dr O'Hare, that ...

Q. Let's pull that up and see if that helps. If we start at 090-011-013. That's the actual referral. If we put next to that the note that I think Dr Puthucheary takes at 012-014. There we are. That's the admission. So you see the description there.

If we then move on to the note or at least the beginning of the note that Dr O'Hare takes at 090-022-050, we'll just run through these and you can help us with what, in this, would you have thought should really have guided Dr O'Hare to have had some word with you, however briefly. That's the first page of her note. We see it starts at 8 pm and she takes a history. If we go on to the next page, 051.

THE CHAIRMAN: Well, you've seen these notes, I presume,

doctor?

A. I have, yes.

THE CHAIRMAN: Can you tell us, what is it about what is contained in these notes which makes you say that you would have been expected to have been told something at about 9 am?

A. Again this, is with hindsight having reviewed the notes, and I appreciate I wasn't there when Dr O'Hare saw Claire at that time. But it's the level of consciousness, it's the concern over the level of consciousness both in the A&E department and when Dr O'Hare writes:

"Not responding to parents' voice/intermittently responding to deep pain."

MS ANYADIKE-DANES: In fairness, if we pull up the next note, 052, then you have the two pages of her examination, which may be the most useful things for you to help us with.

So that's her examination and the results. It also captures midnight, so that's helpful. You have talked about the level of consciousness and the reflexes, did you say?

A. Well, the neurology generally, the abnormal neurology, which I think the casualty doctor noticed as well, and was in the GP referral too, all of which raised

concerns. I think what makes the difference, though, is that Claire seems a bit more responsive at 12 midnight when Dr O'Hare reviews her. I also think what probably makes a difference is that, according to the nursing notes, Claire seemed brighter.

Q. Yes. But you wouldn't have seen those nursing notes at the time?

A. Absolutely, no, I'm just reconstructing this from having looked at the notes.

Q. And it may be that Dr O'Hare wouldn't have seen them just before she left.

A. Quite.

Q. So if you're saying why you would have expected Dr O'Hare to have had even a brief exchange with you, it's based on, essentially, these two pages --

A. Yes.

Q. -- and also the page from A&E and, to some extent, the reason for admitting her in the first place?

A. Quite.

Q. And it's all the neurological concerns so far as you've told us so far?

A. Yes.

Q. Is there anything else that you would have thought she should have maybe just drawn to your attention?

A. Those would have been the main things, I think.

THE CHAIRMAN: And just to get this clear: you're saying there are issues in these notes which do cause you concern, which make you think that there might have been a handover, but on the other hand you say, for instance, the 12 midnight entry, "Slightly more responsive", maybe that's what makes the difference, maybe that's why there wasn't a handover?

A. That, for me, sort of balances a little bit Dr O'Hare's view for me a little bit.

THE CHAIRMAN: It suggests that Claire has not got worse overnight, but that she may be a little bit better?

A. That's certainly possible, yes.

THE CHAIRMAN: Is that what you think might make a difference as to why there wouldn't be a handover.

A. Yes.

THE CHAIRMAN: Okay, let's move on.

MS ANYADIKE-DANES: Yesterday when Dr O'Hare was asked by the chairman -- it's at page 178, line 18 -- she said:

"If I were to hand over, I would have said that this is a child that I wasn't 100 per cent clear about her diagnosis and I would like her reviewed on the ward round."

And given what you have seen there from those two pages of notes, is that the sort of thing that you might have expected Dr O'Hare to tell you?

A. I think she may have told me a little more than that, rather than saying she wasn't 100 per cent sure what was going on. She may have said a little bit about the abnormal neurology or the reduced level of consciousness.

Q. And that's notwithstanding the fact that she notes at midnight a slight improvement and that if she'd had an opportunity to note it, she could have said: that's confirmed with the nurses. Leaving aside that, you'd have still expected her to have had some sort of word with you about Claire?

A. I think it would have been appropriate, but as I say, it is balanced probably by the fact that she felt Claire to be a little bit better.

THE CHAIRMAN: It also must be balanced, doctor, by who else Dr O'Hare was looking after.

A. Quite.

THE CHAIRMAN: Because we now know she had this ridiculous workload where she is the senior doctor in charge of over 100 children. So it might be that she did have concerns about Claire and she has expressed her level of concern about Claire, but it might also be that there were other children who she was still, for instance, working on at 9 o'clock.

A. Yes.

THE CHAIRMAN: And let's say hypothetically she's working on a child from 8.30 to 9.30, there won't be any handover to anybody, will there?

A. I think that's right, and those sort of contingencies will have happened, do happen, will get in the way of what might be best practice, what one would intend and hope to do.

THE CHAIRMAN: It's easy for us to say today there should have been a handover and things are better now, I understand. The major problem seems to me to be that, in 1996, there was a single registrar in charge overnight of the Children's Hospital.

A. Yes, and I did that job as well. I would agree with the doctors who have given evidence about that already. That was an onerous job, a big responsibility.

MS ANYADIKE-DANES: Thank you. Dr O'Hare does write in her note -- would you agree that's a fairly full note that she writes, those two pages?

A. Yes.

Q. Whatever the pressures of time on her, that's a fairly full note she writes.

A. Yes.

Q. And she goes back to see her again at midnight. On both occasions, she says "reassess". So she is regarding Claire as a patient that needs to be reviewed. Had you

read it -- and I know that you're not sure that you would have looked at the notes before the ward round. I presume you'd have looked at them at some stage.

A. During the ward round, it may have been that the senior house officer had the notes sitting on the trolley and read the notes to me.

Q. Assuming that had happened and he had read out the salient features of that, including the "reassess", what would you understand "reassess" to mean?

A. I think there are two mentions of "reassess" and Dr O'Hare does the first reassessment herself and then suggests "reassess in the morning". I think Dr O'Hare has probably said she felt that was on the ward round, do that reassessment on the ward round rather than beforehand, if I'm taking that correctly.

Q. Yes. Assuming that's the case, she thought that reassessment would take place as part of what would happen during the ward round. What would you have understood that that involved?

A. I think on the ward round that really involves starting from the beginning again and going through things in terms of history, examination, investigations, management plan.

Q. Yes. It's not up here, but it has been up a few minutes ago and you have obviously seen it and so has everybody

else. When Dr O'Hare goes through her examinations, she goes through -- and in fact one had the benefit of her evidence yesterday to understand exactly what all this means and how she went through it. She went through quite a detailed CNS examination, if I can call it that: she was trying to sit her up, she was testing her motor power, her tone and her reflexes, and whether there was any cogwheel rigidity. She has recorded all of that for left and right and so on. If you say that you were effectively going to start from scratch and do your own, would you have done the sort of thing that she has recorded as having done, would you have been doing the same thing yourself?

A. Similar, perhaps not in quite so much detail as one would do for a clerk-in, the very first time you see a patient.

Q. Why?

A. I think a clerk-in is often the most complete record of physical -- sorry, history taking, physical examination, and you will see the clerk-in notes are often the biggest notes in the medical charts.

Q. Yes, but given that there was a concern about her neurological condition and there was some suggestion that she might have improved a little bit, although you'll hear in a moment that the parents' view was that

she had not, would you not have been wanting to repeat some of that test so that you can compare the results that Dr O'Hare had got at 8 o'clock in the previous evening with the results that you were getting now and form your own view as to what was happening?

A. Yes.

Q. Does that mean that these tests, if I can put it that way, that Dr O'Hare had carried out, say in relation to her reflexes and so on, you would have carried those out yourself?

A. Yes.

Q. And do you think you did?

A. Yes.

Q. The results of those are not recorded in her notes, though, are they?

A. I think they are under --

Q. Sorry, maybe I have missed that.

A. -- "bilateral long tract signs". That's a term used to catch a number of things.

Q. Maybe we'll go to that so we see that. If we pull up two pages together, we have the 052. If we pull up 053. Then I think you have it. So the start of it is right down at the bottom, isn't it, "Ward round, Dr Sands"? Where are you referring to now?

A. "Pupils sluggish to light." It's under, "CNS

examination, difficult to see fundi", that was difficult at that stage to see the back of the eyes with an ophthalmoscope, but clearly we were trying to do that. "Bilateral long tract signs", suggesting bilateral upper motor neurone lesions, suggesting abnormal power in the upper and lower limbs, abnormal reflexes in the upper and lower limbs, and suggesting tone was increased in the upper and lower limbs, and also that the plantar reflexes were abnormal.

Q. If anybody was wanting to see what the differences were between when she was clerked in and those tests or examinations being made at 8 pm, and this record here of your examination during the ward round, how would they be able to tell what the change or difference in her condition was?

A. I think that note could be expanded somewhat to be a bit more specific, but --

Q. It's a bit dense.

A. I think it is, yes.

THE CHAIRMAN: Let him finish.

A. Dense in one way, but condensed in another. Maybe condensed in making it difficult for some people to interpret or to work out.

MS ANYADIKE-DANES: If you were coming to that, would you necessarily be able to see what difference there had

been in the results that Dr O'Hare had obtained and the results of your examination?

A. I think I would, but I might want some more detail.

Q. And how would one gauge the difference in her condition between the two from the note that's recorded there? If that's all you had, Dr O'Hare's notes and the note which is made on the ward round which includes that expression, how would you tell the difference?

A. I'd probably need to see Dr O'Hare's note again to try and contrast.

Q. If one takes off the 052 and puts up 051. 090-022-051. I think that's there.

A. So Dr O'Hare has been able to examine more of the cranial nerves, she's ticking off the cranial nerves as being ticked individually, so they seem to be intact and normal. The fact that we haven't been able to assess the cranial nerves, it has been difficult to do that, perhaps suggests that that was technically difficult to do at the time. If there were bilateral long tract signs, it does suggest that the cranial nerves were also affected. Pupils were equal and reactive to light at that stage. Here the pupils are sluggishly reactive to light only. Sorry, equal and reactive to light and accommodation, Dr O'Hare's written "PERLA", suggesting the patient is able to focus and that the pupils are

constricting as Claire focuses on something as well as constricting with light, whereas here the pupils are just sluggish to light.

Dr O'Hare also got a better look at the fundi, the back of the eye, and suggested the discs were not blurred.

Q. Sorry, could I just pause there? When you said the pupils are sluggish to light, is there a difference between that and Claire not liking light?

A. I think, yes, I think there is a difference. I think that specifically relates to the pupillary response rather than a patient shying away from the light or closing their eyes to light.

Q. Does one develop from the other?

A. No, not necessarily.

Q. Thank you. So you had noted your conclusions in relation to the reaction to light.

A. And I commented just that Dr O'Hare was able to see the fundi, the back of the eye, the retina and the optic discs and she commented that they're not blurred, and I think I find it difficult to see the fundi at that stage. That is my view of the fundi with the ophthalmoscope: it was not clear enough or was impaired.

Q. I suppose what I'm trying to ask you about -- and that was very helpful, your explanation there -- but if you

take from the "sit up [and so forth] stares vacantly", take that from Dr O'Hare, right down to the tests on the reflexes and so forth: is all of that condition, if I can put it that way, addressed by your bilateral long tract signs? Is that where you are dealing with the sorts of things that are addressed there?

A. Yes.

Q. And that's actually the point that I was asking you. If you had that information from the "pros" right down to the clonus, if I can put it that way, from Dr O'Hare's report, and you had your bilateral long tract signals, would you be able to tell between those two things as to what was the change in her condition?

A. The biggest difference looking at it now is that the reflexes are particularly brisk on the right side, I think, when Dr O'Hare records it. And it seems to be that it's bilateral, it's both sides where the reflexes are abnormal, on the ward round.

Q. Yes. And clonus?

A. That's not specifically recorded on the ward round. I suppose that's sustained abnormal movement of, typically, the ankles or some of the other joints.

Q. Did you want to see whether that had got any worse?

A. It may not have been considered as a critical thing at that point, the presence or absence of clonus or whether

it was worse or better. The fact that there were bilateral long tract signs suggests that the tone was increased and that often goes along with clonus as well.

Q. So if I understand you correctly, you would be able to tell a level of deterioration or, put it this way, a level of change between those two notes, even though the reference that you have got is actually very succinct, nonetheless anybody coming to it and looking at those two notes would be able to see that?

A. I think they would see a difference. I have to say, I think it would be helpful to have the same person do both, and that's often the advantage of having continuity, having one person examine the child and then another so that they examine in exactly the same way and their notation is exactly the same.

Q. If you had had the note in front of you and seen the way that Dr O'Hare had reflected that information, might you have tried to do it in the same way yourself so that somebody could maybe more easily see the differences?

A. Perhaps so.

Q. And if you haven't got the note in front of you, is it something that you expect your SHO to either try and see if he can record it in that way, so that somebody can readily see the differences, or point that out to you, or ask you even?

A. I think that would be ideal, but it is very individual.
Q. I understand. Really what I was trying to get from you is what information you might have had going into the ward round. How unusual was it, if I can put it that way, that it would be you who would be leading a ward round in October 1996, because that might change over time?
A. It is certainly something that has changed over time. I don't think it would have been exceptional in 1996. I suppose we may be need to draw the distinction between a post-taken ward round, a pick-up ward round, if you like.
Q. What does that mean?
A. I mean where patients who had been admitted the previous day or previous night are being seen on the ward round. Versus ward rounds that took place on a daily basis whereby if a patient has been in maybe for a day or two, you might find an SHO doing a ward round or a registrar or both.
THE CHAIRMAN: But is the difference that it's more important that the pick-up ward round is conducted by somebody more senior?
A. Yes.
MS ANYADIKE-DANES: Is that because that's really the start of the formulation of the diagnosis, the start of the

whole plan of treatment and care, so you want to get that established in the best way possible, if I can put it that way?

A. I think that's one of the main reasons, and these patients have perhaps not been seen by too many people as they've come in. And you've got some observations done, you've perhaps got a feel for what's going on. If a patient has been in for several days, that clearly becomes more established, so perhaps it is perceived at least that junior doctors, at this stage, would have been okay doing those subsequent ward rounds or would have been able to cope with those better and manage the patients.

Q. You mean following an established plan as opposed to be part of actually establishing the plan?

A. Yes.

Q. So if we go back to your impression, was it more unusual then not to have, unless there were some very pressing good reason, the consultant do this post-take ward round?

A. At the time, I have to say I don't think it was exceptional that a registrar would do this post-take ward round.

Q. Did you have any knowledge of Dr Steen's practice about these matters, if I can put it that way?

A. I find it very difficult to recollect exactly what Dr Steen's practice was in relation to ward rounds. My understanding is, where she could, she would take them.
Q. If she wasn't going to take one, how would you get to learn of that?
A. I suppose one of two ways. She may have been able to tell me herself, "Look, I'm not able to take the ward round this morning", or had a senior nurse say, "Dr Steen has been in and has informed us that she can't take the ward round this morning because she has other commitments". I think that might be particularly true of doctors with limited sessional commitments to the Children's Hospital who perhaps did a lot of community commitments, for example.
Q. But did you expect to know that she wasn't going to be able to do the ward round in one way or another?
A. I think so.
Q. And can I then ask you about the ward round on this particular day? Although we talk about it as if it only involved Claire, we now know from having looked at file 150 that it involved actually a number of children that were being seen. Can you recall whether you knew beforehand that Dr Steen wasn't going to be able to take the ward round?
THE CHAIRMAN: Sorry, how long beforehand? Because you must

have known as you started the ward round. Do you mean did he know the night before or ...

MS ANYADIKE-DANES: At any point until you were about to start it and she wasn't there.

A. It's difficult to be absolutely certain. I don't think I would have known the night before. I may have done, I suppose, if Dr Steen had said, "Look, I have this important meeting, I've got a case conference that I have to go to". So I might have done. But more likely, perhaps, I would have known on the morning.

THE CHAIRMAN: That's part of the job for you, that you --

A. Yes.

THE CHAIRMAN: Not only are you going to be on the ward round with Dr Steen or whatever other consultant you are due to be with, but also you know it's part of your job to step up to lead the ward round if the consultant is not available?

A. Yes. That's right.

MS ANYADIKE-DANES: You said that you do remember some aspects of the 22nd. Do you remember whether she was part of the ward round or not?

A. My recollection is that Dr Steen wasn't part of the ward round that I did that morning.

Q. That's an actual recollection as opposed to a reconstruction?

A. Yes.
Q. Can you help us with who else would have been involved? We can see that it certainly seems that Dr Stevenson was involved because he signs the note. But do you know who else was involved in the ward round?
A. I assume Dr Neil Stewart was as well. I guess that information comes really because he's written up the prescription for diazepam.
Q. Although he could have been asked to do that, I suppose, by Dr Stevenson if they were sharing things between them.
A. Sure.
THE CHAIRMAN: Surely more to the point, he has also written up other ward rounds from file 150.
A. That's true too. I think as well there would have been the expectation that if we're doing a ward round, that all available doctors would be there and would be on it together, sharing information, sharing the jobs, as you go. An exception to that might be if something needed done very urgently, a patient needed seeing, and you just had to go on without maybe one of the doctors.
THE CHAIRMAN: Dr Stevenson suggested to us on Monday or Tuesday that what would happen would be that he and Dr Stewart would go with you and they would effectively take it in turns to be scribe, as he said, which

indicates that they're generally both with you through this ward round; does that make sense?

A. That makes sense.

MS ANYADIKE-DANES: When Dr Steen was giving evidence -- and I think you were there for most of it -- I read out to her a passage in relation to ward rounds in the report that has just been produced by the Royal College of Physicians and the Royal College of Nursing. I don't propose to go into that except to say that she accepted that that was a fairly accurate reflection of at least the importance that was being placed on ward rounds, even though it didn't, in those days, comprise of the multidisciplinary teams that it might now. Would you accept that a ward round is a fairly important event in the day of the hospital, if I can put it that way, the Children's Hospital?

A. I think that's right. I think if I might add, if it's conducted by the registrar, it perhaps would tend to be more functional and maybe not have all of the teaching elements that you might hope for or expect with a consultant sort of grand round with as many people in the multidisciplinary team there as possible.

Q. And if you are doing it, or the registrar is doing it, you have with you whichever SHOs are available to you, or available to participate, as I understand it.

A. Yes.
Q. And you have nurses as well.
A. Usually at least one nurse. I'm not sure you'd always have had more than one nurse, although maybe I should qualify that. You may have had a nurse from an individual bay or patient area who would contribute to the ward round as you arrived with them.
Q. Yes, because that nurse is the one who's allocated to that bay and those particular patients. Although she might not travel from bay to bay with you, she might contribute to the discussion when you reached her particular bay; is that correct?
A. Yes.
Q. The nurse that did travel with you, would that be a senior nurse?
A. My understanding is that that would usually have been a senior nurse.
Q. Is the purpose of that so that senior nurse can in turn impart what has to be done to her own nurses who are going to look after the individual patients?
A. I would also say probably as well to keep the junior doctors up to speed and maybe make some notation on their behalf as well.
Q. Yes. Do you recall at all whether there was a senior nurse with you on the 22nd?

A. I don't recall who the nurse was at that stage. Some of the evidence suggested it might have been Staff Nurse Linsky.
Q. That's correct.
A. But I have no independent recollection of that.
Q. Had you been in Allen Ward sufficiently long to know those nurses individually, to be able to have recognised any of them?
A. Oh, I think most of them I would have done, yes.
Q. So if the senior nurse had been with you on that ward round, do you think that's something that you might have remembered or not?
A. I can't say. I can't say.
Q. That's fair enough. You say that your recollection is that Dr Steen wasn't on that ward round with you. I just want to put to you a number of things that Dr Steen has said in and around that issue, just so that we have your view on it, since you actually do have a recollection.

She says she believes that she was -- I have taken this from a number of parts of the transcript, which spanned three days, and I don't have a specific day and line, although if I'm asked to do it, we'll find it. I'm giving you a sense of what her evidence was. She believes she was in the hospital before the ward round

and that morning. Precisely when, she's unsure, but she believes that she was. And she believes it was her normal practice to carry out the ward round, certainly the one that was on Tuesdays. She could think of nothing that would have prevented her from doing that on the 22nd.

She also thinks that the ward round appears to have started late because the practice would be to work geographically, unless for some reason the condition of a child determined otherwise, and if that's what was happening then to have got to Claire around 11 -- which is when her parents recall her being there, and there seems to be some other indication that that's when you arrived at Claire. In her view that was late. She would have expected the ward round to have been completed by then because after then comes the CSF grand round. She also thinks that she may well have popped in and out of the ward round and simply not been recorded as having done that. And that she was in bay 7, which she says is the bay where Claire was, at some point in the morning to examine another child. I think she says there were four beds in that bay. So in her view, she could have seen Claire and she says that, given Claire's condition and her parents not thinking that she was getting any better, she would have wanted to see her.

That was the sense of her evidence coming through. Can you comment on any of that?

MR GREEN: Sir, perhaps the doctor can, in fact, comment on all of that? I will just have to wait and see. However, a lot of information has been compounded into the preamble to that question. I just raise the point.

THE CHAIRMAN: I agree, it runs to a page on the transcript. Let's see.

MR QUINN: Mr Chairman, I would raise a point here: it's a very important issue and I have noted down very quickly six main headings on that.

MS ANYADIKE-DANES: I can take them separately. That might help.

MR QUINN: This is a very important issue for the family.

MS ANYADIKE-DANES: That's perfectly fair and I'll take them separately.

Firstly, Dr Steen says she believes that she was in the hospital before the ward round and during that morning. What is your sense or recollection?

A. My recollection is that Dr Steen didn't come on the ward round with us. She could have been there first thing in the morning, even perhaps before I was there.

Q. But apart from that, were you aware of the fact that she was in the hospital that morning?

A. I'm not aware of the fact that she was in the hospital

that morning and it's to the best of my recollection. It was my understanding that she was out of the hospital at least for part of that ward round and including the time when we were seeing Claire on the ward round.

Q. Why is that your understanding?

A. That's just my recollection, that that's what I understood at the time. That's my recollection.

THE CHAIRMAN: You mean it wasn't just that she wasn't with you on the ward round, that she wasn't physically in the hospital?

A. At least for part of that ward round and the part when we were seeing Claire.

MS ANYADIKE-DANES: We have looked at the medical notes and records of all of Dr Steen's patients who were on the ward, actually on three wards, on that day. And those ward rounds are primarily -- and I think you were there when I went through them -- taken by yourself with the assistance of one or other of Dr Stevenson or Dr Stewart as scribe. And I think Dr Stevenson himself may have taken one ward round also.

None of those notes of ward rounds reflect the presence of Dr Steen at all. And is it your view that that's accurate and that's because she wasn't part of any of those ward rounds, not just Claire?

A. I believe that's right. I think if Dr Steen had been on

the ward round, it wouldn't have been my ward round.

THE CHAIRMAN: So if for instance she was there more for half an hour, she might have come in towards the end of one patient, you move on to the next patient and it's then noted as "Ward round, Dr Steen" rather than "Ward round, Dr Sands"?

A. I think if Dr Steen has contributed to it, in a hierarchical system as we have, it would be Dr Steen's ward round. That is my understanding.

THE CHAIRMAN: Even if she comes in while you are with a patient?

A. Yes, it would be Dr Steen.

THE CHAIRMAN: Let's move on to the next point.

MS ANYADIKE-DANES: She says it was her normal practice to carry out the ward rounds, certainly the one on Tuesdays.

A. I find it difficult to be sure of what Dr Steen's normal practice was. She is in a better position to answer that than me, except to say I think it wouldn't have been exceptional that a registrar would conduct some or all of one of those ward rounds of Dr Steen's.

THE CHAIRMAN: And you made the point a few minutes that Dr Steen and some others who have significant community commitments missed more ward rounds than people who had more clinical sessions in the hospital as a result of

those commitments.

A. That's my recollection.

THE CHAIRMAN: Just to make it clear: you weren't making that as a criticism of her --

A. No, not at all.

THE CHAIRMAN: -- it is just a fact that she and others who work primarily outside the Children's Hospital. Things crop up and they tend to miss, in your view, more ward rounds than others who spent most of their time in the hospital?

A. I think particularly around complex child protection issues and case conferences, which were quite lengthy discussions, as I understand it, and often took place, I think, in Cupar Street and other places in relation to complex family issues.

MS ANYADIKE-DANES: You did know, didn't you, that Dr Steen had a clinic in Cupar Street in the afternoon on Tuesdays?

A. I think I would have known that, yes.

Q. So what you're talking about is, yes, you would have known and would have expected that and would factor that into your care of the patient, but this is something over and above. You would have anticipated her to be in the hospital on the Tuesday morning and your recollection is that she wasn't there for some part of

the Tuesday morning, including the ward round.

A. At least part of the ward round, if not all of it, yes.

Q. Certainly including the part that involved Claire?

A. Yes.

Q. If you had thought that she was in the hospital and just for some reason you hadn't seen her at the beginning of the ward round, is that something that you would have made some efforts to see if she was actually wanting to participate in the ward round or lead it, rather?

A. Yes, I would.

Q. Even as a professional courtesy apart from anything else?

A. Yes. I wouldn't want to start the round unless I was sure that's what Dr Steen wanted me to do or needed me to do.

Q. Yes.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: She says she personally can think of nothing that would have prevented her doing the ward round on the 22nd. Can you help with that?

THE CHAIRMAN: I don't think the doctor can comment on what Dr Steen thinks. Let's move on.

MS ANYADIKE-DANES: No, but about anything else that might have been going on in the hospital in the same way that you are able to talk about lunchtime meetings and so

forth. There's nothing that you can think of going on?
A. No definite fixed Tuesday event, if you like. I also take Dr Steen's point about the ward round seeming to be relatively late. I do take that point. However, it was me doing it, I probably would have been a fair bit slower than Dr Steen about going round, and that may be partly why it was maybe running behind, if you like, by Dr Steen's standards. But I do take the point that it seemed to be quite late by the time we were getting to see Claire.
Q. And might you have waited for her, might that account also for a slightly late start or you can't remember?
A. I can't remember. I don't think so.
Q. Thank you. She also indicated how the order of the ward rounds was that they moved geographically and that assisted her in determining, all things being equal, when she would have expected that ward round to get to Claire, if I can put it that way. Is that your understanding of how the ward round, that it was geographical unless somebody identified that the condition of a child required higher priority?
A. Things are often done in a geographical way, but there are exceptions to that. Such exceptions might be if a patient is known to be unwell and someone says you must start here, you must see this patient first.

Alternatively, I've been in situations and recall situations where you perhaps had to go to Musgrave Ward first of all to discharge a patient from there, or potentially discharge a patient there, because perhaps they needed a bed freed up or a parent said, "Look, I have to go or I have somewhere to be, can you come and see this patient first?". So I think you'd be obliged to follow those sorts of -- those leads if you had to.

Q. How often did that sort of thing happen?

A. Oh, quite frequently.

Q. So is it not quite accurate to say that there was a practice that you started at one particular end and worked your way down to the other?

A. You did that, but you could quite often have deviated from that for some of the reasons I have mentioned.

Q. Can you recall whether there was any of that on 22 October?

A. I don't recall specifically, though I think there probably were patients in Musgrave Ward. I think I'm right from file 150, there do seem to have been patients in Musgrave Ward --

Q. That you think you might have seen out of order, if I can put it that way?

A. Potentially only. I don't recall.

Q. Was there any sense that for some new admissions, if I

can put it that way, you might want to see them first? Was there any sense of that?

A. Again, I think if they were flagged up as being an unwell new admission, yes.

Q. Was Claire the kind of child you might have wanted to see sooner rather than later?

A. I thought that when I got to Claire.

Q. It hadn't been flagged up to you beforehand, but when you got to her, you thought: this is child I might like to see sooner rather than later?

A. That's my recollection. I was concerned.

Q. Does that mean when you got to Claire you were in no doubt as to your concerns about her presentation?

A. That's correct.

Q. If you had thought -- I know this is hypothetical -- that Dr Steen was somewhere available to you in the hospital, when you got to Claire and had your concerns about her, would you have tried to make contact with her?

A. I would have.

Q. And would you have wanted her to come and see Claire?

A. I would have.

THE CHAIRMAN: And that must be right. Can we take it that you wouldn't have gone off looking for Dr Webb if you had thought that Dr Steen was available to you?

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

THE CHAIRMAN: I know you now describe that as your understanding, but that must have been the reality of the morning, mustn't it?

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

MS ANYADIKE-DANES: Then if we are taking these things in order, and you may have already dealt with some of them so we can move quickly on, I take it that you have no recollection of Dr Steen popping in and out of the ward round?

A. I have no recollection.

Q. Apart from the fact that, if she had stayed sufficiently long, you might have invited her to take the ward round or deferred to her, but say it hadn't happened like that, she really was just having a look to see how things were going on because she had to do other matters, would even that popping in and out have been recorded on the note?

A. If she was actually contributing to patient care, yes, I think it would be. If it really was very transient and not contributing, just... Then conceivably not.

But if you're contributing to patient care, I would expect it to be recorded.

Q. And however transient she had been, if you had been able to see her, you would have wanted her to contribute to Claire's care?

A. Yes.

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

A. Yes.

Q. Thank you. And then she says that at some point she was in bay 7 in the morning to examine another child, and you would have heard that. I don't want to go to 150 in particular, but you would have heard that, that she thought she was in there examining a child, you'd have heard the exchange with the chairman as to how seriously ill that child may or may not have been by comparison to Claire. But her conclusion was she was in the proximity of Claire and so she could have seen Claire. Were you aware at all of her being in bay or ward 7?

A. Not that I can recall. That may have been quite early in the morning.

Q. Yes. Had she been there at any point in time after the ward round, is that something that you think would have been drawn to your attention?

A. I think it would have been, yes.

Q. Well, without leading you, why do you think it would

have been drawn to your attention?
A. If she had returned to the ward maybe just to clarify, is that --
Q. Yes, if she had returned to it and been seen in the ward, more to the point in bay 7, examining a child, is that something that you would think would have been drawn to your attention?
A. Yes, because I think the staff would all have been aware of my concern about Claire in particular and would have said, "Dr Steen's here, don't you want to talk to her?"
THE CHAIRMAN: And if you weren't immediately available, would the staff have said to Dr Steen, "There's an issue about Claire Roberts, Dr Sands is going off looking for Dr Webb", and that would highlight the issue for Dr Steen if she was there?
A. I expect so, sir, yes.
MS ANYADIKE-DANES: Does that mean that you had sufficiently well communicated your concerns about Claire, both to the junior doctors and to the nurses, so that if they had an opportunity to do that, you would expect them to do that?
A. With hindsight, was the communication with the nursing staff and the junior doctors good enough?
Q. Yes.
A. Um ... That may not have been good enough. They may

not have understood things as I -- understood my level of concern. They may not have had a full grasp of that, but they were with me on the ward round and we would have talked.

THE CHAIRMAN: For instance, how would Dr Stevenson not get your level of concern when he has noted that the plan is rectal diazepam and then the next line is Dr Webb? That would not be a standard entry from the limited number that we've seen, it's not a standard entry for a ward round by you to add the name of a different consultant.

A. No.

THE CHAIRMAN: Would he at least have known?

A. Yes. It's not standard at all. I suppose I'm thinking particularly of the nursing staff and communication to all of the nursing staff.

THE CHAIRMAN: Well, if there was a nurse with you on the ward round --

A. I think she would have been aware, but would all of the nurses have been aware, would the nurse in charge have been aware? I can't say I would be certain of that.

THE CHAIRMAN: So it depends who was with you?

A. Yes.

MS ANYADIKE-DANES: And if the person who was with you was not a very experienced nurse herself, would that discussion, whatever discussion that you had with the

junior doctors to lead to that note being recorded, have been sufficient, do you think, for such a nurse to have understood the seriousness of Claire's condition?

A. Again, looking back, that might be a difficulty.

Q. They might not have?

A. They might not have fully appreciated my concern and that of the doctors on the ward round. I think we would have been quite open in discussing it, but they may not have understood exactly how concerned --

Q. Yes.

A. -- we were. Depending on the level of experience, depending who that person was and their background.

Q. Just so that I understand your evidence, are you saying irrespective of whether they would have actually appreciated that, what they would have appreciated is that you would have wanted to get hold of Dr Steen and so she was about, you'd have wanted something communicated to her?

A. I do think so, yes.

Q. Just as we have the last part of Dr Stevenson's note there where it says "Dr Webb", how common was it for you as a registrar to go and seek a consultant opinion in another discipline without discussing that or communicating it to your consultant?

A. I think there are probably two types of referral to

another team. There are the sort that one might do as a matter of course. An SHO or a registrar might go and speak to an SHO or a registrar in another department and say, "We have this patient, who you may wish to see, they have these clinical signs and symptoms, would you come and see them?" I think the patient in whom a cardiology opinion was sought from the additional notes falls into that sort of category, where the cardiology team are at liberty to say, "We're not too worried about that, we'll see that patient as an outpatient", or alternatively, as Dr Mulholland was able to do, come and see that patient in the afternoon.

This is different because the consultant is named, the consultant neurologist is named, and I leave the ward round to go and speak to him in person and that's different I think from the routine everyday type of referral that would have happened, that does happen, happens to me today. If cardiology referrals come my way, they often come through the junior staff and --

THE CHAIRMAN: You mean there's an urgency about this --

A. Yes.

THE CHAIRMAN: -- which isn't standard?

A. It's not standard.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: Was there a registrar in nephrology?

Paediatric neurology, sorry. Was there a registrar?
A. There was, I'm told. I didn't know this until recently, that he was on leave at this time.
Q. So you wouldn't have known that at the time?
A. I may well have done.
Q. What I'm trying to get at is: if you had thought this was just a matter of trying to get some sort of neurological insight, you might not -- well, I don't know. Would you have just sought somebody from the neurology team?
A. Most likely. Say it was a child who had a history of seizure or seizures in the past and had come in with a seizure, we might seek advice from the neurology team as regards treatment. But that I think would have been on a different scale and more like the cardiology referral that I've mentioned.
Q. So as the chairman has picked up, this is going straight to the consultant?
A. Yes.
THE CHAIRMAN: Sorry, one more point. Should I interpret this sequence to mean that not only was Dr Steen not there, but that she was not contactable?
A. That I can't be absolutely certain of, but my feeling is that I didn't think I could get hold of Dr Steen quickly enough. I may have already tried at this

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

THE CHAIRMAN: Then you need a feel for just how important the meeting is, not to interrupt it, don't you?

A. Quite.

THE CHAIRMAN: Okay.

MR QUINN: Just before we leave this point, and I'm very mindful of the time, there's one other issue that we should perhaps raise at this point so we don't have to come back to it.

Dr Steen made the case that perhaps there was an emergency she was dealing with or some other issue on the ward. And that's perhaps why the ward round was a bit late. But she did raise this two or three times -- and perhaps that could be put as maybe 6(a) or 7 and the witness could be asked now if he does recall anything on this issue.

MS ANYADIKE-DANES: Thank you. That was the very next point I was going to ask him about. That was her explanation, in part, for maybe her absence or maybe the lateness of the ... She said something was happening. I think she referred to it as something abnormal, it wasn't the usual day. Do you have any sense or recollection of what that might be or whether that is the case? If it is, what that might have been?

A. I don't recall a major event on that day. Which means either I just don't remember, I may not have been involved with it, whatever it was. Say it was happening in casualty or something like that, I perhaps wouldn't have been called there. Dr Steen might have been for whatever reason. To be honest, my main recollection from this day is interacting with Claire and not other events.

THE CHAIRMAN: Can I ask you it in another way? It can't have been -- correct me if I'm wrong -- another major incident on Allen Ward because if it was, then you and Dr Stewart and Dr Stevenson would not have been doing the ward round together, would you?

A. I think that's correct.

THE CHAIRMAN: If there was a major incident, then surely one of you would have been taken off on that with Dr Steen.

A. I think, had it been in the Allen Ward, yes.
THE CHAIRMAN: Right.
MS ANYADIKE-DANES: Just one final question on that point, Mr Chairman, if you'll permit.
Your ward round involved not just Allen Ward; isn't that right?
A. That's right.
Q. Yes. So if it had been a major event not on Allen Ward but on any of those other wards, like Musgrave Ward for example. I think there was one on Cherry Tree Ward, maybe, that you may have been involved in, but certainly Musgrave Ward. If that had happened, do you think you would have been aware of that as well as you're going through?
A. Yes, I think so. I think so. Although --
THE CHAIRMAN: You would have been aware in 1996?
A. Yes, whether I'd remember it now, perhaps not. Unless it's something that becomes really etched in your memory for a particular reason. So I may not remember it now. The other thing I can't quite remember is what the provision was for the cardiac arrest team in 1996, and say for example there was a cardiac arrest in the A&E department, who would have gone to manage that, who would have been expected to be there, managing that.
MS ANYADIKE-DANES: Is that something that the records might

show, who would be on duty for that, or be expected to respond to that?

A. I expect somebody is able to find that out. I'm not sure how relevant it is.

THE CHAIRMAN: We have to be a bit careful about who we ask to find out. Okay, we'll take a break for the stenographer and resume at 11.40.

(11.30 am)

(A short break)

(11.43 am)

MS ANYADIKE-DANES: Dr Sands, what textbooks were available for people to have as a resource to assist them? Medical textbooks, I mean.

A. I think there were probably a number. Most of them would have been housed in the Allen reading room up on the third floor, I think, of the old building in the Children's Hospital.

THE CHAIRMAN: That has been described as a library before; is that the same thing?

A. Yes, it's the same thing. So that had a reasonably extensive range of books, both general and for some of the paediatric specialties. Individual wards -- this is a variable thing, but individual wards may keep one or more books as well in, if you like, a mini library on the ward.

MS ANYADIKE-DANES: Yes. Of those books, might they include Nelson, for example?

A. It may have done, but perhaps not every ward.

Q. So far as you're aware, when you were the paediatric registrar and moving around the wards, Allen Ward included, would you have had, so far as you can recall, ready access to Nelson?

A. I could have found one, yes.

Q. Without too much difficulty?

A. Yes.

Q. Forfar & Arneil?

A. Yes, I think it was also available, perhaps Nelson may be a little more widely used, but Forfar as well.

Q. Just so that we're clear about that, I understand "available" -- that might mean it's in the library and I think from the evidence we heard yesterday, that might take about ten minutes to fetch? You seem to be suggesting something a little more available than that.

A. As I say, that's a variable thing. Not all wards would have kept many books, but you might have, say, one in Musgrave Ward, you might have a Forfar in Allen Ward and you could --

Q. So in some shape or form you might be able to get your hands on one rather more speedily than having to go all the way up to the library?

A. Perhaps so, yes.
Q. Thank you. What about the Royal's own paediatric prescriber?
A. I think that was readily available. The Children's Hospital Paediatric Prescriber, yes.
Q. And the British National Formulary?
A. I think all the wards should have had a BNF.
Q. Dr Stevenson wasn't terribly sure about those textbooks, but he said what he did have is some sort of condensed notebook sort of book that he -- he indicated he sort of carried it with him. Were you aware of anything else that junior doctors might have had available to them?
A. He might be referring to the Oxford Handbook of Clinical Specialties.
Q. Is that something that was commonly used by the junior doctors?
A. I couldn't say how commonly. I think it would have been around at the time.
Q. Not necessarily you personally, but did the more senior clinicians guide the junior doctors as to what they might be looking at and when they might be consulting such works?
A. I think day-to-day, the larger textbook would have probably been used not very frequently, or maybe not as frequently as one would want, and that's probably due to

time constraints and people trying to get through their day's work. They may have taken a textbook home, even borrowed it from the library and gone and read up on a particular topic. I don't think they would have used a big book like Nelson or Forfar as a ready means of getting information on a day-to-day basis in the ward, so a smaller handbook may well have been more useful in those circumstances.

Q. But the formulary, is that something that you would expect them to be using more frequently?

A. Yes.

Q. In fact, would you expect them to look at it before they prescribed if they were unfamiliar with the medication?

A. If uncertain, yes.

Q. For yourself, though, if you were uncertain with the presentation, would you consult Nelson or Forfar if you could get your hands on one?

A. If I was left on my own to try and work out a problem, I would have had to go to a big textbook.

Q. And did you in those days?

A. I think I would have done at times if I felt that I -- I would have looked first of all, probably, for somebody who could give me the information I needed more directly, because that's ... Perhaps easier and better, and more efficient. But if one was left with a clinical

problem for which one didn't have a ready answer, then yes. We couldn't go online, if you like, to look things up, which we maybe do now much more readily, so you would have had to have had recourse to a textbook and perhaps have a bit of time to look something up.

Q. Claire was a bit of a problem to you?

A. Yes.

Q. And if you were going to even contemplate differential diagnoses such as status epilepticus, is that something that you might look up in a textbook? It's not a very common condition.

A. That's true, and at that stage that was an impression.

Q. Yes.

A. It wasn't a firm diagnosis.

Q. Yes.

A. It was a possible diagnosis. And if I had been left with no support, no access, perhaps to neurology to a paediatric neurologist, if I'd been trying to look after things by myself, I would have had to sit down with a textbook and perhaps work through not just that possible diagnosis, but perhaps many others or some others.

Q. Yes. But even if you didn't think to go and look at what the textbook told you about that, in order to be having that kind of impression or even formulating the

sorts of differential diagnoses that were ultimately formulated for Claire, you would have had to presumably know something of what those sorts of textbooks say about that condition.

A. One would have had to have had some knowledge or -- not necessarily textbook knowledge, theoretical knowledge, perhaps experiential knowledge of having seen a patient or patients with that condition. Sometimes that is what brings a particular diagnosis to light if you've seen something similar before.

Q. Because you'd formulated some of that before you actually went to discuss with Dr Webb. In fact, that's part of your reason for going to discuss these matters with him because you thought you'd got yourself into neurological territory, if I can put it that way.

A. Yes.

Q. Two things I've been asked, before we move away from this, to ask you. Firstly, although you have told us when you might -- if you were at the clinic that Dr Nan Hill has spoken about, you have told us when you think you might have been there. How long would it have lasted for roughly?

A. I suppose her usual clinic length might end up some time between 4.30 and 5 o'clock.

Q. So most of the afternoon if you were doing it?

A. Yes.
Q. And then another matter, which is: you think that you might have tried to contact Dr Steen in the morning, but you're not sure about that. You are sure about it in the afternoon --
A. Yes.
Q. -- because you achieve it. In the morning, if you were doing that, what means would you use?
A. It might depend if you knew where Dr Steen actually physically was. If I knew where she was and had a landline telephone number, I would probably use that and may have left a message, if I couldn't talk to her directly. For example, if she were in a meeting, I would have left a message that she should phone back as soon as possible or ...
Q. Was that a thing that you would do, use her bleeper?
A. I think we would have done, but again I'm not quite sure whether everybody had a pager for all of the time during that particular time frame.
Q. Did you know she had a mobile phone?
A. Again, I don't remember that.
Q. I understand.
THE CHAIRMAN: Did you know she had a secretary?
A. I believe so. As far as the evidence suggests, from previously, maybe that secretary was based in

Cupar Street.

THE CHAIRMAN: So if you were particularly anxious to find her and the pager didn't work and you didn't have a direct line, asking her secretary where she was and when she might be available would be a fairly obvious recourse?

A. Yes, and a senior nurse would often know the consultant's whereabouts.

THE CHAIRMAN: As she says sometimes, and you have agreed, sometimes she's in before you in the mornings and she had to go off to something urgent, then since the nurses are there -- their shift change is at 8 am and yours is at 9 -- there might well be a nurse who's able to say she was in for 20 minutes and then went on somewhere.

A. Yes.

MS ANYADIKE-DANES: If we move into the substance of the ward round in relation to Claire now. Were her parents there?

A. My recollection is that they were. Particularly, I have to say, I particularly remember Mrs Roberts, but I'm very content to concede that Mr Roberts was probably there too given the other evidence I've heard. But I remember Mrs Roberts particularly.

Q. Do you remember being called to see Claire at all before you actually reached her in the normal order in the ward

round?

A. No, I don't remember that. I know that has been mentioned in some of the nursing evidence, I think.

Q. Yes.

A. And if we weren't coming to Claire or at her already, I think we must have been very close. I'm not saying that they mightn't have deviated slightly to see Claire because of a comment made or advice.

Q. So as opposed to perhaps a separate visit to see her, you might have, in the way that you were explaining to the chairman before the break, actually simply bumped her up in the order in which you'd have seen her in the ward round --

A. Yes.

Q. -- and incorporated that in your ward round visit?

A. Yes.

Q. Do you remember the actual examination of Claire at that ward round?

A. I do.

Q. Do you remember the information that Claire's parents whether it be Mrs Roberts or both her parents, gave you in relation to Claire?

A. I believe I do.

Q. Do you recall them saying that they thought she actually wasn't any better that morning?

A. I think that's correct.
Q. And how did that affect your thinking, bearing in mind that Dr O'Hare had thought she was a little improved and, for that matter, the nurses had?
A. It made me concerned, and at the time I thought: why are we only seeing Claire now?
Q. And what does that mean?
A. Well, I was concerned that we were -- that she perhaps hadn't been flagged up as a patient whom we should see sooner because it was clear to me that Claire's parents were worried about her, that she was unwell, and that I also believed her to be unwell. I agreed with them. And I would have expected and hoped perhaps that we might have seen her sooner or that she would have been -- I would have been alerted to her presence sooner.
Q. So even if her parents hadn't drawn to your attention that, in their view, she wasn't any better, leaving aside that, are you saying that on your examination of her, her condition was such that you would have been wanting to have been alerted to her before and seen her sooner?
A. Ideally, yes.
Q. So how long do you believe, if you can remember, you spent in combination examining Claire and talking to her

parents?

A. At an estimate, the whole thing, perhaps 20 minutes. That has to be an estimate.

THE CHAIRMAN: In relative terms, doctor, for those of us who don't know, is that longer than usual than you spend with a child on a ward round or shorter?

A. Longer.

THE CHAIRMAN: If there is such a thing as a norm, what that might be?

A. It really depends on the complexity of the problem, and it depends whether there's a parent there or not. If there's no parent there and you just do a clinical examination, it might be five minutes. If there's a parent there, you're obviously obliged to engage in a conversation with the parent, take a history from them perhaps and relay some information so that at least doubles the time to 10 minutes.

THE CHAIRMAN: Is 20 a significant amount of time?

A. It may have been longer still. I can only give a very rough idea that we spent longer, I believe, with Claire than we would have done with other patients on the ward round that day.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Claire's parents think that actually you were only there -- and it will be for them to give

evidence as to whether they mean talking to them or there all told -- five to ten minutes with Claire.

MR GREEN: Forgive me, that's not an accurate reflection of the statement in question.

MS ANYADIKE-DANES: Let's pull it up. 253/1, page 7.

MR GREEN: It relates to a point you yourself made, sir, the other day. You raised the point and you'll see it once you see the material on the screen.

THE CHAIRMAN: It's the conversation with Dr Sands lasted for five to ten minutes, not the total time there.

MR GREEN: Exactly the point you made the other day, sir.

MS ANYADIKE-DANES: Sorry, I thought I had already distinguished that. It's not entirely clear whether the five to ten minutes related to the time spent talking with them or the conversation. I'd already made that distinction and that we would hear evidence from them about it. I'm alive to that point, I'm simply asking him how he --

THE CHAIRMAN: I think Mr Green's objection is that your question, Ms Anyadike-Danes, was: Claire's parents think that actually you were only there all told talking to them five to ten minutes.

MS ANYADIKE-DANES: That's what I meant, whether the talking to them was the five to ten minutes or whether the full examination including that was five to ten minutes.

That's what I anticipate they will give evidence over.

MR GREEN: But forgive me, the statement on the face of it, subject to any clarification or expansion when they do give their evidence, appears quite clear.

THE CHAIRMAN: Okay. In any event, doctor, if it is suggested that you were only with Claire, including talking to her parents, for five to ten minutes, would you agree with that or not?

A. I think I would have been with Claire for more than five to ten minutes, talking time -- I think it's very difficult to say and it's very difficult to remember for me as well just how long we would have spent and trying to quantify the time spent talking. My recollection of it is that I had to take a history from Claire's mum and that she was able to tell me what Claire was normally like, what she could do, and the things that she had difficulties with. I'm aware too of Claire's mum telling me that although Claire could be quite drowsy and lethargic when unwell, this wasn't Claire, this wasn't Claire's usual situation. I believed that. Having been there and seen Claire and examined Claire, I believed that, that this wasn't how Claire usually was, and that there was something significantly wrong.

So there was some of that history taking. I was obviously aware that Claire had been seen by ... That

Claire had been seen by Dr Gaston and had been followed up in the Ulster Hospital, and we were aware that it might be important to get that information from the Ulster Hospital, that might add something to the overall picture of how Claire was. Because initially, when faced with a child whose level of consciousness doesn't seem normal, it's very important to know what point you're starting from, what Claire is usually like.

MS ANYADIKE-DANES: What your comparator is?

A. Yes. So Claire's mum's history would have been vital.

MR McCREA: Mr Chairman, we have taken very specific instructions on this point and our instructions are that Dr Sands examined Claire and talked to the parents or asked the parents questions as he was carrying out the examination. So the conversation and examination went in tandem and their recall is that the entire examination/conversation was five to ten minutes.

THE CHAIRMAN: I'm not going to challenge Mr and Mrs Roberts' recollection, but as everybody in this chamber knows, estimates of time are notoriously inaccurate. That's not a point against Mr and Mrs Roberts, I'm sure they'll understand that. When Dr Sands gives an estimate of 20, he's also struggling to put a time on it. Of more importance is what information was gleaned and what was found on

examination rather than us getting bogged down in whether it was five, ten, 20 minutes or longer.

MS ANYADIKE-DANES: Maybe this point might be what underlies some of that concern: your consultant wasn't there, you were conducting the ward rounds for all these patients. Did you feel under any more pressure than usual to complete that work?

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

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

A. I think that's right, and again I don't mean to say that the conversation with Claire's parents was truncated or time with Claire was truncated because I don't think that's the case.

Q. I understand. When you have examined her and you've spoken to her parents, whether you do that separately or all at the same time, you end up with an impression. If we keep up 090-022-053, that is your impression. If we leave aside the encephalitis and encephalopathy, the impression is: non-fitting status.

At the time you have that, you know, because apart from any other thing -- we can see it from slightly higher up -- that she's been on IV fluids really since being admitted to the ward. And even if you didn't look at the notes yourself, you would have known what IV fluids she was on because, if you were in that territory, you'd have asked Dr Stevenson.

A. Yes, I think we would have talked about it. It would have been mentioned and been at the side of the bed.

Q. And you'd have known that that U&E result of sodium of 132 related to blood that was taken the previous evening. Sorry, would you have known that?

A. Yes, I think that's a reasonable question. I would have ... I may not have known the exact time that blood was taken, I think is my answer to that. Insofar as I would have known that it related to her admission, but as to what time thereafter it had been taken, I may not have been completely clear on.

Q. Let me put it this way. Would you have thought it was something that related to the previous evening, even if you didn't know exactly when it was taken, as opposed to something closer to the actual ward round?

A. I think on looking at it, we may have thought it was done late on in the evening or in the early hours or something like that. But quite possibly we may have

considered it something -- or I may have considered it -- something even a little bit thereafter.

Q. Dr Stevenson doesn't seem to think it was anything more than recording the result that is on the previous page, if you like, that has been recorded by someone whose hand we're not entirely clear on.

A. Yes.

Q. And if he's got the medical notes and records and you're having the discussion with him, would it be reasonable that you might have formed the same view or discussed the same thing with him?

A. It depends very much how it's put to me.

Q. Well, I think the evidence that he gave is that it would be unusual to have had blood tests taken that morning and have got the result back and therefore that been a result from the morning -- and by "morning" I don't mean the early hours of the morning, I mean shortly before the ward round. He said that would be unusual.

A. I think it would be unusual if that blood had been taken at 8 or 9 o'clock.

Q. Exactly. So it is relating to some time further back, even though you can't put your hand exactly on when the specimen would have been taken to give rise to that?

A. That's right.

Q. So his view was that this 132 is in fact a recitation of

the 132 in the previous page, and not a new 132 generated by a new blood test. And would you have understood the same thing?

A. I can't say what I would have understood then, but that seems likely now, certainly as I read the notes.

Q. Yes. So if you saw that, her serum sodium level from blood taken at some stage the previous evening -- or even maybe the early hours of the morning -- was 132 and she had been on IV fluids since about 8 o'clock or whenever they had been erected when she came to the ward, and you had seen that Dr O'Hare wanted her to be reassessed after fluids and had reassessed her and wanted her reassessed again in the morning, would you have wanted to consider again her fluid regime as part of your plan during the ward round?

A. I don't think Dr O'Hare's second request for a reassessment in the morning specifically relates to reassess the fluids.

Q. No.

A. At least that's my impression.

Q. Understood.

A. So I think the reassessment would have been the ward round assessment.

Q. Yes.

A. But yes, as part of that, one would have wanted to

discuss blood tests and I think there likely would have been a discussion about fluids and what fluid we should use, whether we should continue with the present fluids.

Q. So you think that is a logical thing to have wanted to discuss and, if you think that, can you recall actually doing that?

A. I don't recall doing that, but I think it's consistent with what one would do on a ward round at this time.

Q. If you were going to continue the IV fluids and you were aware that she'd been on them for some period of time, she had a slightly below normal serum sodium level, you think at that time, in 1996, it would be logical to have thought about what IV fluids she should continue to remain on?

A. I think there would have been some discussion about IV fluids and whether to continue them and at the present rate.

Q. Yes.

A. That might have been a short discussion, given the overall context of Claire and the focus on the neurological problem, and given that we were using fifth-normal saline, which, again, was what one would have commonly used in a child being admitted to hospital, a medical patient being admitted to hospital. So the discussion around that might have been brief.

Q. If you'd had any discussion at all around that, would you have expected that to be recorded, however brief a note about it was, in her medical notes and records?
A. Not necessarily.
Q. Although the fifth-normal saline that she was on, you say, was fairly standard at that time, certainly in the hospital, to administer that, in view of the slightly low serum sodium level and the fact that she had been on that regime for some time and that she did present with some neurological problems, did it occur to you that maybe you should think a little bit more carefully about the fluid regime?
A. I don't recall thinking that at the time. I don't have an independent recollection that that went through my mind, or our mind at the ward round at the time. It may have done.
Q. Would it have been appropriate to think in those terms?
A. With hindsight, yes.
Q. Then let me put it another way: did you have enough knowledge in 1996 for that to have been appropriate for you to think in those terms?
A. I suppose I can only compare with the knowledge that I have now, that we have now, and I think our knowledge was limited. My knowledge was limited in terms of how to manage a slightly low serum sodium in an unwell

patient. And I think that view has changed, my view has changed, and perhaps the views of many other people have changed.

Q. If you have been looking at the textbooks, Nelson in particular, you might have been consulting them to see whether they offered any guidance as to what to do in a situation like that. I'm thinking in particular of, say, Nelson, that we have an extract from that at 311-018-009. It starts:

"The serum sodium level is most commonly reduced as a result of true sodium depletion, water intoxication or a combination of both."

In other words, water overload, and I think you had conceded earlier that that can produce it. And then it says:

"A low serum sodium level thought to be a result of redistribution of total body sodium may be associated with severe illnesses or occur in the terminally ill patient."

Then I think it goes on, two paragraphs down:

"With water overload, fluid restriction is the appropriate measure and the serum sodium level may return rapidly to normal if there is good renal function, but this may take several days ..."

And then it talks about:

"... increasing the sodium concentration of parenterally administered fluid often corrects a sodium deficit."

And then it talks about measuring urinary sodium concentration.

With the information that you had at your disposal, which was that her serum sodium level taken from a sample at some time in the previous evening or the early hours of the morning, and the combination of her presentations in terms of her neurological signs and the length of time she had been on fluids, did you think that you may be in a situation where you perhaps ought to consult something or think about maybe increasing the sodium concentration of her fluids?

A. Again, I don't have an independent memory of what we considered at the time. Looking back at it, I think that the sodium of 132 wouldn't have caused a lot of alarm. We may not have been exactly clear how long Claire had been on No.18 Solution, although we could have calculated that. I appreciate that we could have looked at that more carefully. But I don't think the serum sodium of 132 would have made us think: this is a hyponatraemic child or a child who's potentially going to suffer from symptomatic hyponatraemia. Even though technically the result is hyponatraemic insofar as it's

less than 135.

Q. You'd have known how long she was on her fluid regime because that's in her medical notes and records. What you're saying is that you wouldn't have known how long her serum sodium level had been 132.

A. We wouldn't have known at what time exactly perhaps that was taken and we would have needed to look at the fluid balance sheet to work out how long the IV fluids had been running for in order to know exactly how much fifth-normal saline had been administered.

MS WOODS: Mr Chairman, if I could just raise the point when we're dealing with Nelson and this discussion about hyponatraemia? It may be that my learned friend is planning to come to this, but in the Nelson textbook, which I believe comes from 1996, on page 311-018-005, you will see right at the bottom of the page another thing that says, "Hyponatraemia".

THE CHAIRMAN: The left-hand column?

MS WOODS: That's correct, yes. You will see what appears to be a definition of hyponatraemia. We see it's a serum sodium of less than 130.

THE CHAIRMAN: Right.

You just said that technically it was hyponatraemia because the level's under 135 and there's a bit of edginess about what exactly the cut-off point is. Is

your point, doctor, that even if we take 135 as the relevant marker, 132 is below it but not significantly below it, and your concerns about Claire were focused not on hyponatraemia but other issues?

A. I think that's correct. To many doctors at the time, hyponatraemia simply meant literally hyponatraemia, a lower than normal sodium level, without a full appreciation of what it might mean and particularly what symptomatic hyponatraemia -- how it might develop, what its implications might be. I think the chairman's correct insofar as I think our focus wasn't on the serum sodium and its potential importance at this point.

MS ANYADIKE-DANES: No, but I think one of the things we're trying to see is the extent to which perhaps it ought to have been, I suppose. Finally on that point, particularly as you didn't actually know when that sample was taken and therefore when her serum sodium level would have been 132, did it not occur to you that you ought to try and find that out in case it had stabilised itself or, which would be more problematic, reduced yet further?

A. We may have done that, we may have done that. I think more likely -- and I've said this in my witness statement -- is that I think we would have viewed this as a result that should be done again. Sorry, a test

that should be done again.
Q. So this would be part and parcel, would it not, of the tests that you would want to have done as part of your plan for Claire?
A. Yes. I would have to say, though, probably not at the top of the list in terms of how I and we were thinking at this moment in time.
Q. But that her electrolytes should be tested at some point after that ward round?
A. Yes. And we may not have specified a time, and I don't have an independent recollection to say that we said or that I said we must do another U&E.
Q. It's not recorded.
A. I know that.
THE CHAIRMAN: Just to get to the point on this: if it's not recorded in the plan, whereas three other points are recorded in the plan, do I not infer from that that it was actually not intended to be done?
A. Obviously not everything that's discussed is written down.
THE CHAIRMAN: I understand.
A. And sometimes I think -- again, I've maybe made this point in my witness statement -- quite often when we were doing a ward round, indeed when I do ward rounds now, I think best practice is to write that you plan to

do a U&E, to write it in the notes, but also to write it on another piece of paper for the SHO or whoever is going to come back and do the blood tests. And the reason I say that is that when you've done a ward round, and when you've finished with all the charts and they're all back on the trolley and back at the nurses' station, the SHO or the registrar, whoever's there, won't know what tests to do, what know in what order to do them, unless they go through every chart again one by one to look at what has been discussed on the ward round. So you need a piece of paper, you need a to-do list.

THE CHAIRMAN: Right, so there was a bit of discussion about this earlier in the week, but does that mean that the plan should have a to-do list and then the SHO might be keeping a separate note so that when the ward round is over, he has a list of things which he has to do or organise for different patients?

A. Yes.

THE CHAIRMAN: Right. I understand.

MS ANYADIKE-DANES: Dr Stevenson's evidence is, I'm sure you heard, he doesn't recollect that practice at all. Sorry, he didn't recollect doing that or that being something to do.

A. Mm-hm.

Q. I think you also refer to it might have been included in

a book, and he wasn't sure about that either.

A. Yes, I ward round book or a ward diary, if you like.

Q. Is the other place where that sort of prescription or part of the plan might be in the nursing notes?

A. Again, sometimes. Sometimes, but not always. And there are points where it is noted down in Claire's chart and others that a U&E has been done, and there'll be a tick beside it.

Q. There's none recorded for just after this ward round. You'd accept that?

A. Yes.

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

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

And I have thought about this and asked myself what does that mean, and it was something I wasn't sure

whether I should put in because I wasn't sure exactly what it meant to me now. But to me now, it suggests to me that at least I had expected that a blood result or a blood test had been done or had been requested, that it might be due back in the five to six slot when blood results usually came back. Or alternatively, if I or we discovered that it hadn't been done, or the sample had been lost or misplaced or unsuitable for analysis, that we would mention it again at 5 o'clock or 5.30 with a plan to do it shortly thereafter. And that might explain why it surprised me that there wasn't a result available until, you know, much later on in that evening. That's only a fragment of memory, but I put it in witness statement 3 because I remember it.

MS ANYADIKE-DANES: As you put it in that way, during the course of Claire's care and treatment over the day, irrespective of whether it had been specifically noted or requested during the ward round, would you have expected somebody to have wanted to know or have an up-to-date reading of her serum sodium levels?

A. If we were aware that the sample was from 10 o'clock the previous evening, yes, definitely.

Q. Even if you thought it was from the early hours of the morning, would you still have wanted to know that?

A. Still yes because -- and the reason I go back to the

point about trying to do routine blood work. I think it would have been considered routine blood work to try to do that between the hours of 9 and 5, if at all possible. I think that would have been standard practice and it's what we were encouraged to do. And doing blood tests outside of that, we were -- it was suggested to us that you needed to have a reason to do that, there had to be a purpose to that and try and concentrate routine work within the hours of 9 to 5. So yes, I would have -- and clearly, with hindsight it would have been the right thing to do, to have a result in the chart.

Q. The purpose to it might have been that her neurological signs continued to deteriorate, she remained on the same type and rate of IV fluid and nobody knew whether the one related to the other in any way and nobody knew what her serum sodium level was. That might be the reason to do it.

A. I think, again, with the knowledge that we have now, absolutely, a serum sodium would have been very helpful.

Q. Dr Steen's witness statement -- I think her first witness statement -- has considered ... We can pull it up, I think. 143/1, page 55:

"State whether you agree that Claire was at risk of electrolyte imbalance between 21 and 23 October, and if

not, explain why not. I agree that Claire's overall clinical condition including vomiting, deteriorating level of consciousness and requirement for IV fluids put her at risk of electrolyte imbalance (sodium and potassium) along with an increase in urea and possible hypoglycaemia."

Would you accept that?

A. I think Claire probably had stopped vomiting by the time the ward round had come to see her.

Q. Yes.

A. I'm not sure that I would have appreciated that the deteriorating level of consciousness would have alerted me to the serum sodium as being particularly important.

Q. So does that mean you did or you did not think that she was at risk of electrolyte imbalance?

A. I can't recall if it was part of my thinking at that time except to say that I'm sure we would have acknowledged that the sodium was lower than the normal range and that that sodium ought to be repeated. That's my feeling on reviewing the chart as well.

Q. If we then go back up to 090-022-053, let's look at the first impression of what might be the cause of her condition. Non-fitting status. What led you to identify that as a possibility?

A. Again, I think this is based on probably several things:

the history from the GP, which was probably related as part of the ward round presentation; the history given by Claire's mother that she had had a history of seizures in the past, though had been seizure-free for some time now and indeed off medication for about 18 months and, I think, had just had one seizure at the age of 4. So a lot of those seizures seemed to be concentrated around about the six months to one year period when that was her most troublesome time. But nonetheless, a child with a history of seizures. The GP, I believe, had raised the concern over possible further seizure activity.

Q. The GP had two possible concerns. That was one of them, seizures.

THE CHAIRMAN: Sorry, let the witness finish this answer about -- the basis of your impression that this was non-fitting status. We've got the GP's note, you have Mrs Roberts' history of seizures in the past, admittedly some time in the past.

A. And I believe Dr O'Hare as well has mentioned about "query if seizure, given IV diazepam". So I think it was in several people's thinking that this might be part of a seizure disorder or presentation of a seizure disorder. The fact was, though, that on examining Claire, her neurology was very abnormal, but I didn't

think she was having overt seizures, that is visible tonic-clonic jerking type seizures. So I wondered whether this might be a seizure disorder but without the overt jerking that one perhaps associates more usually with seizure activity.

MS ANYADIKE-DANES: Had you any experience of that before?

A. I believe I'd seen one patient perhaps with this condition at some time previously. So my experience would have been very limited in practical terms. I might have had some theoretical book knowledge about it.

Q. Did you know how you would confirm such an impression?

A. Again, I don't know at the time whether I give that a lot of thought, other than to go and get expert advice on the matter, because this is an unusual condition, one that perhaps I might have seen once. And my feeling would have been that I needed somebody much more senior with much more experience to either confirm or refute that diagnosis completely. And just while I'm mentioning that, I maybe should say now that very much high up in my thinking, but not recorded here in the notes, is the fact that I felt that Claire may need an urgent CT scan, and that has been my independent recollection from the very start, as part of my desire to go to speak to Dr Webb and my discussion with

Dr Webb.

Q. And just so that we finish off that, why would that thought that she might need an urgent CT scan cause you to go and talk to Dr Webb, apart from any other reason that you might have wanted to talk to him about her presentation?

A. Because it's my understanding that we would have needed a consultant neurologist to authorise that.

Q. Can we then just go back -- I had interrupted you, for which I apologise. When you had referred back to the GP's referral, there is a query under "further fits", there's also a query about "underlying infection". When you talk about gleaning these impressions or understanding what the clinicians before you had thought, is that because they were drawn to your attention at the time or is it because you have now or since looked at them and seen this pattern?

A. I think it's likely because they were drawn to my attention at the time as part of the history of presenting complaint.

Q. In addition to the GP identifying an underlying infection, did not Dr O'Hare also consider there might have been a viral illness? That was one of her notes, and under that she had "encephalitis", which she had thought about and then struck through. But in any

event, something else other than pure seizures, if I can put it that way. And if you had had that drawn to your attention, what else would that have caused you to do?

A. Well, I think we did actually think of viral infection, specifically encephalitis, because again, as part of the wanting a CT scan, I remember thinking about what a CT scan might show, and it might show some kind of focal inflammation in the brain.

Q. And do you think that was discussed during the ward round, the encephalitis?

A. I think it was discussed amongst the medical staff, and I may not have used those words with Mr and Mrs Roberts. I may have couched it in different terms. But yes, I do think it was discussed at the ward round and it's not noted.

Q. Yes, it's not noted. If you had discussed the possibility of blood tests, that's not noted here, but in addition, that bit isn't noted. Is that to you important that that wasn't noted at that time?

A. I think that's a ... It just doesn't reflect my memory of the ward round.

Q. So it should have been noted; is that what you're saying?

A. I think so, yes.

THE CHAIRMAN: So that I understand that, the note doesn't

fully reflect your memory of the ward round --

A. That's right.

THE CHAIRMAN: -- in terms of the alternatives which were discussed or in terms of what tests were to be done?

A. I think that's -- I don't have an independent memory of requesting a urea and electrolytes -- I repeat, I don't -- at that point.

THE CHAIRMAN: But reading back from when you found out about Claire's collapse, your reason that you give that piece of evidence was because you were surprised that there hadn't been a test done with results before 11 pm or 11.30.

A. Yes, but the other things that aren't recorded in the ward round note are discussion with mum and dad and again I have a recollection --

THE CHAIRMAN: If we go back a page, can you give us page 052 as well as 053, please?

MS ANYADIKE-DANES: There is a reference.

THE CHAIRMAN: There is a reference to the parents, I think it says, at the bottom of the previous page. Just so that you have the full note, doctor:

"Usually very active. Has not spoken to parents as per normal."

And then the last line:

"Vagueness/vacant (apparent to parents)."

A. So there is some history-taking from mum and dad, but nothing about what was said to mum and dad.

THE CHAIRMAN: I understand.

MS ANYADIKE-DANES: When you had, in your mind, seizures -- even not evident seizures -- as something that might be giving rise, did it occur to you to try and think through what might be causing those seizures?

A. Well, I think this is part of where the possibility of encephalitis comes in as a possible contributing factor to a seizure disorder. I'm not sure that we went into it in a lot more detail, but I would suspect that if we were thinking about a CT scan, it's quite a major investigation to undertake -- and again I can't remember this directly -- but what else might a CT scan show or rule out? I suppose that we might have been thinking that it would rule out something like a cerebral haemorrhage or even a tumour, unlikely though those might be as a cause of the clinical presentation.

Q. And if you were going to put in train the kind of test to help you or any consultant coming after you who was going to deal with Claire's care as to what might be causing the seizures, what sort of test do you think, from 1996, you would have wanted to have carried out?

A. At the time, I think I would particularly have wanted to get advice from a neurologist to advise on that, because

I think I would have felt unable to put down a comprehensive plan or -- maybe not unable to, but it would have been better, more efficient, more full to get that advice about those tests from a consultant neurologist.

Q. Yes, but while you're going off to go and do that, could you, for example, not have directed, "For a start, let's have full blood and urine tests done? That will help us with whether there is any kind of toxicity involved in there, anything of that sort going on, any other sort of abnormality that might be reflected whilst I'm going to find the neurologist who may guide me yet further as to more particular things"? Did that occur?

A. I'm not sure that occurred at the time. Again, you could do a very wide range of blood tests and toxicology screens, although you'd need to know what toxins you were looking for. You'd need to have a list of what laboratory tests you wanted the toxicologist to look for. Liver function tests, you could do, and the result would probably be available -- well, it may be available that evening or possibly the following day. But I appreciate there are other causes of Claire's -- potential causes of Claire's presentation that weren't explored in detail.

Q. I think Dr O'Hare thought that there -- it was either

Dr O'Hare or Dr Bartholome who thought there might be a liver function test that could be done. It's Dr O'Hare. So that could have occurred to you in 1996, that's not a hindsight point?

A. Yes.

Q. And it could have occurred to you to have had full bloods carried out?

A. Full blood count?

Q. Yes.

A. There was a full blood count done. It wasn't markedly abnormal, but the white cell count was elevated at 16.5.

Q. Might you have wanted to see where that was now?

A. Whether it was rising or changing? Yes, I think that's not unreasonable.

Q. That might have been useful?

A. Yes.

Q. If those are all things that you could have known about and therefore could have prescribed or put in the plan for the SHOs to do, why didn't you?

A. I think because my impression was that I was going to speak to Dr Webb and that he, in fact, would come, I -- hoped soon -- and would give us a steer, give us a direction to go down, because it seemed to me quite clear that this child, that Claire, had a major neurological problem that Dr Webb would be able to help

with, and that he would guide us in terms of a line of investigation or lines of investigation, rather than me suggesting a number of investigations. And then I'd have had to think probably for quite some time, maybe with a book in front of me, to decide what would be the most sensible lines of investigations to go down in this case.

Q. I can understand that if -- well, it's not for me to understand. I understand what you're saying, if you had gone off and been able to get hold of Dr Webb fairly speedily to return and start to formulate a plan and put something in motion, if I can put it that way, for Claire. But by the time you left for that clinic, there'd been two hours, roughly, from the way we've been able to calculate it, of you really wanting Dr Webb to come and assist and nothing had happened. So from the point of view of finding out what was causing her deterioration, really you'd had a sort of standstill for about two hours. Did it occur to you at some point during that -- and certainly before you left, when you still really didn't know when Dr Webb was going to come -- that you should have at least some of these things put in train?

A. I'm not sure if that did occur to me at that time. That time interval of 2 hours that we're estimating was

probably longer than I had anticipated. And I think probably the bloods would have taken at least that length of time, if not longer, to actually have any results back within that two-hour time frame. But yes, we could have, perhaps should have, had those tests under way, at least some of the tests under way.

Q. Is that not the point, that there is a time lag, even if you ask them to come urgently, it's maybe an hour, even if you really tell them you need them quickly. But that's the point, is it not? There is a time lag. So all the time you haven't sent them off, you're postponing knowing what the position is, and if they had been sent off fairly speedily, it might have been that some or other of them could have come back in time to inform whatever Dr Webb is going to start thinking about when he examines Claire.

A. I take that point.

Q. And so even though it is with retrospect, do you think that it would have been prudent at that time to have set those things in train?

A. I do.

Q. Thank you. I know you have couched these in terms of impressions, so you haven't actually identified them as differential diagnoses at the time, have you? They're just your thoughts as to what might be the problem. Did

you think about raised intracranial pressure in some way, SIADH maybe?

A. I don't recall thinking that.

Q. From what you have said before about the history that you got from the referral letter, do you think the fact that you knew she had had seizures before in any way led you maybe more quickly to focus on the whole aspect of seizures as opposed to retain a broader perspective of the things that could be causing her presentation?

A. Looking at it now, looking at the chart now, I think that's a fair comment, that there is a focus on seizure history and that undoubtedly influenced probably not just me but undoubtedly influenced probably several of the doctors in terms of how they interpreted Claire's condition and managed Claire's condition. A history of seizures was important and did have an influence.

Q. Is that because it provided an explanation?

A. Partly that.

THE CHAIRMAN: There's nothing unnatural about that, doctor, is there?

A. No. It's an important history.

THE CHAIRMAN: It is. And if that is part of Claire's history, even though it's somewhat distant, then that is at least a starting point for investigating why she is unwell on the Tuesday morning. I think really the issue

is: at least with the benefit of hindsight, did it lead you to focus too much on that and perhaps not consider as prominently as you might have done other possibilities?

A. I take the point you make, sir, and I think it became central to Claire's management, the history of seizures, and I do think it is an important history in any child. Whether it then made people a little bit less aware of other possibilities, what else might be going on, that's a point that one could make, and I can see that point.

MS ANYADIKE-DANES: Could that have been assisted by the fact that the consultant who was actually providing advice and guidance was a neurological consultant, and so may be naturally focusing on the neurological aspects because that's what you brought the consultant in to guide you on, as opposed to also having at your disposal a paediatric consultant, who might have looked at some of these broader possibilities for producing that kind of presentation, if I can put it that way?

A. I think all of these things rather fall within neurological conditions. Again, I can only -- I'm bound to, I suppose, draw comparisons between my own practice and if I'm called to see a child in whom there is a cardiac diagnosis, and that's established, I would seek to manage that child.

Q. Yes.
A. And yes, I'd want to have a word with the consultant under whom that child had been admitted, but I would want to manage that child, all of that child, unless there were multiple other organ system disorders that needed other input.
Q. Yes.
A. So I suppose I'm bound to make that comparison in this case.
Q. I suppose what I was inviting you to consider is, if you had had -- maybe you would say it wouldn't make any difference and that's actually what I'm asking you to consider. If you had had the expertise and guidance of Dr Steen as well -- so you'd got two consultants, one who is specialising on the neurology and the other who is an experienced paediatric consultant -- do you think that it may have been you could have had a broader approach to the underlying causes of Claire's presentation?
A. I'm not sure how much difference that would have made, but it's certainly good to have two consultants instead of one. Two people thinking about the same problem, three people thinking about the same problem or problems.
Q. Yes. Then can I ask you about the non-fitting

status epilepticus specifically? I'd like to put to you what the inquiry's expert, Professor Neville, says about that. It comes in two pages of his report, 232-002-005, and if we can pull up along side that 006.

It really comes from (iv), if you see it there on 005, which is the quality of your diagnostic assessment and management of Claire, including the reasonableness or otherwise of your diagnosis of non-convulsive status epilepticus on that morning.

And he gives a number of reasons why he doesn't think that non-convulsive status epilepticus was the likely diagnosis, and the first really is that it wasn't common, epilepsy was not prominent in Claire's recent history; would you accept that?

A. That is the case, that it's an uncommon diagnosis as I understand it, and that epilepsy was part of Claire's history, but not her recent history.

Q. He says in his opinion that that really needs to be proven by urgent EEG. Did you think about, in addition to the CT scan, perhaps if you were along the lines of considering status epilepticus, whether you should have also been querying with Dr Webb: should we not be arranging an EEG?

A. We may have discussed an EEG. I may have discussed it with Dr Webb, but again, the consultant neurologist held

the keys to the EEG, if you like, and I would have needed him to say, "Yes, I think that's what's going on and the only way to confirm that is to do an EEG", if that were possible.

Q. Did you know from your own knowledge that the only way to confirm that was through an EEG?

A. I don't remember at the time. I don't remember at the time.

Q. Did you know whether it was possible to -- I used the poor expression of "bump" when I spoke to Dr Steen. The EEG department has its slots with patients who are planned for their EEGs, as I have understood it from the evidence. Did you know if it was possible for a child who urgently needed an EEG to be substituted for another child? Had you any experience of that at all?

A. I don't recall having any experience of that. I'm not sure as well -- and again there will be others who maybe will know this -- whether a bedside EEG could be done at that time because the alternative would have been to bring Claire round to the EEG department, and whether that could accommodate a bed or not ... I'm not certain.

Q. What sort of equipment would be required to do a bedside EEG and do you know if the Children's Hospital, or for that matter the hospital, had access to that in 1996?

A. I don't know if there was access to it, and to be honest, I don't really know exactly what equipment is required. I've seen it done since and I believe the equipment is there now, and it basically is a portable trolley with all of the electrodes and computer screens on it. I assume it would have been a more rudimentary affair were it available back then.

Q. Perhaps we can make enquiries about that. In any event, I think what I'm understanding you to say is that if that sort of thing was going to be arranged, whilst you might have raised it, you would have been in Dr Webb's hands for whether he felt that was appropriate and how and when it could be arranged?

A. Yes.

Q. He also says that one of the reasons why he says it's so important to get this right is that an incorrect diagnosis of non-convulsive status can lead to inappropriate treatment and that means that you could be having anti-epilepsy drugs, which could further affect consciousness level and respiratory drive; would you accept that?

A. Yes.

Q. And I suppose that's part of wanting to see Dr Webb. You're just offering up a suggestion; is that how you'd have seen that?

A. Yes, and my independent memory of it is that CT was, rightly or wrongly, up there in my mind too as well as getting his input and his directs hands-on input.

Q. And then finally what he says -- and you may not have had the knowledge of that at the time -- is that:

"Cerebral oedema relating to hyponatraemia was a more likely cause of the reduced consciousness level and poorly reacting pupils, and should have been considered as a matter of urgency, as it is reversible by treatment in its early stages."

Leaving aside whether you'd have known enough to formulate that at the time, do you accept that as accurate?

A. Sorry, could you just point out exactly where that is?

Q. It's on page 005, if you go up a few lines, above 1:

"Another more likely cause ..."

Would you accept that as you read it?

A. Again, I'm not --

THE CHAIRMAN: We're going back to 1996 now.

A. Yes. I'm not sure what my knowledge would have been of this in 1996. Even now, would I know now that ... Would I believe now that a more likely cause of reduced conscious level, et cetera, would be cerebral oedema related to hyponatraemia? I'm not sure that I would know that in my practice now necessarily if I saw

a child exactly the same as Claire, you know. But I accept it would be something that one would be thinking about much, much more readily.

MS ANYADIKE-DANES: But was Claire's level of consciousness something of concern to you as you examined her at that ward round?

A. Yes.

Q. Is that something that you communicated to her parents?

A. I think, in effect, they communicated it to me and I agreed with that.

Q. Well, as I understand their evidence, they were communicating to you that she didn't seem any better to them, and this was not her normal presentation. I've asked you something slightly different, whether your concerns as a doctor about their child's condition were communicated to them.

A. Yes, I believe I did raise concerns -- not raise, but endorse their concerns that Claire wasn't behaving normally, that her level of consciousness didn't appear normal.

Q. At that stage, how seriously ill did you fear Claire was?

A. I think I didn't really know. But I thought there was a major neurological problem there that I didn't fully understand, that I didn't perhaps even partially

understand, but thought that she was neurologically unwell in a way I couldn't explain.

Q. Yes, that's why I put it in a different way. I didn't ask you, "Did you know?", I asked you what you feared and whether you were likely to have communicated any of that to the family.

A. I think my own concern, fear if you like, would have been balanced by what I remember as Claire's mum's optimism to -- although they recognised Claire wasn't well, they were optimistic that she would soon be well, she would bounce back, she would in a while be herself again.

THE CHAIRMAN: That's a parent's natural aspiration, isn't it? My child's not well, she's drowsy, she's not responding. You then endorse that. I think what you're being asked about is specifically in relation to the ward round, but it leads into the general concern, which is that Mr and Mrs Roberts didn't ever understand that Claire was seriously ill. At the lowest level, that's why they went home on the Tuesday night.

On Tuesday morning, at the ward round, would it have been premature for you to believe that she was seriously ill as opposed to -- a phrase which was used yesterday -- a patient of concern? Had it got to that stage?

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

MS ANYADIKE-DANES: We can pick up the witness statement as to what they did understand at that time, which is 253/1, page 8. I think it's the answer to question

7(c).

MR QUINN: Mr Chairman, if I can come in for one moment here. The parents are very concerned about this, and you actually hit the nail on the head when you said the parents went home that night not knowing, not aware. Mr and Mrs Roberts have conveyed to me this morning that they would like the inquiry to maybe try and unearth the answers as to why they were let even go away at lunchtime if this particular doctor thought Claire was very unwell. They make that point because two factors arise. Number 1, Claire was responding and was awake and wasn't well, but was responding during the examination by the doctor in the morning. And therefore, that put the parents at ease, but now, over two days, they have heard a very different picture. They have heard a picture that would make them very uneasy to leave the hospital at all, even at lunchtime, never mind at 9.30 in the evening.

So perhaps we could ask two things: was Claire responding and did she seem reasonably bright? The grandparents will say she was still responding at lunchtime.

Secondly, did this doctor in any way convey to the parents the seriousness of the condition?

MS ANYADIKE-DANES: In fairness to the doctor, it should be

pointed out what they have put in their statement about that, which I think appears at (c)(i) and (ii):

"Whether [you] expressed at any time during your discussions [this is with Mr Roberts] his view of the seriousness or otherwise of Claire's condition."

They say:

"Dr Sands did not express any view on the seriousness or otherwise of Claire's condition."

The second question is:

"Any concerns about her condition."

And their answer to that is:

"Dr Sands did not express any concerns about Claire's condition."

That is their recollection. That is their evidence. Were you trying to communicate to them your concerns?

A. I believe I was, but again, I have to say, I wouldn't have wanted to take away their optimism that Claire was going to recover. And I didn't know what was going on, I wasn't sure, but I thought there was something serious going on.

Q. Before we go to that specific question about her brightness and responsiveness and so forth, in your view, what were you telling them then?

A. That I thought Claire had a major neurological problem, that her consciousness level didn't seem normal to me

and to the ward round and, I think, to Claire's mum and dad.

Q. And?

A. And that one possibility -- I believe we would have mentioned to them the possibility that Claire was fitting. I know Mr and Mrs Roberts have put in their witness statement "experiencing some form of internal fitting", and that may have been a form of words that I may have used.

Q. Is there anything else you think you would have been telling them?

A. I think I would have raised the issue about possible infection causing some of Claire's problems, infection that might have -- I probably wouldn't have used the word "encephalitis", but may have felt there was an infection also playing a part.

Q. Encephalitis is a particular kind of infection. We're not talking about a more run-of-the-mill infection or a tummy bug, if we're talking about viral illness. Encephalitis and encephalopathy are in a completely different league, I would anticipate, from that. So even if you might not have used those terms because you might not have thought they would understand what those terms meant, did you try and interpret for them what that was?

A. I think I did to some degree, yes, in terms of an infection that might be causing a problem with Claire's brain and thus the need to see a neurologist to get specialist advice.

Q. And if you were telling them that sort of thing, do you think that that is something that should have been recorded, whether it's by your SHO or by the nurses?

A. I think it should have been recorded. Now, I would record it myself.

Q. But you think it should have been recorded at the time?

A. That would have been the correct thing to do.

Q. Apart from anything else, so that anybody coming after you -- particularly as you had in mind Dr Webb -- would know, could appreciate, what level of understanding that Claire's family already had.

A. Yes.

Q. I'm being directed to question 8(b):

"Describe, so far as you can recall, your understanding of Claire's condition before you left the hospital at around 13.00 based on your impression of her and the information given to you by the doctors/nurses.

"My understanding of Claire's condition was that she was unwell, lethargic and pale and that her sickness was no more than a 24 to 48-hour tummy bug."

THE CHAIRMAN: If that's the impression they got, it's not

the impression that you meant to give.

A. No.

MS ANYADIKE-DANES: And it would be incorrect?

A. Mr and Mrs Roberts' impression would be incorrect?

Q. Yes.

A. That wasn't my impression and it's not the impression that I thought I had given to Mr and Mrs Roberts.

Q. I understand and if they had that impression of their daughter's condition, it would be incorrect?

A. Sorry, I'm not quite sure that ...

THE CHAIRMAN: If Mr and Mrs Roberts went off thinking that what Claire had was no more than a 24 or 48-hour tummy bug, that would be an incorrect impression?

A. From my point of view, yes.

THE CHAIRMAN: Let me take you back to a question Mr Quinn had raised a few moments ago. Mr and Mrs Roberts' memory is that Claire was responding, at least to some degree, during her examination by you and that they want you to be asked to confirm whether you agree with that, that she was responding, I think, to some degree during examination; is that correct?

A. I don't believe she was totally unresponsive. I wouldn't disagree with that. It's a question of degree.

THE CHAIRMAN: Mr Quinn used the phrase: did she seem

reasonably bright?
A. No.
THE CHAIRMAN: So any level of response was more limited than that?
A. Yes.
MS ANYADIKE-DANES: Can I maybe put it in this way to you. It's a hypothetical, so if you don't feel you can answer it, please say so. But if, after that, the parents had wanted to know whether it was safe for them to have gone off, if they'd had some other engagement that was going to take them away for a large part of the day, for example, how would you have responded if they had wanted at that stage to know how Claire's condition was and was it okay for them just to go away for a little bit?
A. I think I would have suggested they stay if possible. Not just because I thought Claire was unwell, but because I thought the neurologist was going to come and would probably want to talk to them.
Q. But perhaps also because of your concern over her condition?
A. Yes.
Q. Thank you.
THE CHAIRMAN: It's 1.05. We'll break for lunch, doctor, until 2 o'clock.
I think there's an issue, Mr McAlinden, that we

might have to deal with at 2 o'clock about a nursing expert. I understand that a letter has arrived from DLS while I have been sitting this morning, so I will look at that and then decide whether we will deal with it at 2 o'clock. If you were ready to deal with it then, that might be the appropriate time.

2 o'clock, ladies and gentlemen.

(1.05 pm)

(The Short Adjournment)

(2.00 pm)

(Delay in proceedings)

(2.08 pm)

Discussion

THE CHAIRMAN: Mr McAlinden, just to explain to everybody the point that is under discussion, we received yesterday a request from DLS, on behalf of the Belfast Trust, authority to release to a nursing expert papers, including the inquiry's independent expert report from Ms Sally Ramsay and the nurses' witness statements. The purpose of that, we were told initially, was to obtain an independent expert's opinion in respect of Ms Ramsay's report. That has been clarified at my instigation this morning and I think now, Mr McAlinden, the remit of the report is to obtain an independent nursing report from a nursing expert,

which would be a critique of Ms Ramsay's report, and which would also address the quality of nursing care provided to Claire.

MR McALINDEN: Yes.

THE CHAIRMAN: In the inquiry's procedures, the hearing procedures, there is a provision at paragraph 6, which deals with witnesses and expert witnesses being called. What it requires in general terms is that a party has to provide any written evidence at least 28 days before the opening of that segment of the inquiry to which the evidence relates. And also:

"To provide additional documents, such as all reports, statements, letters, et cetera, written by or on behalf of the proposed witness."

MR McALINDEN: Yes.

THE CHAIRMAN: In this current situation, the experts' reports were sent out in Claire's clinical hearing on 19 July. I understand from what we've now been told by this morning's letter that there were then consultations held in late August and, at that point, concerns were raised about, in essence, whether Ms Ramsay was too harsh.

MR McALINDEN: Yes.

THE CHAIRMAN: And you have been trying since then to find a nursing expert.

If I pause at that point. I entirely accept the difficulties which anybody would have in finding an expert who's willing to give evidence and provide a report to the inquiry because we have been repeatedly delayed over the last few years in finding experts willing to engage. So I'm not concerned about the length of time which it has taken to find an expert who is willing to report. That's not a problem. I also accept that when papers were sent out just after 12 July, by the time they were circulated and consultations start, you are up to mid to late August, and that's not a problem either.

Subject to anything which is said by any other party, my concern is this: part of a reason for getting a report, in effect, is to see whether you get a report which, to put it bluntly, is more favourable to the nurses than Ms Ramsay's report.

MR McALINDEN: Yes.

THE CHAIRMAN: So my position, subject to submissions, is that I will authorise the release to a nursing expert the papers which went to Ms Ramsay and the subsequent nurses' witness statements, but not Ms Ramsay's report because if we're going to have an independent nursing expert to give a report, I want that nursing expert not to have a message, express or implied, that the purpose

of the report is to attack Ms Ramsay.

MR McALINDEN: Yes.

THE CHAIRMAN: So do you have any contrary view to put on that?

MR McALINDEN: What I would hope that she would be able to do, if she hasn't sight of the report, is that the letter of instructions to her could highlight the issues that have been raised so that she can, in the timescale permitted, really focus in on those issues, so that there would be a twofold response from this expert: first of all, a commentary on the care provided by the nurses; and, secondly, highlighting or dealing with the issues that have already been highlighted by Ms Ramsay in her report.

THE CHAIRMAN: But that's really getting Ms Ramsay's report by another method, isn't it? That letter of instruction to the expert who you've now identified would be, in essence, summarising what Ms Ramsay's criticisms are and asking does she agree with them.

MR McALINDEN: Yes.

THE CHAIRMAN: We may as well give them Ms Ramsay's report then. That doesn't deal with the issue at all, with respect. If you want an independent nursing expert's report, which may or may not take issue with what Ms Ramsay has said, then I don't agree that the Trust's

independent expert should be armed with Ms Ramsay's report or a summary of the criticisms which she makes in her report. I want that expert to come with a fresh approach, which may or may not chime exactly or largely with Ms Ramsay's, but to the extent that they are the same, that's fine, and to the extent that they are different, we can then deal with that in a way which I'll need to come on it in a few minutes.

MR McALINDEN: There is a logistical issue, Mr Chairman, of whether such a report would be available within the timescale that's foreseeable for the hearing of the nurses' evidence and also for the hearing of evidence from Ms Ramsay. It certainly wouldn't be the Trust's wish or desire that this matter should be put back, pending the production of such a report. So if a report cannot be obtained within the timescale, within the likely timescale that's envisaged for the hearing of this evidence, then the Trust would take the matter no further. If a report can be available, but the author of the report is not available to give evidence at any time convenient to the inquiry, the purpose in essence of obtaining such a report for the nurses was simply to obtain expert advice on the issues raised by Ms Ramsay in her report in order to ascertain whether questions could be submitted to the inquiry counsel to put to

Ms Ramsay during her oral evidence. It wasn't actually envisaged that another expert should be added to the list of witnesses and this inquiry should be postponed until that expert is available for hearing.

So in a sense, for that exercise to be in any way successful or purposeful, the author of that report would have to have access to Ms Ramsay's report in order to address the issues so that instructions could be obtained by the Trust and then forwarded to counsel for the inquiry to address to Ms Ramsay.

THE CHAIRMAN: There's a couple of issues about the timing, which trouble me. One is, let's suppose that if this goes ahead, that the expert identified by the Trust is actually critical of the nurses. And let's suppose she's critical of the nurses in a way that Ms Ramsay wasn't. We know from the history of this inquiry, for instance Professor Neville against Dr Scott-Jupp, to the extent that they are critical, their criticisms vary, and on some points they're milder or more gentle on one doctor than they are on another, and then they switch.

MR McALINDEN: And in the context of nursing care, we have the report from Sarah Chapman, who was the coroner's expert, who was in no way critical of the nursing care in this case.

THE CHAIRMAN: She was particularly involved in the PSNI

investigation, wasn't she?

MR McALINDEN: Yes.

THE CHAIRMAN: In the PSNI investigation, the issue which was being addressed, fundamentally, was whether there was a basis for bringing any criminal charges against the nurses, which is something of a different scale to anything that I'm involved in.

MR McALINDEN: My recollection of it was it was not a case of her saying that any shortcomings didn't reach the criminal standard; it was a case of her saying that she didn't consider that there were any significant shortcomings.

THE CHAIRMAN: Sorry, I think that's broadly right, but you have to consider the context in which she was writing the report, which was for the purposes of investigating whether any crime had been committed. What concerns me is -- I'm sorry all parties don't have this correspondence, but I think it's been copied to the ones most directly affected. Mr Quinn, I think you have it and, Mr Campbell, you have it.

What concerns me a bit about this is that you're agreeing you don't want to hold back the inquiry, you're not asking for anything to be adjourned, the nurses will go ahead and give their evidence. What happens if we then do have a report from your expert, which is

more critical of one or two of the nurses? In essence, they'll have to be recalled, won't they, on those points?

MR McALINDEN: Yes.

THE CHAIRMAN: Okay. Let me hear -- sorry, you go on ahead.

MR McALINDEN: The only point I would make, Mr Chairman, is this: in order for this exercise, which I would envisage would be important in this case, to take place, I would respectfully submit that the expert retained on behalf of the Trust should have access to the nursing expert report from Sally Ramsay just as other experts retained by you in this case have had access to not only the statements of the various witnesses, but to other experts' reports.

THE CHAIRMAN: Typically, by and large, they haven't, actually. What we've tried to do as much as possible is not to give one expert another expert's report until the second expert has provided a report. An exchange does then follow. But we have typically not, for instance, sent Dr Scott-Jupp, before he did his first report, any report we had from Professor Neville or vice versa. I think it's happened in one or two occasions in particular circumstances, but generally we've been avoiding that in order to avoid this mischief.

MR McALINDEN: I would be content with that if a nursing

expert could produce a report and then, as a supplementary, comment on the report from Ms Ramsay. The only difficulty I envisage is that that prolongs the time point, and in order to shorten the timescale involved it might be, in this particular exceptional circumstance, necessary to provide the expert with all the information at this stage.

THE CHAIRMAN: Okay, thank you.

Mr Quinn, do you have anything?

MR QUINN: Yes, Mr Chairman. The concerns that we have are really on a time point. That is the main concern. We want to avoid delay. So I want to make that point for the record.

The second point to make is that this report -- and I listened very carefully to your comments earlier and they've touched upon it. This report makes this inquiry more adversarial than inquisitorial. And certainly if you release the report to the Trust's nursing expert, that becomes even more of a contest then. It becomes a ping-pong match, with respect. So that's the other point I want to make.

In essence, we're in your hands, Mr Chairman, but we just don't want delay and this to turn into a contest. We want it as it is now: we want to have questions asked and fairly answered.

THE CHAIRMAN: Yes, on the basis that Mr and Mrs Roberts and various other people have been waiting for too long already?

MR QUINN: I should follow-up and make the point that it may set a precedent that when the other children come along to be investigated that other reports are then produced, which could then add more delay.

THE CHAIRMAN: Mr Campbell?

MR CAMPBELL: On behalf of Nurse McCann and Nurse Field, my principal concern would be the possibility of delay, with the Trust's confirmation that they don't envisage any delay being caused by this report being obtained, I would be basically neutral as to whether such a report is obtained or not.

THE CHAIRMAN: Okay, thank you.

Mr McAlinden, did the Trust consider approaching Miss Chapman? Because she's already familiar with the papers and it's not exactly the same as Mr Koffman was in Adam's case. But Mr Koffman had provided a report at an earlier stage, not for the inquiry, in Adam's case, and was then, at the instigation of Mr Keane's solicitors, the inquiry agreed to call him as a witness.

MR McALINDEN: Rightly or wrongly, the Trust decided it would not approach Miss Chapman simply because she had already given an opinion which was, in a sense,

favourable to the nurses, and it would appear that if the Trust did approach Miss Chapman, it was simply approaching her on the basis that she would give favourable evidence. It was for that reason that no approach was made and it was decided to try to ascertain the identity of a new expert to instruct.

THE CHAIRMAN: Okay. Thank you. Ms Anyadike-Danes?

MS ANYADIKE-DANES: Mr Chairman, one point to make first, and that is I think my learned friend Mr McAlinden referred to the letter of instruction. If, Mr Chairman, you had the view that the appropriate way was in fact was to put the new expert on the same footing, so far as that could be done, as the inquiry's expert, it might be helpful that not only did that expert receive the same documents as the inquiry's expert received, but also received the same brief, so, so far as possible, that expert was in the same place.

THE CHAIRMAN: So she would know at least what brief had gone to the inquiry's expert?

MS ANYADIKE-DANES: Yes, and with the addition of the nurses' witness statements, because the inquiry's expert has already seen that and that has not given rise to her wishing to put in a supplemental report. That's one point.

The other point would be to pick up on something my

learned friend Mr Quinn made. You have been throughout this inquiry -- and it's indeed in all our procedures -- that this is an inquisitorial exercise, not an adversarial one, and there is a concern if people feel that some experts are harsher on them than they would like them to be, that that would create some sort of precedent -- and there is still a way to go in this inquiry -- of people wanting to consult alternative experts, which they can do, but in any event to use them as rebuttal witnesses. That could not only change the nature and character of the inquiry, which is your inquiry, but also prolong it without it necessarily assisting you in the task you have before you.

THE CHAIRMAN: Thank you. I'm naturally attracted by the idea that we don't need any more experts. I think I would be in very difficult territory legally if I said no party is entitled to seek to engage an independent expert to give evidence on any specific area, which is causing concern to the inquiry.

For that reason, Mr McAlinden, I'm going to agree to the Trust engaging the expert who has been identified. I will not, however, agree to that expert receiving Ms Ramsay's report until she has provided a report of her own.

So the inquiry can arrange to provide to your

instructing solicitor -- in fact, you already have brief which went to Ms Ramsay --

MR McALINDEN: Yes.

THE CHAIRMAN: -- because it's in the expert papers, and you probably have that on CD-ROM also.

MR McALINDEN: Yes.

THE CHAIRMAN: You have the brief and the documentation, I think, is identified in that. If there's any query about the documentation, please liaise with us between now and Monday. In addition to that, the other documentation which can go are the nurses' witness statements for the inquiry.

I really would like to know when the Trust's expert will provide a report.

MR McALINDEN: I certainly will be able to give you an update in relation to that matter very early next week. I understand the expert is on holiday this weekend and could not be contacted this weekend about a timescale as such, but I would hope to be able to advise you, Mr Chairman, in correspondence very early next week as to the likely timescale.

THE CHAIRMAN: Ms Ramsay is due to give evidence three weeks from yesterday.

MR McALINDEN: Yes.

THE CHAIRMAN: And it seems to me that there will inevitably

be difficulties if the report from your expert, even with a supplementary report dealing with Ms Ramsay's criticisms, isn't available before that.

MS ANYADIKE-DANES: There might be some suggestion that if the report was maybe going to come in later, maybe the Trust would choose not to use it. Whenever the report comes, I would ask that we see it. I think that would be relevant.

MR McALINDEN: I hope the correspondence made clear that when the report is produced, it will be furnished immediately to the inquiry.

THE CHAIRMAN: There are a couple of conditions in paragraph 6, sub-paragraph 9, and I presume that they will be met.

MR McALINDEN: They will be.

THE CHAIRMAN: Thank you very much.

Dr Sands, please.

DR ANDREW SANDS (continued)

Questions from MS ANYADIKE-DANES (continued)

MS ANYADIKE-DANES: Good afternoon, Dr Sands.

I think, when we left off, we were dealing with discussions that you might have had with the Roberts family, either during the course of that ward round or at the end of it, and what impression they might have been left with about their child's condition.

Dr Scott-Jupp has dealt with what, in his view, in 1996, the parents ought to have been being told. I think we see that at 234-003-007.

If one summarises from that page:

"Any changes in diagnosis, the possible reasons for any deterioration and the management plan and any significant neurological deterioration."

Although I think he concedes that he wouldn't expect the parents to be told that periodic neurological assessments and/or Glasgow Coma Scale recordings were being done. Leaving that aside, would you accept that's the sort of information that should be provided to the parents?

A. Yes, I think that's a fairly full list of information that might be passed on to parents, perhaps not all at the one time. Again, sometimes this information is given over a period of time, particularly to reflect any changes in a child's condition. I think the points made are well made though.

Q. Can I ask you this, though: however it was explained to them, or over what period of time you chose to do it, is it the case that parents should not be left in any doubt as to whether their child is considered seriously ill by the clinicians treating her or the nurses treating her?

A. I think parents should be fully informed in a way that

they will understand and I do have to say that I think we as clinicians -- and me as a clinician -- haven't always taken care to ensure that a parent has absolutely understood what I've said. That's something I've learnt over time and I think still we -- and still I -- don't always achieve that understanding in parents.

Q. I see what you are saying. But in any event, so that we're clear: if the clinician feels the child they're examining is seriously ill, at some point in time, the parents need to know that?

A. Yes.

Q. Would that sum that up?

A. Yes.

Q. Given that you had not been in your position for very long and you were missing, at that stage, your consultant, if I can put it that way, is that sort of discussion to really convey to the parents exactly where you think their daughter's condition lay in terms of the spectrum of seriousness, is that something that you would have wanted Dr Steen to have discussed with the parents at some point?

A. I think a consultant, so by that I mean Dr Steen or Dr Webb.

Q. Would it have made any difference in relation to Dr Steen since that was Claire's named consultant?

A. Again, if Claire's condition was felt to be acknowledged to be a neurological problem, I think it would be reasonable that a neurologist would give that advice, that extra information, that more definitive information.
Q. So at some point in time, at least at consultant level, for that discussion to happen?
A. Yes.
Q. That obviously wasn't going to happen at the ward round because neither Dr Steen was there and you hadn't had an opportunity to locate Dr Webb and brief him on it. Can I get some sense from you as to when you think that kind of discussion, all things being equal, ought really to have been had with Claire's parents?
A. I think the short answer to that is as early as possible.
Q. Some time before lunch?
A. If possible.
Q. Thank you.
THE CHAIRMAN: Well, at least by lunchtime or when the ward round is finished, as I understand what you're saying, doctor, what you would have liked them to understand from you is that you were worried about Claire and you weren't sure what exactly was wrong with her, that wasn't apparent, and for that reason, you were now going

to bring in a specialist neurologist, who would help to identify what's wrong and hopefully you would be in a position or he would be in a better position to advise them over the next hour or two.

A. Yes.

THE CHAIRMAN: That doesn't appear to be what they picked up at all, sure it isn't.

A. I would agree.

MS ANYADIKE-DANES: Then if we move on to what happened after the ward round, which is that you're trying to locate Dr Webb.

MR GREEN: Sir, if we're moving on from the ward round and the diagnosis as issues, may I raise a matter? It's in relation to the reference before lunch to Professor Neville's report. I had rather hoped that, as a matter of balance, my learned friend would put what Dr Scott-Jupp said about the impression of non-fitting status. Because it's an example of where one expert is significantly more critical than another. And I simply raise it because I have well in mind what my learned friend said about these proceedings being inquisitorial and it's therefore important that they're characterised by balance, not polemic.

THE CHAIRMAN: Give us the reference.

MR GREEN: 234-002-004. If we go down in the first

paragraph just to where the cross is there, in the middle of that sentence it starts:

"This diagnosis was not unreasonable, but other differentials probably should have been considered at the time."

It then goes on to deal with the issue of an EEG being desirable, and then in the paragraph below, with an asterisk at the side of it, a reference to Dr Webb's statement, and the concession to the effect that if no urgent EEG service was available at the Children's Hospital at the time, that the particular criticism in the paragraph above may therefore be unjustified.

I simply raise it because Ms Anyadike-Danes, before lunch, put it to Dr Sands that Professor Neville was critical of the provisional diagnosis. In the interests, as I say, of balance, I would simply point out that Dr Scott-Jupp's position seems to be somewhat different.

THE CHAIRMAN: Okay, thank you.

MS ANYADIKE-DANES: Thank you very much. I do try and present a balanced view, and if anybody, as I circulate round and ask for their comments, ever thinks that there is something else I can put, I'm always receptive to that and seek it throughout the day. In any event, thank you for that.

Mr Chairman, you will see there the entirety of what Dr Scott-Jupp has said in relation to that diagnosis.

THE CHAIRMAN: I've got it, thank you.

MS ANYADIKE-DANES: In due course we will deal with the issue of the urgent EEG.

Mr Chairman, you'll be aware of the fact that in that file 150, there was a patient of Dr Webb, who in fact had an EEG that morning, and unfortunately we don't have Dr Webb here to have found out how, if it was indeed possible, for one child to be substituted for another. The Trust, I think, has also given us information to the effect that there were, I think, five children who had EEGs in addition to that during that day, and we hope to find more information out about the possibilities of that during the day. Thank you very much indeed.

THE CHAIRMAN: That would primarily be a point for Dr Webb because, as I understand it, there can only be any bumping in the EEG queue at the instigation of the neurologist.

MS ANYADIKE-DANES: That's correct.

THE CHAIRMAN: So while Dr Sands might convey to Dr Webb how concerned he is about the condition and that is why he's bringing him in, when he does bring in Dr Webb, if Dr Webb isn't so concerned, he will not bump Claire

in the queue --

MS ANYADIKE-DANES: That's correct.

THE CHAIRMAN: -- or he will have an idea, which Dr Sands won't possibly have, about what the urgency is of the people who are in the queued for an EEG.

MS ANYADIKE-DANES: That's correct. I think Dr Scott-Jupp's point was not necessarily that. He was expressing some surprise -- it's just below that first highlighting -- that there was no record of a discussion about attempting to do that, that that is a discussion that Dr Sands might have had with Dr Webb. I think he concedes himself he might have had a discussion like, that although ultimately it will be a matter for Dr Webb.

That's just where I'm going to now, discussions with Dr Webb. After that ward round, is it a priority of yours to try and locate Dr Webb?

A. Yes.

Q. And I think I asked you this -- and forgive me if I did and you've already answered it -- did you think of trying, at that stage, to notify Dr Steen that you are trying to seek a specialist opinion?

A. I don't recall whether I did try and contact Dr Steen at that point or perhaps knew that she -- it wasn't going to be easy to get Dr Steen just at that time. So

I can't clearly recall my thought processes at that point.

Q. If you thought you could get hold of her, would you have tried to let her know that that was your take on matters and that's who you were going to seek specialist advice from?

A. I'm not sure exactly what order I would have done things in as I wouldn't have wanted to delay or miss an opportunity to get to Dr Webb.

Q. But at some point, you would have been telling her that?

A. Yes.

Q. Thank you. Can you help us with exactly what your discussion, so far as you can, with Dr Webb would have included?

A. Here I have to try and reconstruct what I might have done at the time rather than have a definite memory, except I do remember talking about a CT scan.

Q. You have a definite memory of that?

A. Of a CT scan being part of the discussion.

Q. Do you have a definite memory of anything else in that discussion?

A. I don't.

Q. I understand. So doing the best you can, and everybody else has been pretty much in your situation so far, can you try and help us with what you think you would

have wanted to discuss with Dr Webb?

A. I think I would have come to him with a clinical history and said, "This is a girl who was admitted", what Claire's problems were, maybe a little bit about her background history, what her physical findings were on examination and what the concerns -- maybe from the time of admission and indeed as part of the ward round examination -- what the concerns currently were.

Q. Would have you conveyed to him that you thought she might have deteriorated since she had first been admitted?

A. That I'm not sure of.

MS ANYADIKE-DANES: I understand.

THE CHAIRMAN: Surely he would have asked you in this discussion, "How has she been responding?"

A. In which case I would have done my best to answer that.

THE CHAIRMAN: It's a bit unlikely that there would not have been some discussion about how she had been since she came in on the previous evening.

A. Yes, I think as part of her history, yes, that probably would have been discussed.

MS ANYADIKE-DANES: And I think elsewhere in your witness statement you think you raised the issue of rectal diazepam with him.

A. Yes.

Q. That might have indicated to you, might it not, that you had said something about her condition because the seizure issue, if I can put it that way, was only a query from the previous evening with Dr O'Hare?
A. Yes.
Q. And you've actually formed an impression about it, and actually thought about something which was, effectively, an anticonvulsant and therefore seeking to address that?
A. Yes.
Q. So that would mark a deterioration, is that right, in your mind?
A. Not necessarily. If it had been something that had been there when Dr O'Hare was seeing Claire as well, because her neurology seemed to be quite abnormal at that stage as well. So it might have difficult to determine whether it was something that had been fluctuating, perhaps had been quite bad at one at that stage, had improved at 12 midnight or thereabouts, and perhaps had gone back to some degree by the time of the ward round. So it may have been a fluctuating picture is maybe how I would have conveyed it as I understood it.
Q. It may be that you didn't know sufficient at that time about the non-fitting status. But is that a characteristic of it, that it can fluctuate in that way or does it go in one direction?

A. I don't know, but I think seizure disorders be variable. They're could be that variability, I would suspect, although it's not something I know too much about.
Q. In any event, you would have presented that to him?
A. Yes.
Q. Can you think of anything else that you might have told him about?
A. I think we probably would have mentioned -- in discussion about a CT scan I think I would have wanted to say why a CT scan or why the ward round and I though a CT scan would be helpful. That may have raised the issue of possible brain infection or encephalitis.
Q. Do you think you might have mentioned encephalitis to him then?
A. Yes, because I think I would have needed to have some -- I think if I came to Dr Webb and said, "I wonder about a CT scan", I would have needed to say why. And again, I'm having to reconstruct that.
Q. I understand that. Have you any sense of how long you might have been having that discussion with Dr Webb?
A. Not very long.
Q. And where it might have been taking place?
A. Although I can picture the room, I can't picture it exactly, where it is in the Children's Hospital. It wasn't in Paul Ward and it wasn't along the main

corridor. I think it was in a room off the main corridor somewhere where I actually found Dr Webb and spoke to him.

Q. 138/1, page 5, and I think it's the answer to question 2(a). There we are:

"State the time at which Dr Sands first contacted you, the means and nature of the contact, what you discussed at that time, and whether this was prior to Dr Sands coming to talk to you in person."

THE CHAIRMAN: We took this a bit out of order this morning, didn't we? We've been through this.

You don't think it was as late as 2 o'clock --

A. No.

THE CHAIRMAN: -- or 1.45/2-ish, which is what he suggests at 2(b).

A. I think that's correct. I don't think it was as late as that.

MS ANYADIKE-DANES: Leaving aside the time point, I was actually bringing you back, we had seen it before, but I was bringing you back more now to look at the substance of what you were discussing. Although he says he can't remember the exact details, he thinks you were seeking advice on the management of the child who you felt had non-fitting status. So you had communicated your impression to him, and you were seeking advice on

what medication to prescribe for further seizures and that you wanted him to assess Claire and that you might have asked for a CT scan. And then if we go over the page --

THE CHAIRMAN: Can we stop there and ask: doctor, to what extent do you agree or disagree with what Dr Webb recalls at 2(a)?

A. I think that has most of the key elements in the discussion, that that was the impression of possible non-fitting status, that we were thinking about diazepam as a possible treatment, and that I did want him to assess Claire and that I did mention a CT scan, but I think I probably would have gone on, or I think I would have expected Dr Webb to say: why do you want a CT scan?

MS ANYADIKE-DANES: I'm going to go over the page because I think, in fairness to you, he does go on. Page 6. So:

"It's likely that we discussed the possible differential diagnoses, including meningoencephalitis and epileptic encephalopathy. I would have recommended regular neurological nursing assessments of the Glasgow Coma Scale."

So that's the other part. Would you recollect that?

A. I don't. I don't, but again I could try and reconstruct

it and think that that may not be unreasonable. I don't quite know whether it was Dr Webb or a result of the ward round that the Glasgow Coma Scale observations, the neuro observations, were started. And I've said that in witness statements, that I'm not certain whether they were already started prior to my going to speak to Dr Webb or following on from my discussion with him.

Q. If they started prior to that, is that because you directed that that should have happened at the ward round?

A. If so, then it would have been part of the ward round -- as a result of the ward round.

Q. Is that something that should have been noted as to when they were to start?

A. Yes.

Q. They, in fact, appear to have started at 1 o'clock --

A. Yes.

Q. -- but I will stand to be corrected. I'm not sure that there's a record as to why they were being started at that time.

A. Yes, I think the normal observations seemed to stop -- or the routine observations seemed to stop at 12 and the neuro observations seem to begin at 1. I can't be certain whether it was a result of the ward round or because of Dr Webb's discussion with me.

Q. But if you were looking for matters that perhaps might have been included by 1996 standards, in the ward round note, that might have been one of them if that was discussed?
A. Yes.
Q. Then you said that you don't actually remember the encephalitis/encephalopathy matter being discussed.
A. I think -- I remember a little about this. I think encephalitis was something that we had mentioned on the ward round, and indeed in association with talking about the CT scan, I expect that came up in conversation with Dr Webb as to perhaps something that a CT scan might help with.
Q. Yes.
A. I recall that encephalopathy, epileptic or otherwise, was Dr Webb's term, not one that I thought of, not one that I'd considered.
Q. So if you were having anything to do with encephalopathy, that's because you had received some kind of guidance from Dr Webb about it?
A. Probably he mentioned it to me. That's my recollection, that encephalopathy was Dr Webb's word, and that he had mentioned that to me, not that I'd mentioned it to him.
Q. Did you at that time, in 1996, understand what these terms meant, how they would affect a patient's

presentation and actually what the underlying causes of them might be?

A. My understanding of encephalitis would have been limited, having not seen perhaps any cases of encephalitis, of definite encephalitis. My understanding would have been limited at that time. And even more so of encephalopathy, I think, because it seems to me now, and it seemed probably -- I'm sure it would have seemed to me then a very broad term with many possible features, and indeed an overlap between encephalitis and encephalopathy when I look at the textbooks now.

Q. Are you aware of having looked it up at the time?

A. I don't recall that I looked it up at the time. I believe that I hoped that Dr Webb could give direction as to where along the lines of encephalopathy he wanted us to go. I think my understanding of it would have been quite limited as to what he meant by that. I'm not sure he put it in terms of epileptic encephalopathy to me, which is a more clearly defined, perhaps a more ... a narrower diagnosis rather than encephalopathy, which seems to be a very wide diagnosis with many possible elements to it.

Q. If you had had that discussion with him when these things had been mentioned, so now you have three things

in your mind, you have the non-fitting status, the encephalitis and the encephalopathy, given, as I think you said, it was a rather brief discussion, when did you think the plan for how to deal with all of that would emerge?

A. Well, as I've said, I thought Dr Webb was going to lead on that and would guide us as to how he wanted this investigated managed. And I think again I would have probably had a number of other things that I needed to do as well in addition to trying to get some help for Claire and get some guidance for the staff looking after Claire, me included.

Q. Did you get any sense of urgency from Dr Webb that if these are the differential diagnoses, that this is really a very serious situation we're dealing with here?

A. I think he took me seriously. He listened to me, he took me seriously and I was pleased that he agreed to come and see Claire. I'm not sure that he specified exactly when or how quickly he would come or be able to come.

Q. Did this, so far as you are concerned, put Claire slightly higher up the list of priority in terms of concerns for you once you heard Dr Webb discuss her condition in that way?

A. I don't recall that. I don't recall whether that did

cause that change in my thinking.
Q. Well, will you at least confirm that your concerns and fears that what you had on your hands was a seriously ill little girl -- did you have that confirmation?
A. Except that Dr Webb hadn't actually seen her so he could have come along and said, "I don't think it's exactly as you see it and things are different".
Q. I understand.
A. And we go in this direction, in fact.
Q. Yes. If we look at the notes, which we've had up a number of times, 090-022-053. Just halfway down, the addition to "non-fitting status" of "encephalopathy/encephalitis". That's your handwriting, is it?
A. It is.
Q. Do you know when you actually added that?
A. After speaking to Dr Webb, I came back to Allen Ward and I put that down in the notes. I appreciate it's not signed and dated and timed.
Q. Should it have been?
A. Yes.
Q. When you put that in the notes, are you aware of explaining to Dr Stevenson or Dr Stewart, if indeed he was about, what this now meant in terms of Claire's condition, if any of that was substantiated, if I can

put it that way?

A. I don't recall conversations with Dr Stevenson or Dr Stewart immediately after that point. There may have been, but I can't remember that.

Q. Well, if they just saw that in the notes, let's assume that they did, and given that you yourself were not entirely clear of the full ramifications of that, how were they to understand what the implications of that were for the attention they should be giving Claire until Dr Webb arrived and gave better direction, if I can put it that way?

A. Again, I think my anticipation was that they wouldn't have to wait long for Dr Webb to come and provide that guidance. I'm not sure whether I was there and able to give some guidance or some discussion about it. I can't remember on that point.

Q. Well, what was your feeling, if you can remember it? It is at least possible that you went to the clinic at 2 o'clock. What is your feeling, leaving Claire and the junior doctors and nurses in that situation?

A. I would have been concerned still about Claire, but I would have felt that I had spoken to a specialist whom I knew was going to come and review Claire, I hoped soon. I believe at that stage I would have been trying to or may already have spoken to Dr Steen to let her

know that I'd contacted Dr Webb and he's agreed to come and see Claire. It wouldn't have allayed my concerns completely about Claire, I don't believe so, but I would have felt at least that we were making some progress and that I had got senior help.

Q. Yes. Did you attempt to speak to Claire's family before you left to appraise them of the fact that you had seen Dr Webb or give them any indication as to what was to happen next?

A. I don't remember, I can't remember that. I don't remember whether Claire's mum and dad were there when I came back from seeing Dr Webb. I'm not certain on that point.

Q. Well, did you leave any message for the nurses to convey to Claire's parents, which might have put their mind at rest that you'd actually got in touch with a neurological consultant who was going to come and see Claire? Did you do that maybe?

A. I may have done, but I don't remember. I don't remember.

Q. Would it have been appropriate for you to do that if they hadn't been there for you to speak to?

A. Yes.

Q. And I presume that means that if they had been there, you would have spoken to them about it?

A. Yes.
Q. From what you have said, when you said you got the impression having explained all these matters to Dr Webb and got his further thoughts about other things you might be thinking of, if I can put it that way, that he was going to come and see Claire, did you get any indication of what you might have been doing in the interim period, however long it took him to finally get to Claire, from Dr Webb?
A. Sorry, just repeat that, please.
Q. Did you get any impression from Dr Webb as to what you might be doing, how you might be treating Claire, what might be going on whilst he was getting himself to see her?
A. I don't remember specific instructions from Dr Webb about what we should do, although I think he had agreed that we should go ahead and give a dose of diazepam, and he may well have been the one who said you should start some neuro obs as well.
Q. Would you have asked him: what's the best thing for us to be doing at this stage?
A. I think I would have had some discussion of that type, perhaps: is there anything else that we should be doing or anything else you'd like us to do?
Q. And the CT scan. Can you remember what he said about

the CT scan?

A. I don't. I'm not certain what he said to me at that point or whether he only records it later in the notes about a CT scan the following morning if the conscious level -- Claire's conscious level doesn't improve. He may have mentioned maybe tomorrow for the CT scan or he may have only written that in the note subsequently. I'm not certain of that.

Q. So that has happened, you have come back and you've written this up in the notes. Is there anything else that you do in relation to Claire -- let's call it the morning? I should say longer than the morning. Take it up to, say, 1 o'clock.

A. I'm not quite sure what else was happening at that stage, whether there were other patients as well also needing things done at that point. I'm not sure what else we were doing with Claire. Perhaps we were still trying to get notes from the Ulster Hospital as well at that point. I'm not quite certain.

Q. Now that you mention the notes from the Ulster Hospital, something was faxed through, was it not, from the Ulster Hospital?

A. I believe so. I've seen it since.

Q. Well, do you recall ever seeing it at the time?

A. I don't recall seeing it at the time. I'm not sure

exactly what time the fax came through at. It may be possible to see that now.

Q. I think we can try and find it. It starts at 090-013-015. It says the time is 3.15. Is this something that would have been brought to your attention as soon as it came in?

A. It might not have been, unless it contained something that needed to be passed on urgently.

Q. I'm sure that you've looked at these medical notes and records many times --

A. Yes.

Q. -- quite apart from at that time. Do you recall ever reading this, apart from knowing it might have come in, ever reading the two letters that came from Dr Gaston?

A. I may have done, perhaps at the end of the day, but I don't have a clear recollection of reading them at the time.

Q. Whenever it is that you became aware of what was in them -- whether because you read them or somebody told you what was in them -- can you recall whether it made any difference so far as you are concerned to your treatment of Claire?

A. My impression is it probably didn't make -- have a big impact on treatment. That's my impression.

Q. And why might that have been?

A. Perhaps the information in this is not quite what we would maybe hope for, not telling us terribly much more about Claire's background, because I think Dr Gaston maybe had actually come to see Claire or had seen Claire only quite recently and perhaps just the once or twice. And it may have been Dr Major in the Ulster Hospital and Dr Gleadhill who maybe had been responsible for quite a bit of Claire's care previously.

Q. When you had written as part of your plan in the medical notes and records, "Discussed with Dr Gaston re previous medical history", what exactly was it you were hoping to learn that would have assisted you in your care and treatment of Claire?

A. I don't remember exactly at the time, but I would suspect it was what her neurological examination was like as well as her usual level of functioning. But I think mum and dad were able to provide most of that very effectively.

Q. But in addition to receiving these two letters, which are not directed to your specific queries at the time, they are reporting letters as to what was happening. Because it says, "Discussed with", did you actually intend to speak to Dr Gaston and have a discussion with Dr Gaston?

A. I don't think that was particularly the intention.

Q. Oh. That's not what the "D/W" means in the notes?
A. May I see that?
Q. Of course, I beg your pardon. It's 090-022-053. Sorry. Do you see that under the plan? It's the last line of the plan.
A. I think it means "Discussed with Dr Gaston to get information about the past medical history". That's what I take from it.
Q. Does that mean your preference would have been to actually talk to Dr Gaston?
A. If that were possible, if he were available to do that. I'm not sure he was and that may have been his secretary who faxed those letters, which were the last available.
Q. Do you know what actually generated those particular letters? Well, when it says, "Discussed with Dr Gaston", one response to that might have been that your SHO went away to see if you could get hold of Dr Gaston on the phone and you could have had an actual discussion with him. It might have been that the upshot of it is: can't find Dr Gaston, he's going to fax something through. Do you know what produced this fax?
A. I can try and help with that. I think that the fax was addressed to Dr Neil Stewart, so I'm assuming Dr Stewart probably phoned the Ulster Hospital to try to talk to Dr Gaston to get some information and the result of that

seems to have been the faxed letters.

Q. Which may have been the most recent documents on the file for example?

A. Yes.

Q. So far as you're concerned, you're not entirely sure why there's no reference to you in the afternoon, but you think it might be explained by the fact that you went off to that clinic, and if you did go off to that clinic, you'd be doing that at about 2 o'clock.

A. I probably would have gone a little bit before that, I think.

Q. I think you did say earlier than that. In fairness to you, I think you said 1.30 or thereabouts.

Dr Steen's evidence was that -- she has absolutely no recollection of 22 October, so all she can help us with is what her normal practice would be -- she would leave -- unless there was a pressing reason to do otherwise -- the Children's Hospital at about 1 o'clock. And her practice was that she would try and get a sense of where the children were at that stage before leaving. A sort of final briefing, I suppose.

Were you aware at all of being in a position to give Dr Steen any briefing about Claire at that stage?

A. No. No, I don't think I had ready access to Dr Steen at that stage. I think, had she been in the Children's

Hospital, I would have contacted her directly. I would have just gone to her, as I did to Dr Webb, and spoken to her directly. And it may be that I couldn't get her directly by phone, or I knew there was going to be at least some delay because of whatever important issue she had to deal with at that time. Perhaps a meeting that was outside of the hospital. And that's my understanding, that she wasn't in the hospital at that point.

Q. And you are not there then when Dr Webb comes and actually examines Claire at about 2 o'clock.

A. That's true.

Q. Did you leave any instructions for the junior doctors as to what should happen when Dr Webb came, which you hoped would be fairly speedily?

A. I think I hoped that I would be there --

Q. I understand that.

A. -- because I'd gone and spoken to him and would have hoped to be there to discuss things with him. I'm not sure if I did have a discussion with the senior house officers to say: Dr Webb is coming and you need to make him aware of this or that. I'm not sure that -- that we did speak like that. They would have known that Dr Webb was coming.

Q. That's what I was going to ask you. Would the nurses

have known that as well just in case the junior doctor wasn't there?

A. I think so. I would have told the nurse in charge or maybe the nurse looking after Claire that I'd been able to contact Dr Webb and that he was coming.

Q. As it happens, it seems from the note that he came at 2 o'clock. Well, you can't tell that from the note, but I think we have verified from other ways that that seems to have been 2 o'clock. Had you left any kind of instructions as to what should have happened if it was very much more prolonged?

A. I don't recall if I left instructions of that sort. I would have hoped that a nurse would have phoned me or contacted one of the junior doctors, the SHOs, who would have contacted me and said, "Dr Webb hasn't appeared yet, we need to do something", or, "What do you want us to do?"

Q. If they were in that situation where you had obviously told them that you were expecting Dr Webb shortly, he didn't come within that two hours, he hadn't come by the time you left and there was still some time when he wasn't coming, would you have expected your junior doctors not just to have contacted you, but themselves to have tried to get hold of Dr Webb?

A. Yes, I think that -- I don't think Dr Webb would have

minded that and I think that that would have been not unheard of and perhaps reasonable in the circumstances.

Q. Or if it's passed to a clerk when everybody would have realised that Dr Steen should be at her clinic in Cupar Street, is that something you might have expected them to alert her to?

A. Again that's possible, yes, assuming they knew where she was -- and I think they would have done. A message could then have been delivered to Cupar Street by telephone.

Q. Is it correct then that you, the nurses, and junior doctors would know how to reach her at Cupar Street?

A. I think if we were sure that Dr Steen was in Cupar Street we would have the number for Cupar Street, yes.

Q. Thank you. I think the first record of you actually coming back, just so that we benchmark this, is round about 5 o'clock when you administer the sodium valproate. I think it is actually 5.15 when you administer the sodium valproate. There's no record and you have found no evidence of a record of you being on the ward or dealing with Claire any time prior to that?

A. That's right.

Q. I mean other than the ward round, of course. As you left -- you think you might have left to go to that

clinic -- who did you think was the consultant with overall responsibility for Claire?

A. Obviously Dr Steen was the consultant under whom Claire was admitted. I'd been to speak to Dr Webb, but in fairness to him, he hadn't yet been to see Claire, though I think he was already having -- having agreed to see Claire, he was already involved to some degree. So I think this is perhaps the beginning of a sharing of care, but Dr Steen, I think, would have still been the consultant in charge at that stage.

Q. We'll come back to when you come back at 5 o'clock. As you left, your feeling that the consultant in charge, not just because she's the named consultant, is actually Dr Steen?

A. Yes.

Q. Did it worry you that you had not been actually able to reach Dr Steen by the time you think you might have been going off for possibly most of the afternoon?

A. Well, I may have talked to Dr Steen by that point. I know that I talked to Dr Steen after I had spoken to Dr Webb, but I can't time my conversation with Dr Steen exactly.

Q. You have given some evidence as to that in your first witness statement, and indeed in your second witness statement. I'm not going to pull it up because it

essentially reflects what you have just said now. What you have really said is you think you might have spoken to her before you would have gone off, if that's what you did, to the clinic at about 2 o'clock.

A. I certainly think I would have tried to do that at that point. Whether in fact then Dr Steen phoned me back. If I'd had to leave a message, if she was perhaps still in a meeting, and then she had then returned my call, so it may have been done in that fashion.

Q. What I'm trying to get a sense of, Dr Sands, or invite you to help us with is: if you were having any discussion at all with Dr Steen, whether because you reached her first time or because she called you back, is roughly when that might have been? Can you help with that?

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

Q. Help us in this way: if you had gone to a clinic, when you say "early in the afternoon", might it mean before then or might it have been in the early part of such a clinic?

A. It may have been in the early part of such a clinic. That's possible. Or it may have been just before I went.

Q. If you're talking about early in the afternoon, then in terms of your knowledge of Claire's condition, that's really before you could have known (a) that Dr Webb had been to see her and (b) whatever the outcome was of that examination. So if we were to pull up 310-001-001, and if we were perhaps to stop -- if we don't look further than, say, 1400 hours. From about 9 o'clock, is that the information you would have had to have passed on to her?

A. Yes.

Q. So she would have --

A. Perhaps I would have been able to also comment on Claire's admission details, her presentation and that type of --

Q. From the previous evening?

A. Yes.

Q. Yes. So you would have been able to tell her about that, essentially what was found when she was at A&E, what Dr O'Hare had found, what her serum sodium levels had been at that stage, what IV fluids she was on, what you found during your ward round, your concerns during your ward round and Claire's parents' concerns the fact that you had spoken to Dr Webb, he was going to see her, and that he had confirmed the administration of rectal diazepam and that she had been started on hourly

observations.

A. Yes.

Q. And you would have known that. And you would have known what that initial observation was?

A. Yes.

Q. And that's the information that you would have had to impart to her?

A. If that's the point that we spoke at, yes.

Q. And also, if your recollection is correct, that not only had you started off with your impression that she might have non-fitting status, but although he hadn't examined her at that stage, but other possibilities were encephalitis/encephalopathy?

A. Yes.

Q. If you had been conveying that to Dr Steen, apart from keeping her up-to-date with it, how serious do you think Claire's condition was that you were describing to her in that way?

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

THE CHAIRMAN: When you said to me before lunch that when you saw her on the ward round she was more than

a patient of concern, is there a phrase beyond that which might describe how seriously you regarded her?

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

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

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

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

A. Ideally, I would have liked her there.

Q. Yes. And if you'd had the option of her coming back, even if only at the end of her clinic, would you have liked her to do that?

A. That would rather depend on what Dr Webb had been able to do, was doing, how he felt about the case, whether he felt he was on top of things. I don't think I would have countermanded his instructions or suggestions and said, "No, we'd better have Dr Steen's view on that as well".

Q. No, but at that stage, he hasn't actually turned up when you're reporting that.

A. Quite.
Q. So maybe I can help you another way: did you think she was sufficiently ill that you would have liked her to come from Cupar Street to see Claire?
A. I may not have suggested that there and then because I believed that Dr Webb was coming, who was a paediatric neurologist, perhaps duly accredited and perhaps a consultant paediatrician as well as a paediatric neurologist and he had agreed to come and see Claire.

If he had said, "No, I'm not going to be able to do that", I think I certainly would have wanted Dr Steen to be there and would have asked her if it was possible for her to come.

THE CHAIRMAN: Then it seems to me to follow, Dr Sands, that you're talking to Dr Steen after you'd spoken to Dr Webb, but you're not sure exactly how long after that. However, it's before you have any update about what Dr Webb has found in his examination of Claire and what he's recommended.
A. I believe that is the case, sir.
THE CHAIRMAN: Right. So that must surely be why your primary expectation at that point would be that Dr Steen and Dr Webb would talk. Because if Dr Webb's going to come and see to Claire, the person who can best update Dr Steen would be either Dr Webb directly or through

Dr Stevenson or Dr Stewart.

A. Yes, and perhaps I felt that Dr Steen was going to phone back and speak to Dr Webb or somebody else who had been there when Dr Webb had seen and assessed Claire.

MS ANYADIKE-DANES: In retrospect, because I think it is only retrospect, do you think it would have been preferable to have actually made a record somewhere in the notes that you had contacted Dr Steen when you had done it and what the substance of your communication had been --

A. Yes.

Q. -- because that might, for example, have helped Dr Webb or whomsoever is coming afterwards?

A. Yes. That would have been my practice, would be my practice. I wonder now was it because when Dr Steen and I spoke, whether I wasn't actually perhaps in Allen Ward at the time and didn't have Claire's notes in front of me to make a note. That may be an explanation. Or I just didn't do it. That is I didn't make a note of it.

Q. Dr Scott-Jupp has said in his report, I think 234-002-004 -- and I think maybe it goes on to 005 -- that he found it concerning that there is no record that you discussed the case with Dr Steen, and if, as you say, she was unavailable, that he thought that was

certainly unacceptable that that was the case, that she was not available to you in a situation such as that.

A. I'm not suggesting that Dr Steen was unavailable by telephone throughout the whole day because I know we talked by telephone.

Q. Do you know if you talked more than once?

A. I don't know that. I can't be certain of that. I have a clear recollection of one phone call and me describing Dr Webb's involvement, and I believe that was after I'd spoken to him. I think that that was probably before his first attendance.

THE CHAIRMAN: Do you recall what Dr Steen's reaction was to the information you were giving her about your own views and the involvement of Dr Webb?

A. I don't recall, sir, what we discussed or what Dr Steen said to me.

MS ANYADIKE-DANES: But leaving aside whether you thought it was unacceptable or not, she wasn't where you would like her to be in relation to Claire?

A. Ideally, ideally ... As I said, one consultant's good, two consultants are even better.

Q. Okay. So what steps -- this is, I think, difficult because you are imminently expecting Dr Webb, if I can put it that way. But what steps do you take to ensure that when you leave or are not available during the

afternoon for whatever reason, whatever period of time, that these junior doctors actually understand what they should be doing and how serious Claire's condition is?

A. I don't recall exactly what discussion we had with the junior doctors or what discussion I had with the SHOs at that time. I can't remember that. I think I would have told them that I'd been to see Dr Webb, he said it was okay to go ahead and give the diazepam, and we had started CNS observations, that the Ulster Hospital were being contacted. I'm not sure what further detail we went into at that point. I just don't remember.

Q. Even though you can't remember the detail, would you have wanted them to appreciate that Claire really was very ill?

A. Yes, I would have wanted them to appreciate that Claire -- it was my belief and it seemed that Dr Webb didn't particularly disagree that she had a major neurological problem.

Q. So you'd have wanted them to know that --

A. Yes.

Q. -- and the nurses to know that and appreciate that?

A. Yes.

Q. And is the responsibility for that, given that your consultant isn't there, fall to you to communicate that?

A. I think there would have been a responsibility for me to

tell the junior staff my thoughts. I don't know to what extent Dr Webb could have completely corroborated what I'd thought on the ward round, so the nursing staff and the junior medical staff would have had my thoughts from the ward round, they would have had those there.

I would have told them what Dr Webb had said to me, but I don't think he could have fully corroborated or agreed with everything without having seen Claire.

Q. Then Dr Webb does come and see Claire and we have the notes of that. If we pull up 090-022-053. He sees her at about 2 o'clock even though it says "14". Maybe 1400 hours would have been more accurate. Anyway, he sees her and he takes that history. You see what he says on examination. Then if we go over the page to 054, then you see what he says about clonus and tone and so on.

Then he gives his impression, mainly that he doesn't have a clear idea, and you see his suggestions, starting IV phenytoin, and he gives the formula for it, as stat dose followed by an infusion and then hourly obs. So he has got the hourly obs. Does that mean because the hourly obs had already been instituted, does that mean that he thinks that they should be continued? Is that how one reads that?

A. Yes, I think he's just recording that it's happening.

Q. And the CT tomorrow if she doesn't wake up. You have the note at 2.30. That's a note by Dr Stevenson. And then over the page to 022-055. You have a note that Dr Stevenson records of Dr Webb's attendance, which would seem to be at about 3 o'clock. And then you have Dr Webb's final attendance at 5 o'clock and a note that he has there.

Can you recall when in relation to any of those observations you may have been on the ward or indeed present when the examination was taking place?

A. I don't, I don't remember where I was when Dr Webb was seeing Claire on those occasions, but I have to infer, because I gave a dose of sodium valproate at 5.15, that I was there at that time.

Q. Yes.

A. I may well have been there when Dr Webb was seeing Claire round about 5 o'clock.

Q. Given that you had very much wanted him to come and have his view about Claire, would you not have remembered if you'd actually been there when he was examining Claire so that you could ask him some questions and understand better for yourself what was happening?

A. I may or may not remember that. As I say, I have said in my statement to the coroner that I felt Claire remained unwell, very unwell, at round about 5 o'clock.

So I do have a recollection that I was there at that time. I don't remember what Dr Webb and I may or may not have discussed at that stage. I simply don't remember that.

Q. So he may have examined her on those three occasions, had his first suggestion, then instituted a plan and come back again, and that may all have happened before you were able to get yourself back to the ward from wherever you were, perhaps the clinic or whatever was otherwise occupying you?

A. I think that may be so.

Q. So when you do come back and you do administer some medication -- so when you do come back, firstly, are you asking anybody whether Dr Webb's been there?

A. Yes, I would have done unless he was actually standing there at the time.

Q. Irrespective of that, do you look at the notes to see what has happened in the intervening period?

A. I think I would have asked him directly, maybe even before looking at the notes if he was there if he and I were both there at the same time, we would have --

Q. If he hadn't been there when you were there because he'd come and literally gone as you'd arrived, would you be looking at the notes?

A. I'd probably talk to the doctors as well. Before

actually looking at the notes, I'd probably talk to Dr Stevenson and/or Dr Stewart and said, "What's been happening?"

Q. Dr Stevenson was reasonably junior in these matters, and Dr Stewart -- if Dr Stewart was there -- even more junior. It may be, might it not, that if you wanted to get a clearer impression of what Dr Webb thought, absent being able to actually discuss it with Dr Webb, the better thing might be to actually read his note of his examination, since those junior doctors may not fully appreciate his view?

A. Yes. I may have done that as well. Or, as I say, we may have directly spoken at that time and had a conversation.

Q. At some point though, before you actually leave Claire, do you look at the notes as to what has happened in the intervening period?

A. I'm not certain that I've read the notes at that time. I'm not sure that I have. I will have spoken to people.

Q. Should you have looked at the notes?

A. Again, with hindsight, I think it is -- it's instructive to look at the notes. I think day-to-day we often talk a lot more than we write and we use word of mouth and we speak to our colleagues and get information in that fashion first before we perhaps look at what's been

written. So if I hadn't had a chance to speak to Dr Webb at all, I think I would have wanted to look at the notes to see what he'd said, yes.

Q. I beg your pardon, Dr Sands, that was the basis I was asking you the question. Assuming you hadn't had an opportunity to speak to Dr Webb, would you have wanted to look at the notes?

A. Yes.

Q. Thank you. I'm sorry, I should have made that clear.

So you would have looked at those notes. Would you have looked at other parts of the charts, the medication that has been prescribed and so on and so forth?

A. I may or may not have done.

Q. Would have you wanted to look at the result of the hourly observations to see where she now was on the Glasgow Coma Scale?

A. Knowing that Dr Webb had been seeing her three times or had seen her three times, if I was aware of that and knew he had been in attendance on several occasions, I may not have looked through all of that in detail.

Q. But you might have looked at the note that he inserted into her medical notes and records?

A. Yes.

Q. And would you have spoken to the nurses who are in fact the people carrying out those observations?

A. Yes, I think so.
Q. And if you had done that -- and we now appreciate that you wouldn't necessarily have looked at all the information that's recorded on this. But if we pull 301-001-001, the timeline again, it gets distinctly busier after 2 o'clock. And if you had had some of that information, if you had looked at the medical notes and records, you would have appreciated what is being suggested should be administered by way of anticonvulsant medication. You would have seen that she had been examined three times by Dr Webb, and if you'd spoken to the nurses, you might have learned there had been what might have been considered to be a seizure a little after 3 o'clock and there had been some other episodes as well, well, one episode of teeth tightening some time between 4 and 5. You might have learned that.
And if you had learned all of that, how ill do you think you would have considered Claire to have been?
A. I think I would still have considered her to be neurologically very unwell. But I have to balance that by saying that if I believed she was being looked after by a paediatric neurologist, and had had these neurological problems, that they were being addressed by the best person possible.
Q. Sorry, Dr Sands, that's a slightly different point. I'm

not saying that you didn't have the impression that there was a consultant neurologist there who had a plan -- and whether you were able to comment on the adequacy of that plan is another matter -- but you had somebody in there who had a plan. But that's a different thing from forming the view that: I previously thought this child was unwell and now I think she really is very unwell. Is that how you would have regarded it?

A. Yes, I think ...

THE CHAIRMAN: I think it's the same -- "neurologically seriously unwell" was your description earlier and it's your description at that point too.

MS ANYADIKE-DANES: So it doesn't change. If you thought she was neurologically seriously unwell from what you knew in the early part of the afternoon before you had seen any writings by Dr Webb or any other results, would you have thought that she had deteriorated, for example, over the afternoon?

A. I don't think my impression on leaving the hospital was that Claire was getting progressively worse and worse. I felt she hadn't improved. But I felt that Dr Webb was taking what I assumed were very reasonable steps to try and address her problems. So I probably -- my own recollection is that I didn't feel that she was

progressively getting worse and worse.

Q. Can I put it to you in a slightly different way? Did you think from when you saw her during the ward round and when you saw her at 5 or 5.15, whenever it was when you administered the sodium valproate, do you think she was worse at 5.15?

A. Looking back now, I think yes, she probably was. But that's with hindsight.

Q. Yes. But at the time, did she strike you as any worse than when you had seen her during the ward round at 11 o'clock-ish in the morning?

A. I can only tell what you I recall, that is I still felt she was very unwell neurologically. She didn't seem to me to have improved.

Q. I'm trying to see why you would not have noticed, for example, the difference in her Glasgow Coma Scale. Because the Glasgow Coma Scale is simply a way of trying to reflect her responsiveness, and at the time that you would have been there, at 5 o'clock, it's really quite low. And it's certainly lower than it was when they started recording it, if I can put it that way, at 1 o'clock. So I'm trying to see why it is that you would not have seen that she was actually worse at 5 o'clock than she had been when you examined her at, say, 11 o'clock.

A. I think most of us working in Allen Ward and working in general medical wards wouldn't have been very familiar with the Glasgow Coma Scale, which was largely used in patients with head injury or patients with neurological impairment, not something that we were using all the time in medical patients. We would have all been -- at least would have had some knowledge of the Glasgow Coma Scale and what it meant. But if I felt that Dr Webb had been there and prescribed medication which potentially could have maybe lowered the Glasgow Coma Scale, I may not have treated it with the seriousness that I now think it should have been treated with. That is the falling coma scale.

Q. Did you understand at the time that the medication that you would have seen recorded in her medical notes and records of having been administered to her could actually have produced the lower Glasgow Coma Scales that were being recorded at 5 o'clock than when they first started recording them at 1 o'clock?

A. I think I would have known that Claire had had anticonvulsant medication and would have perhaps known that those could affect her Glasgow Coma Scale.

Q. I'm just going to pull up an actual schedule that we put together of the Glasgow Coma Scales, which might help. 310-011-001. So 1 o'clock -- and this would have been

a time roughly when you were still there -- it's 9 or, based on Dr Webb's calculation, it's 10. Then if we get to 5 o'clock, it's 6 or, based on Dr Webb's calculation, 7. In fact, it was also 6 or 7 at 4 o'clock.

Those who have given evidence already have said that that's very low, that's very serious for a child to be recording that. And that is significantly lower than what it was when they first started recording it.

I think when you were giving evidence in response to a question from counsel for Claire's family, you said that when you were examining her, although you wouldn't describe her as bright, she was interacting in some way.

A. I'm not sure exactly what I said on that point.

THE CHAIRMAN: I think he said, "She was not totally unresponsive".

MS ANYADIKE-DANES: Not totally unresponsive. Thank you, Mr Chairman.

A. Not behaving normally --

MS ANYADIKE-DANES: No, no. I didn't for one moment suggest that she was. But she was at least not completely unresponsive. So you have that at 11, 11.30-ish, whenever it is. Then you have, at 1 o'clock, your first reading. That's 9. That's not good, but you know ... Then by the time you are back, it's 6 or 7, depending, and it's actually been like that for two hours. Are you

saying, really saying, that you didn't appreciate that there had been a deterioration?

A. I don't recall what I thought at that time. I think if I was aware that Dr Webb had been there, who knows much more about these things than me -- and again, I have to relate back to my own practice now, trying to remember what I might have thought. If a specialist is there who's seen the child, who's prescribed medication, and who's been privy to the same information, if they are not worried and doing something different and anxious, then my anxiety, whilst real enough, would be allayed to some degree by the fact that they seem to be in control.

Q. I understand that, but that's a different question to the one that I had asked. There had also been a seizure. When you were examining her, you thought what was happening was that -- in fact, I think you expressly said you didn't see any seizures. So that was why you thought it was --

A. Yes.

Q. -- non-fitting status there.

A. Yes.

Q. But in fact, there had been at least one seizure recorded and something else, an episode of teeth tightening. So that was a deterioration, was it not?

A. I am not sure if I knew of that.

Q. Sorry, if you had spoken to the nurses, then would they have told you?
A. They may have done.
Q. Well, if they were telling you anything about what had happened with Claire, surely they would have told you that she had had a seizure? That would be a relevant thing to tell you, would it not?
A. I can't speak for what the nurses told me. I don't know.
Q. Sorry, it would have been a relevant thing, if you were asking about her condition, to tell you that she had had a seizure.
A. Yes.
Q. Equally, that she'd had an episode of teeth tightening.
A. They may have told me that.
Q. That's part of her condition. I'm not so much getting at whether you think you've got the right consultant, if you like, to take care of her. I'm talking about your own impression. At some point, you are going to have to do maybe some sort of handover to whoever is going to look after Claire during the night. For that matter, Dr Steen might phone you and ask you about what's been happening with Claire. There will be junior doctors that you might have to guide to make sure that Claire is adequately looked after. You're not sure that you've

actually met Dr Webb yourself, so it's not as if you have necessarily got any comfort from him. All you would know is that he had seen her three times, so she had been sufficiently serious for that, and at that stage, she's had three different sorts of anticonvulsant medication, and quite a bit of it.

I'm simply asking you to reflect on your answer that you didn't think that she was necessarily any worse than when you saw her at 11 or 11.30 in the morning. That is all I'm asking you.

A. My best recollection is that I didn't think Claire's condition had improved. I don't get a strong sense that I thought she was deteriorating, from memory. From memory.

Q. I understand.

THE CHAIRMAN: If you had picked up, whether from Dr Webb or anybody else, that she was worse than she had been, in other words that she was worse than she had been when you were already worried about her, can you say how that would have affected your departure from the hospital?

A. I probably would have wanted to have had a prolonged conversation with the Dr Webb, who had been the consultant there and we may well have talked. I think there's every chance we did talk at that stage, given that the timing of the sodium valproate ... But I may

well have -- if I'd felt that Claire was deteriorating, I think I would have wanted to talk to him and ask him what we should do next or what he wanted done next, and I would wanted to know had he spoken to Dr Steen as well, even though I felt by that stage that Dr Webb was managing what seemed to be a neurological condition.

THE CHAIRMAN: Am I right in understanding that Dr Webb also left at round about the normal time?

MS ANYADIKE-DANES: I think that's so. About 5-ish.

A. I'm not sure.

THE CHAIRMAN: If you didn't think that Claire was significantly worse than she had been earlier, and you were going home on that understanding, as was Dr Webb, who was also leaving, then how likely is it that you would have picked up from Dr Webb directly or indirectly that she was significantly worse?

A. I think he would have told me.

THE CHAIRMAN: If that's what he thought.

A. Yes.

THE CHAIRMAN: Well, as a consultant -- and this is obviously hypothetical -- but if you were brought in, as Dr Webb was, to help care for Claire and you saw her condition deteriorate and you believed that it was a significant deterioration, what would you do before you went home at 5-ish?

A. If I was the consultant?
THE CHAIRMAN: Yes. Would you go home at 5-ish?
A. I wouldn't go home. I would make sure there was a plan, that I was involved in that plan, that ... Well, that we had a plan for the evening. I know Dr Webb has felt that intensive care might have been appropriate at this stage. I know again that we're 16 years down the line. Would that have been appropriate? I think we're probably all agreed that intensive care would have been appropriate, and certainly by today's standards that is something that would have been considered. So as a cardiologist now, if I had a patient who I considered was sick and getting sicker, I'd be talking to the ICU.
THE CHAIRMAN: Just on this point, can we bring up at the same time, please, 090-022-054 and, beside it, 055? It just relates, doctor, to the issue of who's in the lead. On the left hand page, 054, at about 2 o'clock, Dr Webb's notes end with an impression and then below that, he suggests; right? And then at 5 o'clock, he sees her again and he then sets out a plan within the bottom third. Does that suggest anything?
A. That is that initially he felt he may have been giving more of an opinion rather than stepping in and taking over, if you like.
THE CHAIRMAN: Yes.

A. I wouldn't read too much into that. I think for some people that is what it means in their practice, and I know people who do that still, and will say, "Thank you for referral, I would suggest ..." However, my own view would be that if one sees a child with a condition that is within one's area of expertise, specific expertise, and that those problems are neurological or cardiological, you are then taking on responsibility, you're then showing that you're involved and that you are continuing to be involved. There may be some process happening here in that he then moves on to talk about a plan rather than a suggestion, but I'm not sure how much I would read into that as a gradual change or a fairly quick change in terms of responsibility. But it's more evidenced by the fact perhaps that Dr Webb has seen Claire on three occasions, he seems to have acknowledged that her problems are neurological and that he has taken a large part of trying to manage those problems.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Mr Chairman, I've been passed a note about a short break for the stenographer.

THE CHAIRMAN: Okay. I'll sit again at 3.55.

In the meantime, can you agree on how much longer we can sit today? I will sit for as long as we can, but

if that could be arranged when I'm out.

(3.45 pm)

(A short break)

(3.55 pm)

THE CHAIRMAN: Can we try to sit on and finish Dr Sands?

MS ANYADIKE-DANES: Yes, that's exactly the idea.

MR GREEN: Just as a matter of courtesy, I should indicate that, for personal reasons, I'm leaving at 4.30. I hope you won't take any discourtesy from that.

THE CHAIRMAN: I've been offended by a lot worse than that! Thank you.

MS ANYADIKE-DANES: As well as you can do it, you're back on that ward around 5-ish. Also, as well as you can do it, you've had at least one telephone conversation with Dr Steen, which may have been in the very early part of the afternoon --

A. Yes.

Q. -- certainly before you knew anything about Dr Webb having actually seen Claire and what he thought from his examination; would that be fair?

A. That's my best recollection, yes.

Q. When you get back there, do you have any thought that you might like to bring her up to speed now?

A. I'm not sure what I thought at that stage about bringing Dr Steen up to speed or whether I knew that she had been

on the phone or whether she'd said to me earlier "I'll keep in touch". Those are some of the things perhaps that I might have expected her to say. Again, I'm having to reconstruct that because I don't remember ringing Dr Steen again at 5 o'clock.

Q. If Dr Steen had spoken to somebody else in the middle of the afternoon, say, or at some point, whether it was in the middle of the afternoon or closer to when you actually came back on the ward, have you any idea whom she might be speaking to to get some sort of reliable update as to Claire's condition?

A. A senior nurse, a doctor. Ideally, Dr Webb.

Q. It seems that didn't happen. So if it's not the senior nurse, it's Dr Stewart or Dr Stevenson.

A. Those would have been the options: either a member of nursing staff or one of the junior doctors in the absence of a conversation with Dr Webb.

Q. Yes. And if anybody was relaying anything to Dr Steen, whether it's mid-afternoon or 5-ish, would Dr Steen have had the impression that Claire was neurologically very unwell?

A. From what I know and from what I can read from the notes, I believe she would have known that.

THE CHAIRMAN: Sorry. If she was accurately updated --

A. Yes.

THE CHAIRMAN: -- that's what she would have been told?
A. Yes.
THE CHAIRMAN: Since that was your view from when you saw Claire late morning and, at the very least, her condition had not improved --
A. Yes.
THE CHAIRMAN: -- probably got somewhat worse --
A. I think with hindsight, yes.
THE CHAIRMAN: -- so anybody who was giving Dr Steen an accurate update, if Dr Steen asked for an update, could not have led her to believe that things were on the mend?
A. I think that's the case.
THE CHAIRMAN: Yes.
MS ANYADIKE-DANES: And in fact, by the time you spoke to Dr Steen, which would have been after your ward round and so forth, you had the view then that she was neurologically very unwell?
A. Yes.
Q. And when you reported that information to Dr Steen, quite apart from Dr Steen, in your view, perhaps being in touch with Dr Webb, which is something you thought might have happened, what else did you expect over the passage of that afternoon for Dr Steen to actually be doing or do?

A. I would have expected her to perhaps keep in touch with the ward to see what was happening with Claire. This is assuming that she was doing a clinic in Cupar Street and felt perhaps that she shouldn't abandon the clinic completely. Arguably, she may have wanted to come to the ward and see Claire. I don't know. But assuming that she felt she couldn't do that, then she might have phoned perhaps once or twice to be updated as to Claire's progress. I can only guess at that, obviously.

Q. I understand. In all of this -- and I know you are not necessarily there all afternoon -- who is the person who is responsible for keeping the parents up-to-date with the actual condition of their child, the prognosis and the plan going forward? Who's in charge of that?

A. I think, again, there's a hierarchy here. All medical and nursing staff have a responsibility to communicate with parents, patients. The responsibility is most onerous or largest on the consultant, and so on down the line, but it applies to medical and nursing staff, I think.

Q. And if that had been happening, by whomsoever it would have been, whether it's the senior nurse, the junior doctors or Dr Webb, or even Dr Steen, if she had come back at 5 o'clock and informed herself about it, whoever did that, is it your view that the parents couldn't

really have been told anything that would enable them to leave the hospital at 9.30, believing that Claire would be all right the next day and that she wasn't seriously ill?

A. Again, I can only speculate about that. I think the evidence -- my evidence has been and my recollection is that I believed Claire to be neurologically very unwell. What was said to Claire's parents throughout the afternoon, I can only guess at, and their interpretation of that I can only guess at.

THE CHAIRMAN: Let's bring this to a head, doctor. I understand why you say there is a hierarchy and I understand that, as part of the nursing code, they don't just do what doctors say and they have an independent responsibility. But if there is a hierarchy of any sort -- as it happened that afternoon, Dr Webb was the consultant who saw Claire three times.

A. Yes.

THE CHAIRMAN: As a consultant now of some years' standing, would you accept with your patients -- or with patients who you were involved in treating, to put it more neutrally -- that you had the primary obligation to keep those parents informed of what was happening?

A. Yes, I would.

THE CHAIRMAN: And if I formed the view that Dr Webb had the

primary obligation as Tuesday afternoon developed, as he saw her for a second and then third time and became more and more actively involved, would you suggest that I was being unfair or harsh?

A. No.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: And if Dr Webb didn't actually, for one reason or another, speak to the parents at that last examination -- maybe for some reason a parent had gone to make a cup of coffee or whatever -- but if that didn't happen and you were aware that that had not happened, when you were there, you were, at that stage, the most senior doctor?

A. Well, I think Dr Webb was there.

Q. No, when you came back, you said that you may not have met him. We know that you are there at 5.15 because you're administering sodium valproate. So if he had already come and gone, made his note literally as the last act and then he's out at 5 o'clock, then at 5.15, you are the most senior doctor on the ward.

A. Yes, and if I had known that Dr Webb hadn't spoken to the parents and the parents would have needed somebody to speak to them, I think I would have tried to do my best to do that.

Q. And would it have occurred to you to try and find that

out before you left, because you know you're leaving, the parents are still there, you're actually going off duty, Dr Webb is going to be on call, but you're going off duty and you've been the senior paediatrician there all through the day, if I can put it that way, one way or another. Would you have tried to find out what the parents actually knew about their daughter's care or their daughter's condition, more to the point?

A. I may have done, but if I was aware that Dr Webb had spoken to mum and dad or to whichever parents were there, I may not have done that, deferring to his having done that.

Q. My premise was slightly different. If you had not received any information to the effect that the last examination had led to a discussion between Dr Webb and the parents, so whatever he might have said to them when he examined the child at 2 o'clock or whenever it was, but at 5 o'clock the last examination, if you were of the view that Dr Webb had, for various reasons not been able to speak to either of the parents then, do you think that it would have been incumbent upon you to have a discussion with the parents before you go off duty finally?

A. Yes, I think I would have needed to say something, but I probably would have wanted to get Dr Webb back again

to talk to the parents because -- particularly if I knew he wan on call that night and if I thought he hadn't yet spoken to the parents, I would actually want him to do it --

Q. I can quite see why you would.

A. -- and I would ask him to do that.

Q. If he's not available to do that, and there is any way of contacting Dr Steen so that she could divert, if you like, on the way home to the hospital -- as she said she sometimes did after the clinic ... I should ask you, did you know she did that sometimes?

A. I can't recall. I can't recall that that would have been a typical thing or something I would have expected her to do.

Q. If you thought you could have got hold of her and asked her to do that, in lieu of Dr Webb, would you have wanted her to do that?

A. Yes.

Q. Had you any sense of whether you had tried to reach her when you got back to the ward, which would have been 5-ish or so?

A. I don't recall whether I tried again at that stage to speak to Dr Webb -- or Dr Steen, rather.

Q. When you did get back to the ward, and at some point you're looking at Claire's notes in the intervening

period, you're not entirely sure when you would have done that, but presumably you would have done that at some point before you actually left the ward off duty.

A. I may not have done if I was able to speak to Dr Webb.

Q. I have understood you to have said that. I think you're not clear whether you actually did speak to Dr Webb at 5 o'clock.

A. But I think it is likely, if we were both there at the same time, that we wouldn't have spoken.

Q. If that had happened, would there have been a note in the notes to say "discussed with"?

A. Not necessarily, no. If Dr Webb has made the note from 5 o'clock.

Q. Well, when you got there at 5, would you be trying to see what investigations have actually been carried out over the afternoon?

A. I may make an enquiry of that sort. Again, I can only speculate or try and reconstruct that. I don't recall if I asked what investigations had been done, what line is Dr Webb pursuing. I don't recall if that was discussed.

Q. Would you have known there are no blood results associated with that time?

A. It depends really when the blood results come back.

Q. No, sorry, there's no blood results entered into her

medical notes associated with that time.

A. Yes.

Q. And so I think in your witness statement, 137/2, page 16, in answer to question (c), I think the answer there is:

"Although such blood investigations would have often been carried out by a senior house officer, I believe that as part of the medical team, I would have had some responsibility for checking that serum electrolyte testing had not been overlooked. The results of blood investigations often did not return to the ward until quite late in the day."

But would you at least have expected them before you went off duty? If that had been done in the normal time, would you have expected them back for 5 o'clock?

A. Not necessarily, no.

Q. Then if you didn't see them, would you not be trying to check that that had actually happened?

A. I think I would have been asking somebody to look out for the results to see if they were there.

Q. Is that something that you would have wanted to draw to at least the SHOs' attention because, if they're going off duty as well, they need to flag it up in their handover or you need to flag it up as you hand over to a registrar that this might be outstanding, this might

be something that should be chased up; would that be fair?

A. Yes, and although I don't remember what we did on this particular occasion, I've been in that situation before when we have waited for a result to come back, maybe between 5 and 6 pm, found it just wasn't there for whatever reason and found we were missing a result either because it hadn't been requested or overlooked or hadn't made it to the lab.

Q. But in this witness statement, you're assuming some responsibility for making sure that that is happening and if, for any reason it's not there, that something is done about it.

A. Yes.

Q. But you don't recall anything being done about that?

A. I think if I'd been aware that the result was missing or at least we hadn't a result up-to-date, I'd have asked a senior house officer, most probably, to look out for that result. That would involve the oncoming SHO looking out for it, perhaps, if it wasn't through in the lab results. And if it wasn't done, to try and make sure it was done as soon as possible.

Q. Was it your business to be aware?

A. I think as part of the ward staff, yes.

Q. Thank you. Can I pick up a point that the chairman had

asked you, which was who was responsible for the care. You, I think, said whether you spoke to Dr Webb or not, I think you would have assumed that if he had been seeing her that amount of times, that effectively he was managing her care; would that be right?

A. I think that's right. If I may, this has been a difficulty in the Children's Hospital, determining how care is shared between consultants, when care transfers from one consultant to another. I've been aware of this as part of the inquiry and, in looking at a serious adverse incident recently within the Children's Hospital, I flagged this up. Dr Steen made reference in her evidence that a circular has gone around now to try and clarify this issue about consultant responsibility and transfer of consultant responsibility because whilst it can work very well where two consultants share the care of a patient, it can also lead to ambiguity.

Q. Yes. We put together a schedule where we tried to summarise people's views on who they thought had the care. The reference is 310-005-002. That's where a summary of your own views starts, which is all gleaned from your witness statements. Part of what you say is that you thought that you were under the supervision of Dr Steen and that when Dr Webb saw and examined Claire, you thought yourself partly under the

supervision of Dr Webb also, and that following Dr Webb's first attendance, you understood that Claire was being jointly cared for by the medical and neurology team.

You didn't actually have any discussion with Dr Webb after his first attendance, so thinking that her care was being jointly managed in that way, is that something you deduced from the circumstances or something you gleaned from information given to you?

A. It may have been a combination of both, but I think it was largely based on the fact that Dr Webb seemed to have agreed that Claire's problems were neurological and had taken upon itself to see Claire on three occasions to manage Claire's condition and to prescribe her medication and to set out a treatment plan. So I think that's what I base that on.

Q. When you talk about a treatment plan and the fact that Dr Webb thought Claire's problems were neurological, which is something that you would glean from the medical notes and records, how would you know that other than if you read the medical notes and records?

A. Probably from nursing staff as well and from talking to the junior doctors as well as hopefully talking to Dr Webb as well, perhaps at the end of the day.

Q. If when you're coming back and looking at the management

plan or wanting to know what the management plan is and looking at what's happened in the intervening period, right at the outset of all of this, you had three things in your mind that as possibilities: the non-fitting status, which we've gone into, the encephalitis, and the encephalopathy. What did you understand, when you came back, had been the plan in relation to the encephalitis and the encephalopathy throughout that day?

A. Those issues I put down in the chart really as a cue for Dr Webb to reflect the discussion on the ward round, and the encephalopathy -- because I believe that was Dr Webb's word -- to acknowledge that he had mentioned that to me. And to then seek his direction as to where we go with those diagnoses or those possible diagnoses in terms of investigation, what lines to go down.

Q. So presumably you'd want to know that when you came back on to the ward?

A. Yes.

Q. Where did we go with that, if I can put it that way?

A. Yes.

Q. What did you understand the management plan was that had been instituted to address the encephalitis and the encephalopathy from -- it would have been 2 o'clock when he first saw Claire?

A. I think I would have appreciated the information that

Dr Webb thought that Claire's problems were primarily seizure-related and was treating her accordingly. Now, I acknowledge that in his note at 5 o'clock he does make reference to the possibility of meningoencephalitis, so he think that's unlikely, but he says we had better cover that anyway. I am not sure where it has been in his thinking prior to that.

Q. In terms of the actual medications, you're recorded, and we saw it on the prescription sheet, as having administered the sodium valproate. Is there any reason why you didn't, at the same time, for example, administer any of the other medications that Dr Webb had identified? For example, I think it's the acyclovir is identified by Dr Webb at that same consultation at 5 o'clock. But it seems not to have been written up to be administered until 21.30, 9.30. I presume you would have seen that when you were looking at what sodium valproate you had to administer.

Did you wonder why that was, if Dr Webb had come at 5 o'clock and said, "These things have to be administered", why it was that your SHO was prescribing that to be administered at 9.30?

A. I don't recall exactly what discussion took place around acyclovir at that time. I'm not sure whether Dr Webb did ask for a stat dose of acyclovir or whether he asks

for it to be written up as a routine prescription. I'm not sure. The cefotaxime, I think, is given at around 5.30, but that is in accordance with how it was prescribed on the drug kardex.

Q. Yes, but if one looks at 090-022-055, that's his plan. I think the drugs we're talking about are the first part of the plan. Is there anything there to indicate that that shouldn't happen soon thereafter 5 o'clock and that in fact should happen at 9.30?

A. There's nothing to indicate that.

Q. No.

A. It just says, as I read it, "Cover with cefotaxime and acyclovir for 48 hours". I think that's to allow time for any cultures to come back that might indicate whether you're along the right lines in terms of infection treatment.

Q. You're now there at roughly the same time as your SHO is there. And is it not your responsibility to make sure that the plan of the consultant neurologist is being put into effect properly and at least to ask him, "Why is that happening at 9.30?"

A. I can't easily explain that because I don't know what he specified as to when he'd like it to start. It may not have been immediately available. I think part of the problem is that it's written up the way it is rather

than as a once only, as a stat dose, and then as a regular prescription.

Q. Shouldn't you have found that out? This is a junior doctor, you are there to give them guidance as well as take responsibility for Claire's own care when you're the most senior person there. Shouldn't you have satisfied yourself that what this expert, who you wanted to bring in, has formulated as a plan is actually being properly implemented?

A. Yes. I can't really comment, except to say that perhaps the acyclovir wasn't there to be given at that stage. I just don't know. Claforan, or cefotaxime, would have been in the ward right there and then. I'm not sure whether acyclovir would have been. That is one possible reason why it wasn't. I can't think of a good reason otherwise.

Q. Let me put it a slightly different way. Is it not your responsibility to satisfy yourself that Dr Webb's plan is being properly implemented by the junior medical team?

THE CHAIRMAN: Just one moment. Mr Green?

MR GREEN: It may help if we remind ourselves of what Dr Webb says himself on this issue. It's at WS138/1, page 40. The top reads:

"I cannot recall who I spoke to about Claire's

future management at 5 pm, but I know I discussed further drug options and decided to administer intravenous sodium valproate as a further therapeutic option. I believe this discussion may have been with Dr Sands, but I cannot be certain."

I appreciate it's not determinative of the issue, but it's perhaps worth juxtaposing that piece of evidence with this part of the evidence that's being elicited from Dr Sands to assist the inquiry.

MS ANYADIKE-DANES: That's very kind. I think we will find it as well, but I think Dr Webb is specifically asked whether there was any explanation or reason for why there should be a delay in the administration of the medication to 9.30, and his view is that there wasn't any. I can give the reference for that. That is at page 41, the next page to that.

I think it's (c) that we want to look at:

"I recommended that Claire receive cefotaxime and acyclovir at 5 pm. I would have expected this to have been started within an hour or two."

Then he talks about how the non-convulsive status can arise or occur spontaneously.

So then he goes on. He says where his decision to start treatment is recorded:

"There was no delay in the administration of

cefotaxime to Claire and I do not know why there was a delay in administering the acyclovir."

THE CHAIRMAN: It's a bit unsatisfactory, isn't it? Because Dr Webb is saying, I would have expected them to have started within an hour or two, which is a bit -- seems to me to be a bit loose. One of them is started within half an hour, isn't it --

MS ANYADIKE-DANES: Yes.

THE CHAIRMAN: -- which is quicker than Dr Webb suggests, and there is a delay which is not readily explained in the acyclovir.

MS ANYADIKE-DANES: Yes. All that I was seeking to ask Dr Sands is whether, given that there is no indication on the medical notes and records that the acyclovir is to start as late as 9.30, whether it was not his responsibility to at least satisfy himself as to why it was starting as late as that and see whether that was in accordance with either Dr Webb's instructions or some other problem, like we just didn't have access to the medication. That's what I'm trying to find out, your responsibility.

A. I think I would have liked to have known that, when it was meant to be given, could it be given then, and if not, why not.

Q. I understand that you said that you would have liked to

have known it. Was it your responsibility to have found that out if you were there at that time as the most senior doctor?

A. I think it would have been partly my responsibility, yes.

Q. Thank you. Then I wonder if we might -- one question I've been asked is when you looked -- at whatever stage you did it -- at the drug sheet, which you would have to look at to sign off that you were giving the sodium valproate, whether you noticed any of the errors there in relation to the phenytoin and in relation to the midazolam.

A. The answer to that is no, and that sounds strange at this stage because when you look at it in detail and look at it now, it does look quite obvious, but the answer is no.

Q. Do you think you should have?

A. Perhaps.

Q. Thank you. Then can I ask you about the handover and shift and then it will take you slightly out of order, and I apologise for that, but there are some other matters that people wanted me specifically to raise with you. I'm going to move now to the handover of the shift and then go on to those matters.

Sorry, I think I had asked you this, but

if I haven't asked you that: the blood samples at 5 o'clock, I think I had asked you whether it was your responsibility to chase those, see what had happened about them if you didn't already have the results.

THE CHAIRMAN: He said yes. Dr Sands accepted he had some responsibility for checking that these had been done.

MS ANYADIKE-DANES: I thought that had been the case, but I wanted to make sure. Thank you.

Now the handover. When you had been answering questions earlier, you said that the handover at the end of the day was perhaps more important than the handover at the beginning of the day; is that correct?

A. That's right.

Q. Is it something, however informally it was done, that typically did happen?

A. Yes.

Q. Can you remember if you actually did effect a handover on the 22nd?

A. I don't remember the details of the handover on this occasion. I don't remember that.

THE CHAIRMAN: Do you remember the fact of a handover as opposed to the details?

A. I don't have a recollection of the handover.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: But doing the best you can, do you think

it's something that you would have wished to do?
A. Yes. I think that would have been very much my practice.
Q. And that is a handover to Dr Bartholome?
A. Yes. Probably not just Dr Bartholome. I probably would have tried to involve the SHOs as well. It may have been done separately, so one may have talked to Dr Stewart, who was going to be on from 10, as I now understand, but had been there throughout the day. Dr Hughes, who was coming on, I believe, at 5. So she would have needed to be part of a handover. And Dr Bartholome. I have also said in my witness statement that I would have probably tried to find out if there was neurology -- if the junior neurology staff had anything they particularly wanted to add. I understand now from the additional information that, in fact, the registrar was on leave, Dr Jyothi(?), Asha Jyothi, was on call that night. I think she was covering paediatric ICU and children's Clarke Clinic, the cardiology ward. She may have been involved in some discussion about what was to happen with Claire.
Q. Can I ask actually how handovers work? Do all the new incoming team congregate somewhere and have a meeting and then disperse to their various stations? How does it work in practice?

A. They do now and it's much better. It's formalised now. There's a printed-out list of all of the patients and they go through them one by one with individual issues so there's time set aside to do that. In 1996, to the best of my knowledge that didn't happen, it was a much more informal affair, it was a case of: if I had access to the SHOs, I would talk to them there in Allen Ward, but I may have had to find Dr Hughes in Musgrave Ward, although she may have been able to come down to Allen Ward. I am very likely to have had to go and find Dr Bartholome to give her advice about Claire, or indeed other patients as well as Claire.

Q. So you're basically trying to seek each other out, if I can put it that way?

A. Yes.

THE CHAIRMAN: How many wards is Dr Bartholome taking over for the evening?

A. I think it's about 12 altogether.

THE CHAIRMAN: Tracking her down for a handover could literally take an hour-and-a-half or two hours?

A. I would have had a pager, so I would have been able to find her.

THE CHAIRMAN: Right. And join the queue?

A. Yes, but I wouldn't necessarily have expected her to come to me. I may very well have had to go to her.

THE CHAIRMAN: When you said it was very much your practice to do a handover, would that be for children who you were as concerned about as you were about Claire rather than the whole of Allen Ward?

A. Yes, not everybody. Not everybody, it would have been restricted, I think, to those where you had a particular concern or there was something still outstanding.

THE CHAIRMAN: Okay. Let's suppose for the sake of argument that you found Dr Hughes, but Dr Bartholome's also up to her neck with another child or Dr Stewart, I think, is coming --

MS ANYADIKE-DANES: Later on.

THE CHAIRMAN: He was coming later on. If you were able to do a handover, say to Dr Hughes, would you necessarily wait to repeat that with Dr Bartholome?

A. I think I would have still have wanted to get some word to her.

THE CHAIRMAN: You might have to go through Dr Hughes?

A. Possibly, but I think it more likely that I would at least get her on the telephone if she was really tied up. I suppose you could conceive of a situation where, if she was extremely busy and unable to even take a telephone call, you might have to ask somebody to relay information to her.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: I think Dr Hughes was on call from 5 o'clock in the afternoon until 10, and then Dr Stewart took over from 10 o'clock and thereafter.

A. Yes.

Q. I think Dr Webb is literally on call from 5 o'clock together with Dr Bartholome throughout the night.

A. That's right, and I think then, as I understand it, then the -- who I had originally called a specialties SHO. It seems that the specialty SHO was more confined than that. It was paediatric ICU plus children's Clarke Clinic, the cardiology SHO. So not covering neurology and children's haematology as they do now.

Q. Given that this is, in 1996, a far less formal business than it is now in the sense that you don't all congregate in one place and exchange information, if I can put it that way, and you're going to have to go and find people, does that mean that who you are really looking for is somebody that you can impart information to about the patients that you are really quite worried about or something that they need to be particularly alive to during the evening?

A. Yes, I think that's right. It wouldn't be a full list of all the patients, I don't think.

Q. If it's that, one or the other, somebody that you're really worried about or somebody who maybe had

outstanding results and you would just want to prompt them that they should be looking for those, on either basis, is Claire in that category of somebody you would have wanted to --

THE CHAIRMAN: He said he would not do a handover for everybody on Allen Ward, but he would certainly have wanted to do one for Claire due to his concerns about her condition.

MS ANYADIKE-DANES: And if you had a preference, who would you have wanted to effect that handover with?

A. Dr Bartholome.

Q. I know that you can't actually remember doing it, but what would you have been wanting to tell Dr Bartholome at that stage?

A. Again, I would like to have given her some of the happenings earlier in the day, a bit about Claire's background, the fact that Dr Webb had been there and had been involved and what the possible diagnosis was, what had been done for Claire, what medications she had had.

Q. And would you have wanted to give Dr Bartholome an indication of how unwell you regarded Claire to be at that stage?

A. Yes.

Q. Would that have been any advance on "neurologically very unwell"?

A. It may not have been. Again, I'm having to sort of try and piece that together. But I would have given her my honest appraisal of what I thought of Claire, particularly as I was leaving, and that was that she was still very unwell neurologically.

Q. Then in relation to the other children on the ward whose care you have had during the day, where would you place Claire?

A. I would have said at the top of the list in terms of children who were unwell. That's to the best of my knowledge, having looked at Claire's chart and looked at some of the other patients -- bits of the other patients' charts that we've seen.

Q. Given that your actual description of her hasn't changed from when you first formed it after your ward round, so far as you're concerned, was Claire actually the sickest child on the ward throughout the day?

A. Again, looking back and having seen now the notes -- well, I suppose that's unfair because I haven't seen all the notes from all the patients on the ward. That's my impression.

Q. Throughout the day, she would have been the number one concern out of all those children on the ward?

A. That's my impression from what I've been able to see in terms of notes and so forth.

Q. I believe Dr Bartholome's evidence yesterday was that Claire was the sickest child on the ward so far as she was concerned, and would that fit with your view?
A. Yes.
THE CHAIRMAN: In fact, it actually doesn't matter whether she's number one or number two on this unhappy list. She is very unwell and needs to be particularly looked after during the course of the evening.
A. Yes.
MS ANYADIKE-DANES: Yes, I didn't mean to put it in a ranking way.
A. No, of course.
Q. If you are dealing with the sickest child on the ward, maybe it's the child to whom you have to pay special attention to?
A. Yes.
Q. If I might now pick up some points that others wish --
MR QUINN: Mr Chairman, I have marked it in the transcript -- Dr Steen said on the 16th, I think it was, that when she phoned the ward at teatime, she was ...
THE CHAIRMAN: Sorry, if she phoned the ward at teatime. There's a lot of supposition on Tuesday's evidence. She has no recollection of this. She was saying she would have expected that she would have phoned the ward.
MR QUINN: It's day 45, page 19, line 8:

"I said yesterday I can't remember what was said on the telephone call when I phoned the ward, when I phoned the ward around teatime. Whatever was said, I was reassured."

THE CHAIRMAN: I think this witness has said, first of all, there's a fundamental starting point about whether a phone call was made either way to start with. And the second issue is, if she was accurately advised about Claire's condition, she could not have been reassured.

MR QUINN: Yes, that's just what I want to make sure is on the record. And what I want to ask, through you, is: is there any way she could be reassured after what this evidence has been?

THE CHAIRMAN: I thought Dr Sands had said a few moments ago that there wasn't any way -- I think this is repetition, but let's repeat this. Let's double-check it.

If it is correct that either Dr Steen was rung at Cupar Street or that she rang from Cupar Street and asked about Claire's condition, could it have been in your view that she could have been reassured that ... What was the wording?

MR QUINN: "I was reassured" in the context that she wasn't coming back to the ward.

THE CHAIRMAN: Claire was not so unwell that it wasn't necessary for Dr Steen to come back.

MR QUINN: Yes, that's correct.
THE CHAIRMAN: I think you have said you have difficulty understanding how any such reassurance could have been given.
A. I do, sir, unless Dr Steen -- and this is all hypothetical -- believes that Dr Webb has taken everything on board and is fully in control and is content with the situation. That's the only way I could construe that Dr Steen might feel somewhat reassured, but not completely.
THE CHAIRMAN: Even if we step aside from the argument about who's in control, Dr Webb wasn't content with the situation as I understand it. At the very least, from his 5 o'clock examination.
A. Yes.
THE CHAIRMAN: Thank you.
MS ANYADIKE-DANES: The fact that you considered her so early in your examination of her, if I can put it that way, to be neurologically very unwell, and that remained with you as far as you were concerned, and that you considered her to be that serious by comparison with the other children on the ward, is any of that reflected in the notes or instructions for the nurses?
A. I would need to go through all the notes and instructions for the nurses, I suppose, to --

Q. Are you aware of having that recorded for the benefit of the nurses so that when they change shift, they would appreciate that this is the condition of the child whose condition they are monitoring?
A. I'm not sure to what extent the nurses fully understood the severity of Claire's condition. I can't be certain of that.
Q. But should they have or should they have been helped to understand that?
A. Yes, I take the point and I think the medical staff should all have been feeding into that and making -- well, trying to make sure that the nursing staff were aware that this was an unwell child, if they didn't know already. Perhaps they did.
Q. Apart from the nursing staff, should the junior staff have had impressed upon them how serious Claire's condition was? Because I think Dr Stevenson didn't have a full appreciation of how unwell Claire was. He was doing what he was being asked to do in terms of adhering to Dr Webb's prescriptions and so on, but I think his evidence was that he really didn't understand how unwell she was.
A. That may be so, perhaps he didn't and perhaps the SHOs both didn't have a full appreciation. And maybe none of us because we didn't understand exactly what was going

on, didn't really understand quite how sick Claire was, even though we thought -- and I have always said that I felt she was neurologically very unwell. I still may not have understood and wouldn't have understood what was around the corner for Claire.

Q. I understand that. You may not have understood the full depths of it, you may not have understood all the things that were causing that and what its likely progression might be. But you at least had formed the view that she was neurologically very unwell and you continued in that view. All I'm asking you is that, given that you formed that view as early as her ward round, did it not fall to you at that stage, the most senior clinician there, to ensure that the nursing staff and the junior staff, the SHOs, knew that? They might not have understood the ins and outs of how she came to be that way, but that was her condition. Did it not fall to you to make sure they understood that?

A. That's before Dr Webb's visit?

Q. Yes.

A. I think again I would have expressed my concerns to the nursing staff and told them I thought that Claire was very neurologically unwell and said we needed a neurologist to see Claire because I'm not sure what's going on here. I suspect this maybe, but I don't know.

Q. The problem, frankly put, from the nurses' point of view -- and one can't speak for Dr Stewart, he hasn't given his evidence yet -- their impression is that they just didn't realise that Claire was as ill as that. Now, for Dr Stevenson and the nurses, they are the touch point or the contact point with the parents. So if they don't fully understand it, absent yourself or Dr Webb coming and specifically discussing it with the parents, then it's difficult to see how the parents will be accurately informed about the condition of their child. Would you accept that?

A. I think there may have been that gap in understanding.

Q. And is that not a gap that you should have ensured didn't open up?

A. I think I should have been part of that communication to ensure that that gap didn't open up.

THE CHAIRMAN: In conjunction with Dr Webb, surely?

MS ANYADIKE-DANES: Yes. I'm only dealing at this stage with what you would consider your responsibility to be. You're not the only clinician there, we're aware of that.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: I am putting to you issues that people have. If we stay with the nurses, when you formed that view of encephalitis/encephalopathy, albeit contributed

to by your discussion with Dr Webb, did you think that that ought to be recorded in the notes for the nurses anywhere? You have recorded it here in her medical notes and records, but should that have fed through to the nurses for any kind of effect that should have had on their care of Claire?

A. Again, those were only possible differential diagnoses. I'm not sure that the nurses would have necessarily adopted those in the nursing notes at that stage.

Q. I understand. And then, in relation to your views at 5 o'clock as to Claire's condition, do you think that even if you had not done it before, that at that stage you should have made sure that the nursing staff understood that your view was that she was neurologically very unwell and had been all day?

A. I'm not sure what discussion took place between me and the nursing staff at that stage. It may have been relatively limited, it may have been dependent again on what Dr Webb had said to the nursing staff as well. I'm not sure that I fully -- that I asked them if they understood her to be a child who was neurologically very unwell.

Q. What discussion do you think you should have had with the nursing staff at that time before you went off duty?

A. As one of the clinicians there, I think I should have

been part of a discussion with the nursing staff to say that this is a girl we are concerned about for these reasons.

Q. And one of the reasons I'm being asked to put that to you is that when Claire's parents are thinking of leaving the hospital, it's the nursing station they go to to say they're going to do that and to try and get a sense of their child's condition. So this is the significance of the question to you. If they have not had impressed upon them what Claire's condition is, it'd be very difficult for them to pass that on to the parents who could make a decision as to what they wanted to do about leaving for that evening; would you accept that?

A. Yes.

Q. And you would appreciate that the most readily available person, perhaps during the evening, for the parents would be the nurses?

A. Yes.

Q. So if they were going to want to find out about their child's condition and should they stay the night, should they be making arrangements and so on, it's really the nurses they're probably likely to look to in a busy ward in the evening?

A. I think that's correct.

Q. Then can I ask you about a statement that you made at the inquest? It comes in the answer session. There's a formal bit which is typed up and then there's a bit in manuscript. 091-009-059. It's almost exactly halfway down:

"But I cannot be more exact. I probably examined her late morning, but I cannot be more exact. What I saw was outside my experience and then I contacted Dr Webb."

Did you really regard Claire's presentation almost throughout the day or at least whenever you were engaging with her, if I can put it that way, as being something that was just outside your knowledge, outside your experience?

A. Yes, and by that I mean it's not something I could countenance managing myself. It's not something that I had experience of, so therefore it was outside of experience that I'd had prior to this. That's what I mean by "outside my experience".

Q. And absent the comfort of knowing that Dr Webb has agreed to become on board and will see her, would you have felt out of your depth? I don't mean that in a pejorative way at all, but given your level of experience and seniority at the time?

A. To some extent, yes. And by myself?

Q. Yes.
A. But again, I wasn't insofar as Dr Webb was there.
Q. Yes. When you take comfort from the fact that you had brought Dr Webb in, who's prepared to come and give an opinion and give guidance on her treatment, did you think at the time that actually he was going to look at Claire in the round, so not just to come and give a discrete opinion, or are we talking about non-fitting status or are we talking about encephalopathy and so forth, and he was going to regard her in the round and address her management in that way?
A. I think I considered Claire's problems to be neurological and so I felt that Dr Webb was the person to take that fully on board and manage that neurological problem. As I said earlier, it may be that Dr Webb actually, as well as being a paediatric neurologist, is duly accredited as a paediatrician -- I don't know that for sure -- but I would have felt him capable as well of taking on board Claire's care in the round, if necessary.
Q. Then let me ask you in this way. If that's the case, if there were issues to do with her fluid regime, as to whether that was the appropriate fluid regime or whether it should be reviewed and so forth, this is during the afternoon when he's coming to see her, is that something

that you would have thought was also within the spectrum of the care that you believed that he was going to be providing to Claire?

A. Yes, but equally I think the paediatric medical team could have altered fluids too. I don't think one clinician could or couldn't or should or shouldn't have.

Q. And if it was the paediatric medical team that was going to do that, does that mean, because it's not entirely clear where you were in the afternoon, effectively Dr Stevenson?

A. Yes, if necessary, yes.

Q. And did you regard Dr Stevenson at that time in his career, if I can put it that way, given what people were beginning to regard as actually a very complex situation with Claire -- did you regard him as sufficiently experienced to be able to embark on managing her fluid regime and even think about perhaps altering it?

A. I don't know if I thought about that at the time. I would have expected Dr Stevenson to call, perhaps call me for advice about that, if he was contemplating a change, to run it by me.

Q. Would he even have had enough experience to know about contemplating a change?

A. I'm not sure. He had done some adult medicine. I know it was very early in his paediatric experience. He had

done some time as a medical SHO and would have prescribed fluids, not for children, but -- I'm not sure how I would have considered his ability or otherwise at that stage.

Q. If you thought he was capable of -- or at least the paediatric side also had some responsibility for the fluid management element, and if he was capable of doing that in the circumstances of her presentation, should you not have turned your mind to it, either at 11-ish or even at 5 o'clock, when you came back, and would have realised that her fluid regime had remained the same all afternoon?

A. Yes. With hindsight, yes, looking back, yes. I think it would have been entirely appropriate, but that's looking back 16 years. At the time, I think it would have needed an instruction from somebody who had a better idea of what was going on, or another U&E result, perhaps showing that the sodium was falling, which might have then prompted a change in fluids.

Q. The reason I pressed you on that is because when I was suggesting to you that maybe the fluids might have been something you thought were all part and parcel of what Dr Webb was responsible for, you said, "Well, yes, but also the paediatric team had some responsibility for that". And I was really just trying to tease that out

because the paediatric team -- until you get back at 5 o'clock, or it would appear that you weren't there until you arrive at 5 -- is really Dr Stewart and Dr Stevenson, and Dr Stewart has even less experience than Dr Stevenson.

And if you're thinking -- when I asked you, "Well, couldn't you have done that at 5 o'clock", that's something that you might have needed some instructions from somewhere else, how is the paediatric team going to independently address the issue of a review of Claire's fluids if even you're not entirely comfortable doing it at 5 o'clock?

A. I think that's fair. What I would suggest is that if there had been a U&E result available, I think it would have prompted an SHO to think about changing fluids, perhaps after a discussion with myself or Dr Webb, or Dr Steen even. In the absence of that, somebody would have needed to have known what was potentially happening to Claire in order to do that.

Q. And might that be a reason why, if you didn't see that there was a serum sodium result at that stage, you might have asked for one to be urgently sought?

A. Yes.

Q. And that would be something that would be added to Claire's plan to be -- if your current team weren't able

to do it before they went on duty, something to be referred to the incoming team to know that that's something that ought to be done?

A. Handed over, yes.

Q. Yes. Did you ever have yourself a definite diagnosis of Claire's condition?

A. In 1996?

Q. Yes.

A. Or before her death?

Q. Well, before her death, yes.

A. I don't think I did have a definite diagnosis, except to say I would have believed Dr Webb's impression that she did in fact have ongoing seizure activity because he was the consultant neurologist and that seems to be his feeling.

Q. Yes.

A. And I don't believe I heard anything that pushed me away from that.

Q. But in all the time that you had contact, if I can put it that way, between the clinician, the other clinicians and the nurses, did you ever feel that anybody had arrived at a definite diagnosis of Claire's condition as opposed to a number of working possibilities, if I can put it that way?

A. Not a very firm diagnosis, no.

Q. Just finally on this -- and if you can't answer this, please say. Were you surprised that Claire didn't have an inquest when you learned she had died?
A. I don't recall whether I was surprised or not. I can't honestly answer that. I think as a registrar then, I would have gone with, believed, left it, to the consultants who were there at Claire's death to decide whether or not Claire's death was referred to the coroner. I'm quite sure I would have done that.
THE CHAIRMAN: And with the benefit of hindsight?
A. I think it should have been referred to the coroner.
MS ANYADIKE-DANES: Thank you. I think there's just one final question, maybe two, that I've been asked to put to you. Forgive me if you have answered this question, but sometimes people don't always catch the answer that they're looking for and they just want the question put again in case. Forgive me if I have put it to you before. When you spoke to Dr Steen, did you describe her condition in the way that you have described it today to the chairman, "neurologically very unwell"?
A. I don't remember what words I used. I can't remember what words I used to Dr Steen on the telephone.
Q. If that was your view of her condition, is there any reason why you wouldn't have described it to her like that?

A. I think I would have used similar terminology. I can't be more exact.

THE CHAIRMAN: And I think that when you were talking about this earlier on, you said that the phrase "neurologically very unwell" is a phrase which you would use.

A. Yes.

THE CHAIRMAN: You're not recalling specifically using it to Dr Steen, but it is a phrase which would have come from your lips from time to time?

A. Yes.

MS ANYADIKE-DANES: There is just one final question. I wonder if we could pull up 091-011-067, the last four lines. I should say that this is the statement of Dr Steen's at the inquest:

"My recollection is that when I contacted the ward and told Dr Webb had seen her and had taken over her management ..."

That's the bit that you're being asked. Is that how you would have described it at the time?

A. Not unless I was sure that Dr Webb had in fact said that or written it.

Q. And was it your impression that that is what had happened at the time?

A. I think he was the consultant who was primarily guiding

treatment, prescribing treatment, had attended Claire.

Q. Yes.

A. And arguably de facto was the consultant who was leading Claire's care. But I wouldn't have said Dr Webb was -- that he had taken over her care unless I had been told that.

Q. Yes. And if that had happened, quite apart from being told it, would you have expected that to be recorded somewhere?

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

As I say, I brought this up at the op group meeting within the Children's Hospital in June, and it is minuted. I brought this up in relation to a serious adverse incident, that this is something that needs clarified, particularly for junior staff, for nursing

staff and for consultants, that people know where they stand and that there's a clear idea of who's doing what.

Q. Thank you, doctor. I think it's that word "management", that was causing you to take some issue. Whatever Dr Webb's involvement in Claire's care or guidance or provision of opinions, it was that word "management" I think that you thought didn't quite capture what his role was. Would that be fair?

A. Well, "management" to me means that you're actively doing something, you're managing it, you're ...

THE CHAIRMAN: You're in charge?

A. To some degree.

MS ANYADIKE-DANES: And you didn't think that's what reflected Dr Webb's role at that time?

A. I think he was managing her care. In practical terms, he was managing her care. Dr Steen wasn't.

Q. Yes, but not taking over her management?

A. You see, again, I think that's very difficult.

THE CHAIRMAN: Is this the area of ambiguity you are talking about?

A. It's exactly it.

THE CHAIRMAN: Okay. When you had spoken to Dr Webb in the morning, you'd asked him to become involved and to look at Claire and you were glad that he was becoming involved?

A. Absolutely.

THE CHAIRMAN: Your next possible involvement with Dr Webb was at about 5 o'clock because we know you were on the scene soon afterwards. You can't quite recall seeing him. So if Dr Steen was told, if she made the phone call, that Dr Webb had seen her, that would be accurate. The question then is about the difficult phrase that he had taken over her management. If that is done, is that done consultant to consultant?

A. Yes.

THE CHAIRMAN: Have you known it to be done registrar to consultant, with a registrar handing over management on behalf of -- in this case, in other words, would you hand over on behalf of Dr Steen management of Claire to Dr Webb?

A. No.

MS ANYADIKE-DANES: At the time you think you spoke to Dr Steen, which is sort of in the early part of the afternoon and before Dr Webb had actually been there, just so that we're clear, although you had asked Dr Webb to come and see Claire and he had agreed that he would do that --

A. Yes.

Q. -- nothing had happened at that stage, had it, to suggest the extent to which he would become involved in

her care?
A. No.
Q. So if you were speaking to Dr Steen at that stage about matters, you could not have been conveying to her any suggestion that he was taking over the management of her care irrespective of whether --
A. I think I'd have just given a description of what Dr Webb had agreed to do, rather than make any assumption about him taking over her care.
Q. Yes. So if she had got that impression from someone, she wasn't getting it from you?
A. I don't believe so.
MS ANYADIKE-DANES: Thank you very much. I think that's it.
THE CHAIRMAN: Any questions? No? Mr McMillan?
MR McMILLAN: No, Mr Chairman.
THE CHAIRMAN: Dr Sands, thank you very much. Before you leave the witness box, is there anything you want to say?
A. I was wondering, Mr Chairman, if I may just say a word to Mr and Mrs Roberts, with their permission as well. I just wanted to say that I can't know what it has been like for you these 16 years. I need to say that I can't practice medicine without sharing a portion of the sorrow that occurs when a patient dies, and particularly when that's a child. And all I can offer to you is that

sorrow and my sincere sympathy. But, as I say, I can't fully understand or appreciate how difficult these 16 years have been.

THE CHAIRMAN: Thank you very much indeed. You are free to go, Dr Sands, thank you.

Ladies and gentlemen, that brings an end to a very long week. We will not be sitting next week, as you know, and we will resume on Monday week at 10.00.

(5.05 pm)

(The hearing adjourned until 10.00 am on Monday 29 October)

I N D E X