1 Tuesday, 16 October 2012

2 (10.00 am)

3 (Delay in proceedings)

4 (10.22 am)

5 DR HEATHER STEEN (continued)

6 Questions from MS ANYADIKE-DANES (continued)

7 MS ANYADIKE-DANES: Good morning, Dr Steen. We were about
8 to, at least in some way, start to look at what is
9 called file 150, which relates to the medical notes and
10 records of other patients -- in large part your
11 patients -- who were all on the ward for one reason or
12 another on Tuesday, 22 October 1996.
13 But before I start to go through that in a more
14 systematic way, since you have, to some extent, relied
15 on some of those reports to demonstrate your belief that
16 although you have no recollection of what happened on
17 the 22nd, you believe that you were in and about the
18 ward on that Tuesday morning. Before I do that, I've
19 been asked to cover some other points which you did
20 address to a certain extent, but maybe not as fully as
21 some might like.
22 It really relates to your expectations from your
23 junior doctors. Although this is not something that you
24 were prepared to assist with previously, you did provide
25 a witness statement, which is 143/4, which to some

1 extent sought to provide us with information as to your
2 expectations of them. And it's that area that I would
3 just like to finalise before we go into what is
4 effectively trying to establish where you were and what
5 you were doing on the morning of the 22nd.
6 The first question that I would like to ask you
7 is: that paediatric team comprises registrars, and while
8 you were on call, Dr O'Hare was a registrar.
9 A. That's correct.
10 Q. While you were actually on duty, Dr Sands was
11 a registrar. In relation to the SHOs, there was
12 Dr Volprecht. She was an SHO. There was Dr Stewart,
13 Dr Stevenson, whose evidence in part we've already
14 heard; they were all SHOs.
15 A. Yes.
16 Q. And in terms of there on the ward on the 22nd, that
17 really appears to be, so far as we're aware -- you
18 correct us if we're wrong -- Dr Sands as a registrar,
19 Dr Stevenson and Dr Stewart.
20 A. That's correct.
21 Q. We have heard something from Dr Stevenson as to his
22 experience at that stage. It may be that Dr Stewart's
23 experience was even less, his CV is available, and
24 Dr Sands in due course will give evidence as to his
25 level of experience as at that time.

1 But what I would like to ask you to comment on is --
2 if we can split it in two things, one when you're on
3 call, which essentially for our purposes is over the
4 evening of the Monday and when you're on duty -- what's
5 the type of event that you would expect should prompt
6 a junior doctor to contact you?
7 MR FORTUNE: Do you mean a registrar?
8 MS ANYADIKE-DANES: Let's start with the registrar.
9 A. I would be expected to be informed about any child
10 protection issue that had been admitted. That is
11 consultant led, there's no discussion. Any child who
12 had not responded to initial basic resuscitation of
13 fluid bolus and antibiotics, whose condition had
14 continued to deteriorate. Any child who was in the ward
15 --
16 THE CHAIRMAN: Doctor, just a wee bit slower please.
17 Thank you.
18 A. Any child who was, having got through the emergency
19 department and into the ward, whose observations were
20 deteriorating, where they were not expected to
21 deteriorate, who was not responding to medication, who
22 may have required transfer through to paediatric
23 intensive care unit. So basically, I would have
24 expected to be contacted about any patient who was not
25 improving as planned or who really was very sick and was

1 not settling.
2 MS ANYADIKE-DANES: Okay. So that's your registrar.
3 A. Yes. And it's quite difficult because there's lots of
4 different scenarios. If you come in with a wheezy
5 chest, you may get worse before you get better, but
6 there's a treatment plan and providing you get no worse
7 than a certain degree and you turn a corner, that's
8 okay. But when you get to a certain degree of the
9 treatment plan and you just keep going downhill, then
10 the consultant needs to be informed.
11 Q. And if you're on call, in what circumstances would you
12 expect an SHO to contact you?
13 A. The SHO quite often contacted when the registrar was
14 busy. The registrar looked after the entire hospital.
15 I'm not sure if there was 120 or 125 beds. So there
16 would have been -- quite often, the registrar would have
17 been caught up with children elsewhere and at that stage
18 the SHO would contact us. At night it would be
19 delegated for the SHO to telephone.
20 Q. Yesterday, you explained how people would know how to
21 contact you, but how would they know what your
22 expectations were of them?
23 A. The expectations would have been the expectations that
24 would have been there throughout. When they come to the
25 Children's ... Certainly my practice is always to be --

1 you'll get in more trouble for not phoning us than
2 phoning us and that we do want to hear, we do want to be
3 in contact. If the nurses are raising concerns with
4 you, then think about it, because the nurses know the
5 patients well and know the consultants well. So
6 throughout their training from when they started right
7 in as a houseman right through, it would have been clear
8 that they had to work within their level of
9 competencies, that if they had concerns that things were
10 not moving forward or someone else raised concerns, such
11 as the nurses, then they should approach the
12 consultants.
13 Q. Just so that we're clear: is this part of their general
14 training or is it something that you as the consultant
15 feel it's an obligation for you to reiterate or make
16 clear to them?
17 A. I think within paediatrics we would have emphasised it
18 even more. We do a consultant led service, which means
19 we're not really on the ground very much, we're
20 frequently doing other things, we're not actually in the
21 wards very much. So we -- and the juniors when they
22 come in have experienced a lot of adult medicine in
23 their training, but not a lot of paediatrics. And
24 children get sick quite quickly and they get better
25 quite quickly, but they get sick quite quickly, so

1 within paediatrics we would emphasise that if there's
2 any concerns, give us a call.
3 Q. Yes. I mean, you've referred to that, using the pronoun
4 "we", and so forth. If we're a little more specific
5 about that, let's, for example, since we're talking
6 about SHOs, and it is Dr Volprecht who is an SHO and who
7 happens to be on duty on the evening of the 21st. How
8 does Dr Volprecht know that in certain circumstances if
9 she can't reach Dr O'Hare because Dr O'Hare is in
10 another part of the Children's Hospital dealing with
11 another patient, how does she know the circumstances in
12 which she's expected by you to pick up the phone and
13 contact you?
14 A. As part of her training and her role as SHO she should
15 have been aware that this is a situation I can't deal
16 with, I need to contact someone. The registrar is busy,
17 I will phone the consultant.
18 Q. Does that mean you would have imparted that information
19 to Dr Volprecht at some stage?
20 A. I cannot remember exactly who I impart that to, but it
21 has always been part of my way of working with the
22 junior staff, from the minute they enter the Children's
23 Hospital.
24 Q. So whether or not you can specifically recall imparting
25 that to Dr Volprecht, for example, at some stage during

1 their rotation in paediatrics you would have imparted
2 that to each of those SHOs because that's part of your
3 practice; is that what you're saying?
4 A. Yes, and in those days it was much easier because you
5 had a very concise team. Now with shifts, et cetera,
6 sometimes --
7 Q. We're really only talking about those days at the
8 moment.
9 THE CHAIRMAN: Is that what you were taught as an SHO and
10 a registrar?
11 A. Yes. In the Children's Hospital, the consultants have
12 always been very approachable. Perhaps some people see
13 it as a relaxed atmosphere, it's not. Everyone is just
14 very much around. If there's any question about
15 anything, you can phone somebody, it's not a problem.
16 And as I say, you're more likely to get told off if you
17 don't phone than if you phone.
18 THE CHAIRMAN: But you learned this when you were an SHO and
19 then a registrar? You learned that from the consultants
20 you worked under and then you continued that?
21 A. Yes, the consults I worked under were always very
22 approachable.
23 MS ANYADIKE-DANES: You made the point just a little while
24 ago that children can get very sick very quickly and
25 they can also get better very quickly. That means they

1 can also deteriorate quite quickly and presumably that
2 might be in a span of time when, as it happens, the only
3 doctor about is an SHO. That may happen right at the
4 beginning of their rotation. When Dr Stewart was on
5 duty, for example, I think he had been an SHO for three
6 months. We'll be able to check from the CV, but
7 I believe that's the case.
8 In any event, does it make any difference to you
9 that some of these SHOs that you're dealing with could
10 be actually very new into paediatrics? Is any special
11 care given to make sure you're not on your own, if you
12 feel at all concerned get in touch with me, these are
13 the sorts of things that might happen, that could
14 require you to act fairly speedily? Is there any
15 exchange like that going on?
16 A. There's a formal induction now. I'm not sure what was
17 happening in 1996 around formal induction or ward
18 induction. There would have been what we imparted to
19 the juniors. They had already been housemen -- it was
20 "housemen" in those days -- so they would have been well
21 aware that once they got to a stage that they were
22 having concerns, they needed to pass it up the line.
23 Q. Okay. If we come now to the actual events. In your
24 witness statement at 143/4, page 3, you say that you
25 didn't expect Dr O'Hare to contact you when Claire was

1 admitted.

2 A. No, when I reviewed the notes -- and this is from

3 reviewing the notes -- Claire's condition had originally

4 given some concerns, but she was reassessed and it was

5 felt that she had settled. And therefore Dr O'Hare felt

6 confident and I don't see any reason why she would have

7 phoned me.

8 Q. And when Dr Volprecht is making her note, you wouldn't

9 have seen any reason why she should have contacted you

10 either?

11 A. No.

12 Q. Leaving aside what we're going to come to deal with,

13 which is where you actually might have been on the

14 morning of the 22nd, assuming that there was a perfectly

15 good reason why Dr Sands was doing that ward round and

16 it was acceptable to you that he was doing the ward

17 round, do you think that Dr O'Hare should have contacted

18 you in relation to that ward round?

19 A. Dr O'Hare would normally --

20 Q. Sorry, Dr Sands.

21 A. Dr Sands should have let me know if there were any

22 patients that were giving him concerns that needed to be

23 discussed with myself.

24 Q. Let's think about Claire. So we now know the note that

25 he wrote about Claire. So assuming that that is the

1 ward round, that's the situation, that's her
2 presentation on examination, those are his concerns.
3 Would you have expected Dr Sands to have contacted you?
4 A. Yes, I would have expected him to contact me.
5 Q. When and why?
6 A. I would have expected him to contact me some time in the
7 following 20 minutes, 30 minutes, because what he had
8 was a child who was getting more ill. He had given an
9 assessment, he had started a medication, and he had
10 sought a sub-specialist opinion. He had gone looking
11 for neurology. So if you need to prioritise what
12 Dr Sands can do, he was looking after the patient first
13 and then I would have expected him to ensure that I was
14 kept me informed about what was happening next.
15 Q. Well, would you have expected to know that he was even
16 going and looking for a neurological opinion, that that
17 was the level of his concern?
18 A. I would have expected to be told, but it would depend on
19 how ill the child was, what order that was in. The
20 first priority was to get the child sorted, the second
21 one was to make sure that I was kept aware of what was
22 happening.
23 Q. Would you have expected to be told that he had at some
24 point in time -- it's not clear when, we'll explore that
25 further -- that in addition to status epilepticus there

1 could be encephalitis/encephalopathy as working or
2 differential diagnoses? Would you have expected to have
3 been told that?
4 A. Yes, I would have expected when he contacted me that he
5 would have updated me on Claire's condition, what the
6 possibilities were and what was happening with her.
7 Q. And if you learnt that those two were potential
8 diagnosis for Claire at that stage, would you have
9 expected to have discussed what was to happen about that
10 in terms of a treatment plan?
11 A. I would have expected what happened, which was to get
12 a neurology opinion --
13 Q. That's the status epilepticus?
14 A. Also the encephalopathy/encephalitis. We would have
15 wanted to know what investigations had been done, what
16 were being done, and was the neurologist coming to see
17 her.
18 Q. Assuming that there was some sort of viral infection or
19 something like that, would you have expected to know or
20 given any guidance on what the treatment plan was for
21 that?
22 A. The viral infection, if it was the viral infection
23 causing encephalitis, the only treatment is for herpes
24 simplex encephalitis -- we don't have good antivirals.
25 And so there would be -- it quite often gives you what

1 we call focal seizures. It gives you -- it fluctuates,
2 the type of seizures you get fluctuates. There may be
3 a history of cold sore. I do not think and I know
4 Dr Webb did not think that it was likely to be herpes
5 encephalitis. My understanding is that bloods had
6 already gone for virology during the night so the start
7 of the investigation is to try to elicit whether there
8 was a virus causing the problem were already there.
9 Q. Ultimately though there was a form of treatment plan to
10 address that side of things.
11 A. In the afternoon, Dr Webb said --
12 Q. Just bear with me. Ultimately, there was. What I'm
13 trying to understand from you is, given that there was
14 some thinking that she might actually have that as
15 a cause of her condition, would you have expected to
16 participate in some form of discussion, impart some sort
17 of guidance to Dr Sands, as to what should be being done
18 to address that?
19 A. Yes. I would have.
20 Q. Thank you. Would you have expected to be told that
21 repeat serum sodium tests were going to be carried out?
22 A. I can't be precise at this time. I can't --
23 Q. No, would you have expected to be told that sort of
24 thing?
25 A. Yes, I suppose I would have.

1 Q. So the upshot of it is you would have expected to have
2 some sort of discussion with Dr Sands fairly shortly
3 after his examination of Claire?
4 A. Yes.
5 Q. And am I to understand from what you said earlier that
6 Dr Sands would have appreciated that that was your
7 expectation?
8 A. Yes.
9 Q. And he would have appreciated that because it was either
10 common paediatric practice or because specifically it's
11 something that you might have mentioned as part of the
12 training?
13 A. Yes.
14 THE CHAIRMAN: Could we just pause for a moment, doctor?
15 There will be, as you indicated, some circumstances
16 where it wouldn't be absolutely clear whether it was
17 necessary to contact the consultant who was otherwise
18 engaged. But there's some cases where it would be
19 absolutely clear that it's necessary.
20 A. Yes.
21 THE CHAIRMAN: Am I right in understanding Claire's case as
22 being one in which it would be absolutely clear to
23 Dr Sands that he should try to contact you --
24 A. Yes.
25 THE CHAIRMAN: -- because you had a differential diagnosis

1 and a non-responding condition?

2 A. Yes. You had a child who was deteriorating.

3 THE CHAIRMAN: So this is not a grey area; Claire was

4 a patient about whom efforts should have been made to

5 contact you?

6 A. Yes.

7 MS ANYADIKE-DANES: Thank you. Given when you've said,

8 absent that it shouldn't compromise the need to get in

9 a neurological opinion, but the sort of time frame that

10 you have given in relation to when it would appear that

11 Claire was being examined, that would suggest that that

12 contact should have been made whilst you were still on

13 duty in the Children's Hospital.

14 A. Yes.

15 Q. And although you can't remember where you actually were

16 or what you were actually doing, apart from what you

17 surmise from the medical notes and records in relation

18 to other children, your view is that not only should

19 you have been contacted, but you were contactable at the

20 Children's Hospital?

21 A. Yes. And I also have the impression that there was

22 a conversation about Claire, but there was no

23 documentation.

24 Q. And if you had been contacted, what is it that you would

25 have been guiding Dr Sands in relation to?

1 A. I would have been going through the history with him,
2 what the clinical findings were, what the situation was
3 in her treatment, how soon would she be seen by
4 neurology, would she be stable enough until she is seen
5 by neurology, did I need to see her.
6 Q. Would you not have wanted to see her anyway, given that
7 you were in the Children's Hospital at that stage and
8 you would know that, absent something really quite
9 dramatic happening, you were actually scheduled to be in
10 Cupar Street in the afternoon?
11 A. I would have wanted to see her and I've already said
12 I don't know what was happening in Children's that
13 morning.
14 Q. That's a different matter.
15 A. I would have wanted to see her.
16 Q. So if he had contacted you, this is a child that you
17 would have wanted to see?
18 A. Yes.
19 Q. Then if we just carry on with your expectations, if I
20 can put it that way. It would appear that you're not
21 contacted during the morning and you go to Cupar Street;
22 is that right so far as you're aware?
23 A. Yes.
24 Q. So you're in Cupar Street and that is a clinic. But are
25 doctors still able to contact you whilst you were

1 attending at that clinic?
2 A. Yes, they are.
3 Q. And do they know that?
4 A. Yes.
5 Q. Do they know the circumstances in which they can contact
6 you?
7 A. There's a bleep there to be used at any time.
8 Q. That's how they do it. Because you're doing other
9 things, seeing other patients, so it's not quite the
10 same as if you're in the hospital doing administrative
11 things or other matters like that. Do they know what
12 the threshold is for: this is when you really need to be
13 contacted?
14 A. They should have, yes. They should have known that if
15 there was a sick child and things were happening, they
16 needed to contact me or, indeed, if there was a parent
17 or something else that had arisen, they could contact
18 me. I may not be able to respond straightaway, but
19 I could phone at a later time.
20 Q. I put up yesterday the timeline. It might assist, so
21 let's put that up very quickly now. It's 310-001-001.
22 Do you see that there?
23 A. Yes.
24 Q. Okay. When do you leave the hospital to go to
25 Cupar Street roughly?

1 A. 1ish. It depends on what's happening and Cupar Street
2 was a booked clinic, but we also had options for
3 children who had become unwell to be seen, not quite
4 walk-in, but urgent ones. So if I'd been made aware
5 that there were maybe three or four to be seen before
6 2 o'clock, I would leave about 1.
7 Q. So typically you're leaving the hospital about 1 pm for
8 one reason or another?
9 A. Yes.
10 Q. If we look at that, we can see from 1 pm to, say,
11 5 pm -- that's when you come off duty, is it?
12 A. Well, that's when my clinic would be over in
13 Cupar Street.
14 Q. Right. So if we look at that band there, we can see, as
15 I was showing you yesterday, what actually was
16 happening, or at least a distillation of the main things
17 that were happening. I'm sure there were other things
18 going on as well. This is from the records. Given
19 that, is there anything there that would suggest to you
20 that you would have expected the junior doctors --
21 whether it be the registrar or the SHOs -- to have
22 contacted you at Cupar Street?
23 A. Yes, I would have expected them to contact me to tell me
24 that Dr Webb had been asked to see Claire, that he had
25 seen Claire and that this is what was happening, what

1 his treatment plan was.
2 Q. And if you had been contacted and told that, would
3 you have expected to want to know any of the other
4 results that one sees displayed there, for example, her
5 Glasgow Coma Scale? Would you have wanted to know what
6 the hourly observations were showing?
7 A. Yes.
8 Q. For example, there are references there to what might be
9 supposed to be seizures. There's an episode of teeth
10 tightening, for example, a little bit after 3 o'clock.
11 Would you have expected to be told that sort of thing?
12 A. Sorry, where's the teeth tightening?
13 Q. Can you see in red, "teeth tightened slightly". Follow
14 that arrow up --
15 A. Is that the seizure -- the seizure is 3 and the teeth
16 tightening is half 5, 5, 6 o'clock --
17 Q. Sorry, the seizure is just after 3 o'clock.
18 A. Yes. Dr Webb was in attendance at that time and he was
19 managing those seizures, so if the ward was very busy
20 I wouldn't have expected the juniors to, every half
21 hour, update me. I would have expected to have been
22 told that Dr Webb was there, seeing the child, carrying
23 out investigations, starting a treatment plan, and then
24 what was happening at a time after that.
25 Q. Yes, but whenever you were contacted, if any of those

1 events had happened -- for example, the seizure just
2 after 3 o'clock and the teeth tightening just between 4
3 and 5 o'clock -- would you have expected to have been
4 told about those events if those events had happened
5 prior to them contacting you?
6 A. I'm not sure I would have been given that amount of
7 detail.
8 Q. Right. Looking at that pattern there, Dr Webb sees
9 Claire three times in the afternoon. At which stage
10 would you expect either the registrar or the SHO to have
11 contacted you?
12 A. I would have expected to have been contacted at the
13 beginning of Dr Webb seeing her and then, unless Dr Webb
14 had asked specifically for me to be contacted again,
15 I would have left it that I would have come back to the
16 ward at the end of the day, or the ward would have come
17 back to me at 5ish.
18 Q. Right. And if you had been contacted and said Dr Webb
19 is examining her, you understood what his treatment plan
20 is, and then you had subsequently contacted the ward at
21 5ish, and been told that pattern of events, if I can put
22 it that way, since then, would you have come back from
23 the Cupar clinic to have seen Claire?
24 A. I said yesterday I can't remember what was said on that
25 telephone call when I phoned the ward around tea time.

1 Whatever I said, I was reassured --
2 Q. Sorry, I asked you a different question. Bear with me.
3 We're now looking at the results.
4 A. Yes.
5 Q. I know that the results don't say absolutely everything
6 that was happening, but if, as you look at that, if you
7 had phoned at 5 o'clock and been given that pattern of
8 what had been happening with Claire over the afternoon,
9 would you have thought, "I ought to just go and see
10 Claire and meet her parents"?
11 A. Yes.
12 Q. You would have done that?
13 A. Yes, I would have thought that I needed to see Claire.
14 Q. And you would have come back in the way that you have
15 said that you have done at other times?
16 A. Yes.
17 Q. After your clinic, you would have come back and seen her
18 and examined her?
19 A. Yes.
20 Q. And if you had done that at that stage, what is it that
21 you would be wanting to find out, what would you be
22 asking for, who else would you be wanting to talk to at
23 that stage?
24 A. I'd be wanting to talk to Dr Webb because this was now
25 acute neurology as the primary problem, and I'd want to

1 make sure that he was aware of what was happening,
2 what was the treatment plan, what were the criteria if
3 she deteriorated further, what needed to be done.
4 I would want to know what investigations had been done
5 and what results were back, and were other
6 investigations needed. I would want to also know what
7 the parents had been told and the parents'
8 understanding, because we can tell people things but
9 they might not necessarily understand, so it's always
10 that two-way: what have they been told, but also what
11 have they taken on board.
12 Q. The first time you said you would have expected to have
13 been contacted round about that first examination by
14 Dr Webb, which was about 2 o'clock, so you would pretty
15 much have just got to your clinic. You might not even
16 have properly started it at that stage.
17 A. I probably was through the first few.
18 Q. If that's the case, who would you have expected to
19 contact you at that stage?
20 A. Any of the staff on the ward. It depends who was doing
21 what and how busy it was. As we work our way through
22 the patients, it would seem that there were still
23 patients being seen from the morning.
24 Q. Let's just stick with this for the moment. It could
25 have been the registrar, it could have been the SHO, one

1 of those doctors?
2 A. Yes.
3 Q. A nurse?
4 A. A senior nurse, yes.
5 Q. And those people would have known, would they, that that
6 was your expectation?
7 A. The senior nurse would have been directed by one of the
8 medical staff because they weren't able to do it.
9 Q. No, that was a different question. Those people would
10 have known that it was your expectation that you should
11 be contacted in those circumstances, even though you're
12 at the Cupar Street clinic?
13 A. I would have expected them, yes.
14 Q. Thank you. And then when you say that you would have
15 made contact at about 5 o'clock and we're assuming that
16 you would have learnt these things that we see from the
17 timeline, at least some part of them, and heard about
18 what had happened to Claire over the afternoon, you say
19 that in those circumstances you believe you would have
20 made your way to the hospital to examine Claire and
21 maybe meet with her parents. Whoever you're speaking to
22 at that stage -- and it's presumably whoever is able to
23 talk to you -- would you have made it clear to that
24 person that you'd actually like to speak to Dr Webb?
25 A. I would probably, yes. I can't say what I did.

1 Q. No, none of this is actually what you did do.
2 A. Right, because we don't know what I did.
3 THE CHAIRMAN: Sorry, one of the people who you might have
4 expected to contact you was --
5 A. Yes, I'd have expected Dr Webb, if he couldn't manage to
6 phone me or bleep me or contact me himself, to at
7 least make sure that the registrar had said, "Dr Webb
8 has said this is what's happening and this is what --
9 I would have expected some contact.
10 THE CHAIRMAN: Because the best conversation to take place,
11 if you're in Cupar Street, might well be between you and
12 Dr Webb.
13 A. Yes.
14 MS ANYADIKE-DANES: Well, at some stage, maybe after you'd
15 been briefed, if I can put it that way, in your
16 5 o'clock phone call, if you had made one then, did you
17 think that you might try and contact Dr Webb yourself
18 since it's clear that he didn't contact you?
19 A. I don't recollect what I think.
20 Q. I know you didn't do it, I'm asking you would you have
21 thought that that is something that you might have done?
22 A. Yes.
23 Q. Yes?
24 A. Yes.
25 Q. So given that he had not contacted you, you in those

1 circumstances might have contacted him?
2 A. Yes.
3 Q. Or at least tried to see him when you got back to the
4 hospital, which is something that you think you might
5 have done?
6 A. Yes.
7 Q. I'm not saying you did any of these things, this is
8 what -- you're guiding us now -- you recognise would
9 have been reasonable things to do and were things that
10 you might have done --
11 A. Yes.
12 Q. -- if matters had happened differently?
13 A. Yes.
14 Q. When would your duty shift, if I can put it that way,
15 have actually ended on the 22nd?
16 A. It's a three-and-a-half hour shift, so theoretically it
17 ended -- it was a seven-hour working day, so
18 theoretically it ended at 4 o'clock, 5, 4.30.
19 Q. So thereafter, if you'd gone back to the hospital,
20 you're going back really at the end of your working day?
21 A. Yes.
22 Q. And thereafter, you weren't on call, were you?
23 A. No, I wasn't on call.
24 Q. Nonetheless, in the circumstances of Claire being your
25 patient and given the condition that she had, would

1 you have expected to be contacted by anybody over the
2 evening of the 22nd?
3 A. Yes.
4 Q. Even though you weren't on call?
5 A. Yes. On the on-call rota there is a paragraph, very
6 clearly written, that if there is a deterioration in
7 a patient, that you contact the named consultant first
8 because quite often we can deal with it as we know the
9 patient. And then if that consultant for some reason
10 isn't contactable -- because they don't have to be,
11 they're no longer on call -- you go to the on-call
12 paediatrician.
13 Q. So if we carry on looking at this timeline, we can see
14 some discrete points of things that happen. One of them
15 might be thought to be a fairly low point at 9 o'clock.
16 A. Yes.
17 Q. Would you have expected, as opposed to the registrar who
18 was on duty that night, to be contacted about that?
19 A. Yes, I'd have expected not only me but Dr Webb, as
20 he was the consultant neurologist on call. That's my
21 understanding. He actually was on call. And this was
22 to do with seizures and her -- the drugs she was using,
23 that were being used, were way beyond what I would have
24 used as a paediatrician.
25 Q. So even though you weren't on call or on duty in any

1 way, she's your patient. In the circumstances, you
2 would have expected, when that episode of screaming and
3 drawing up of arms occurred, that that is something that
4 should have prompted some contact to you as well as
5 a contact to Dr Webb?
6 A. Yes.
7 Q. And then when Dr Stewart is examining Claire at 11.30
8 and receives the low sodium result, the very low sodium
9 result of 121, would you have expected to have been
10 contacted then?
11 A. Yes, because this child's condition was extremely
12 serious, her Glasgow Coma Scale was low, it may not have
13 fallen any more significantly, but it was low. She had
14 had further seizure despite everything that was going on
15 and now, on top of that, we have a very low sodium. So
16 the picture during the night is getting more and more
17 complex: a sicker and sicker child with more
18 complications.
19 Q. Dr Stewart contacts the registrar and has an exchange
20 with the registrar. Am I understanding you to say that
21 in addition to that, you would have expected to have
22 been informed? Whether it be by Dr Stewart or by the
23 registrar, you'd have expected to have been informed
24 about that?
25 A. Yes.

1 Q. So in other words, Dr Bartholome should have contacted
2 you in your view?
3 A. Yes.
4 Q. And she would have known that?
5 A. Yes.
6 Q. That would have been your expectation?
7 A. Yes.
8 Q. And then ultimately you are contacted?
9 A. Yes.
10 Q. So on this sort of alternative basis of what may have
11 happened but didn't happen, you would have had yourself
12 quite heavily involved in Claire's case?
13 A. Yes.
14 Q. But you weren't?
15 A. I have no recollection, there's no evidence, there's no
16 documentation.
17 Q. If you had been involved to that degree and then had
18 a child nonetheless die, would you not remember that?
19 A. Well, at the time I may have remembered it.
20 Q. Yes. And therefore the statement that you made closer
21 to the time, the analysis you made closer to the time,
22 will have borne out the fact that you had been involved
23 to that degree.
24 A. The analysis I made was eight years later.
25 Q. No, any statements that you made or any writings that

1 you produced would have borne out the fact that you had
2 been involved to that degree if you had, would they not?
3 A. Yes. In the perfect world, if I was looking back,
4 a retrospective note even in the chart to say, "Had
5 discussed earlier or had seen earlier", would have been
6 of help.
7 Q. Well, you've criticised the note keeping yesterday. If
8 you had been involved to that degree and then actually
9 the first time there's any record of you seeing the
10 child is when you arrive with her terminal collapse,
11 would you not, like any other doctor, like other doctors
12 seem to do, have written something in her notes that
13 reflected the fact that you had been involved with this
14 child, but despite all these efforts, nonetheless we
15 arrive at this situation?
16 A. I would have expected myself to, yes.
17 Q. And in fact if we look at your note, 090-022-057,
18 there's absolutely no reference in there to you having
19 had any of the prior contact, which you're now
20 explaining to us would have been appropriate, would have
21 been your practice.
22 A. Yes.
23 Q. Thank you. Then if we move on to issues more
24 particularly to do with trying to establish where you
25 were and what you were doing. I'd like to take you to

1 the file that you should have there, which is file 150.
2 MR FORTUNE: Can I just ask if file 150 has been completely
3 updated, sir?
4 THE CHAIRMAN: Yes.
5 MR FORTUNE: Thank you.
6 MS ANYADIKE-DANES: Let's start with S1, which is
7 150-001-002. That is a child who's admitted on the
8 21st, the Monday, at 6.30 in the evening, 18.30. You're
9 looking at an admission sheet.
10 A. Yes.
11 Q. Do you see that that child's date of admission is
12 21 October?
13 A. Yes.
14 Q. And do you see that it is admitted under you as
15 a consultant?
16 A. Yes.
17 Q. And the admission to Allen Ward -- "AW", as I understand
18 it -- and the admission time, 18.30.
19 A. Yes.
20 Q. Just as a clue to the coding of all of this -- you're
21 probably far more familiar with this than we are -- but
22 down the right-hand are a number of little boxes that
23 are numbered and there are options you can fill in.
24 Let's do this once and then people will pick it up. At
25 32 on "admission type", there's "1". That's an

1 immediate admission.
2 A. Yes.
3 Q. And then if we go down, one looks at 39, which is the
4 type of incident. It's a "14", which is not applicable.
5 None of those things are applicable?
6 A. Yes.
7 Q. That gives you -- the very briefest, admittedly -- but
8 some information about the patient when the patient
9 comes in. Then if we go over the page to 003, you see
10 the first note in the records, which is at 7.30 in the
11 evening. So this child is being admitted actually not
12 so far away from the time when Claire was admitted.
13 This child's been admitted while you were on call.
14 A. Yes.
15 Q. And then if we go to the page 005 -- I'm not going to
16 read out, so that it's in the record -- the particular
17 condition of this child, but it's there in the notes for
18 those to see. In any event, you see just a little bit
19 less than halfway down, "22/10, WR [ward round]
20 Dr Sands".
21 A. Yes.
22 Q. And that is signed off by Dr Stewart as the SHO.
23 A. Yes.
24 Q. You see the details there and "Home later today".
25 A. Yes.

1 Q. There's no reference to you.
2 A. No.
3 Q. No. Then a little bit later on on that same page we
4 see, "Ward round Dr Hill". Dr Hill's another
5 paediatrician?
6 A. Dr Hill would have been in the hospital. She, like
7 myself, had two sessions in the hospital, one of which
8 was the Tuesday afternoon. She came in on a Tuesday
9 afternoon to do a clinic.
10 Q. Yes. But this probably is something that's happening
11 in the morning. Actually, we'll find out when it is.
12 In the same way as you come in for 9 o'clock, Dr Hill
13 comes in for the afternoon?
14 A. For the afternoon clinic and would have popped in to the
15 ward to see any of her patients that were in.
16 Q. This patient is under your name.
17 A. Yes, but it is one of -- if you have a chronic disease,
18 so if you're in and out a lot, you may be admitted under
19 the admitting consultant that night, but the consultant
20 who knows you best, if they're not on annual leave or
21 anything, takes you over and follows you through the
22 ward admission.
23 Q. Do they formally take over your care?
24 A. At this stage -- there was a lot of discussion at this
25 stage whether we closed one episode of care -- this is

1 a process, managerial process -- and opened another
2 episode of care and the decision at that stage was that
3 it didn't, we weren't going to do that.
4 Q. So this child is still your responsibility?
5 A. Yes.
6 Q. Thank you. Then in any event, we see the ward round by
7 Dr Hill, the note he made of that. And it's signed off
8 by Dr Stevenson. There's no reference to you there.
9 A. No.
10 Q. If we go over the page, 006, the same date, "Ward round,
11 medical SHO".
12 A. I don't think this is the same date, I think it's the
13 23rd. I don't think it's the 22nd.
14 Q. It might be.
15 A. Because the child is on erythromycin --
16 Q. We will get just there in a minute. We will look at the
17 discharge papers in a minute, but let's work through the
18 documents as we have them. In any event, whatever the
19 date is, it's a ward round that is being carried out by
20 the medical SHO.
21 A. Yes.
22 Q. As a matter of fact, Dr Stevenson is the medical SHO.
23 A. Yes.
24 Q. And he signed that. He refers to an episode of vomiting
25 in the morning and then, right down at the bottom, with

1 his plan, he says:

2 "If stable, home today. Discuss with mother re

3 physio."

4 No reference to you.

5 A. No.

6 Q. So then if we go on and we can see in the nursing notes

7 at 009, up at the top you'll see for the 21st, which is

8 when the child was admitted:

9 "Seen by Dr O'Neill SHO."

10 Then if you see for the 22nd, 8 pm to 8 am, you'll

11 see the concerns that were being expressed about oxygen

12 saturation and so on. Then you see, 12 midday, another

13 nurse's hand has written there and it ends up with:

14 "Seen by Dr Hill. To commence physio."

15 And so on. So what you had indicated might have

16 happened, that Dr Hill, before commencing her clinic

17 that afternoon, had actually come in and seen this

18 child --

19 A. Mm-hm.

20 Q. So she's made time to see the child.

21 A. Yes.

22 Q. There's no reference to you in those nursing notes.

23 A. No.

24 Q. And if one sees, over the page, 010, 2 pm to 8 pm, the

25 temperature gradually came down because she had been

1 pyrexic before. If one goes to the discharge summary --
2 MR FORTUNE: Before you do that, it's quite clear that the
3 child is detained overnight because Nurse Maxwell is on
4 night duty.
5 MS ANYADIKE-DANES: Yes, we are going to come to the
6 discharge summary, which usually makes clear the date of
7 discharge. If one looks at that at 011, that's quite
8 clear: we see the child was admitted on the 21st,
9 you are the consultant, the ward is Allen Ward. The
10 discharge is, I think... Ah, discharge is the 22nd. It
11 could be the 23rd.
12 MR FORTUNE: It's the same top and bottom.
13 MS ANYADIKE-DANES: Slightly fuzzy on the bottom, but in any
14 event, there is no reference in any of that time to your
15 name.
16 A. No.
17 Q. I mean, your name in the sense of being connected with
18 being asked about the child, seeing the child,
19 expressing a view about the child.
20 A. No.
21 Q. So this child in your name comes in and out and there is
22 absolutely no reference to you having engaged with the
23 child?
24 A. No.
25 Q. Or the child's parents for that matter?

1 A. No.

2 Q. So then if we go to S2. S2 maybe requires a little more

3 thought. That child is admitted on the 21st, in the

4 afternoon, 13.03. Under your name?

5 A. Yes.

6 Q. As a matter of interest, at 13.03 on the 21st, what was

7 your position? Were you on duty, were you on call?

8 A. I was probably doing clinics in the community. I was

9 somewhere between Cupar Street or Carlisle Clinic doing

10 clinics.

11 Q. So you were actually on duty?

12 A. I was on duty, yes.

13 THE CHAIRMAN: You're on duty, but not in the Children's

14 Hospital?

15 A. Yes. We are not allocated free time for our on call.

16 So we are continuing with our ordinary clinics, and if

17 an emergency arises between 9 to 5 of the day we're on

18 call, then we need to be able to either drop what we're

19 doing and go, or get a colleague to assist us.

20 THE CHAIRMAN: Just for my own ignorance: why are you named

21 as the consultant at 1 o'clock on the Monday afternoon?

22 A. Because I was the consultant on call from 9 am on the

23 Monday to 9 am on the Tuesday. So any medical

24 admissions coming in in that time were placed under my

25 name.

1 THE CHAIRMAN: Thank you.

2 MS ANYADIKE-DANES: Thank you. Then if we go over the page

3 to 012, one sees that this child has actually started,

4 if I can put it that way, from Cupar Street. This is

5 a letter that's written by Dr Livingstone. Is

6 Dr Livingstone a senior registrar?

7 A. Yes.

8 Q. So Dr Livingstone is writing this letter on 21 October,

9 senior registrar, to Dr Bartholome. And he explains

10 that the child has been seen at Cupar Street clinic that

11 morning, so the morning of the 21st, which was in

12 response to an urgent request by child's GP because of

13 respiratory distress; is that correct?

14 A. Yes.

15 Q. That's quite a serious matter. At least the GP is

16 recorded as having considered it serious. Then if we go

17 half the way down, it talks about the problems that have

18 been noted and associated with the child, which I'm not

19 going to read out, but they're there for you to see,

20 particularly the block just above the second redaction.

21 Then if one goes over the page, 013, this is the

22 result of Dr Livingstone's own examination, isn't it?

23 A. Yes.

24 Q. "O&E", on examination. And one can see there, certainly

25 the third line might be a matter to cause some concern.

1 And then if one goes down to his impressions, he queries
2 asthma, myocarditis and cardiomyopathy. That's quite
3 serious, either of those?
4 A. Yes.
5 Q. He also indicates that there has been a discussion with
6 Dr Stewart.
7 A. I think that might be Dr Moira(?) Stewart, who was
8 a consultant in Cupar Street and would have been doing
9 a clinic alongside me on the Monday. I'm not sure it's
10 Neil Stewart because of the way the letter's written.
11 Q. I haven't said it is.
12 A. But I think that's probably the consultant who saw the
13 child at that point.
14 Q. Then even more so. So the senior registrar is
15 sufficiently concerned to have a discussion, if that be
16 the case --
17 A. Yes.
18 Q. -- with a consultant available to that doctor, and as
19 a result of which is seeking to have that child
20 admitted?
21 A. Yes.
22 Q. That's the upshot of it?
23 A. Yes.
24 Q. So that would appear to be a reasonably serious case on
25 the face of it?

1 A. Yes.

2 Q. So if we go and look at the next page, which is 014.
3 It's 21 October. One sees that's the first note, if I
4 can put it that way, on the clinical notes and records.
5 I'm not going to go into all of that. The next page is
6 what is found on examination. It's quite a detailed
7 note. It goes over a number of pages and you end up
8 with a summary on 016.

9 Then you have, on 017, the suggestions, a sweat test
10 being one of them, a number of things being indicated
11 there at 2.30. Then there's another note. That is
12 Dr Stevenson who's taken that note at 2.30. Then
13 Dr Stewart also examines the child or looks at the
14 notes, and he makes his own note at 3 o'clock in that
15 afternoon.

16 A. Yes.

17 THE CHAIRMAN: That's Dr Neil Stewart?

18 A. Yes, that is.

19 MS ANYADIKE-DANES: Over the page to 018. One can see the
20 ward round.

21 A. Yes.

22 Q. "22 October. Ward round, medical SHO."

23 A. Yes.

24 Q. And they review what has happened in the past. This
25 seems to have been also contributed to because that

1 would appear to be Dr Stevenson's writing there at the
2 beginning and seems to have been contributed to by
3 Dr Stewart, who, if nothing else, would appear to have
4 added the plan and signed it.
5 A. Yes.
6 Q. No reference to you.
7 A. No.
8 Q. In fact, no reference to you in the previous doctor's
9 notes.
10 A. No.
11 Q. And then if we look and see what the nurses have to say,
12 which starts at 021. They refer to the child being
13 admitted as arranged from Cupar Street and the history.
14 And then at 8 pm, they talk about the respirations and
15 oxygen saturation, "Doctor informed". Then 22 October,
16 oxygen saturation, that is discussed and noted. "Quite
17 unsettled at times." A reference to vomiting.
18 Over the page, reference to commencing on nebulisers
19 and so forth. It gives a description of what happens
20 in the afternoon. No reference to you.
21 A. No.
22 Q. Then if we go over the page to 023, this is one of those
23 exceptions where we were permitted to include material
24 that fell outside the time frame to try and indicate
25 something of what had happened during the hospital stay.

1 This is a letter written by Dr Sands to the consultant
2 ear-nose-and-throat surgeon thanking the surgeon for
3 agreeing to see the child and summarising the problems.
4 So it's effectively a letter of referral.
5 A. Yes.
6 Q. And then talking about the particular concerns on
7 admission and what had happened, the tests that had been
8 carried out, and then:
9 "Despite this, remains tachypnoeic."
10 I understand that to mean rapid breathing.
11 A. Yes.
12 Q. And they then identify a respiratory rate:
13 "Continues to have hyperexpansion with some
14 indrawing."
15 And then there's another suggestion. It would seem
16 that bronchoscopy might help to rule out structural
17 abnormality in the lungs and so on. The upshot is,
18 leaving hospital, they still weren't entirely sure
19 what was wrong with the child.
20 A. Yes.
21 Q. And all that has happened, the child has been in and
22 out, been referred to another specialist for an opinion
23 and there is absolutely no reference to you at all.
24 A. No.
25 Q. And in fact, this letter of referral, far from being

1 consultant to consultant, because it's your patient, is
2 actually written by your registrar?
3 A. Which would not be unusual because the registrar did
4 a lot of the inpatient dictation for discharge letters,
5 et cetera.
6 Q. Yes, but in this, where he's writing, seeking the views
7 or thanking the surgeon for having agreed to assist with
8 this child, there is no reference to what you think or
9 your view or anything like that, "My consultant
10 considered this", or, "My consultant saw the child", or
11 such and such. Nothing of that sort at all.
12 A. No.
13 Q. So a child who you acknowledged there were concerns
14 about, was potentially serious, has come in, gone out,
15 and there is not a single reference to you in any of
16 these child's medical notes and records, even though
17 you're the child's consultant.
18 A. Yes.
19 Q. And just finally, we see the discharge sheet, which is
20 not signed by you. You see the admission on the 21st,
21 discharge on the 29th. There's a brief note, which I'm
22 not going to go into, and we see it's finally signed off
23 by Dr Stewart.
24 Go to S3. This child is admitted on the 22nd to
25 Musgrave Ward under your name as the consultant at 1.48

1 in the morning. So you were on call?
2 A. Yes.
3 Q. If one sees the next page, we can see that the medical
4 registrar has seen the child and has admitted the child
5 for observation. We also see that Dr O'Hare, page 004,
6 has given a very brief summary and it's Dr O'Hare's
7 decision to admit.
8 Then if we look at 005, that's the first note that
9 appears on the notes and records at 2.20 am. We see
10 that this child is a very young child, four weeks.
11 A. Yes.
12 Q. And one goes over the page to see what is recorded on
13 examination. It's quite a long note. It's
14 Dr Volprecht's note. Go over the page to 007. She
15 appears to date hers at the top of each page. So she's
16 dated it again. And then she provides a summary of her
17 findings and then she gives a plan. She signs that off.
18 Then, somewhere down towards the bottom, we see the ward
19 round, "Ward round Dr Sands"; do you see that --
20 A. Yes.
21 Q. -- at that same page? That would appear to be also on
22 the 22 --
23 A. Yes.
24 Q. -- October. And Dr Sands has given the results of the
25 tests that were from the blood taken earlier and he

1 summarises, on examination, he summarises, and then over
2 the page, 008, the plan:
3 "Discuss with cardiology re further opinion."
4 Amongst other things, but I point that out in
5 particular. He signs that as his note, Dr Stevenson.
6 No reference to you?
7 A. No. There is a reference that an ECG was attempted at
8 2 pm, so this would look as if it was in the afternoon
9 of the Tuesday.
10 Q. Yes. But in any event, no reference to you in any of
11 the earlier notes?
12 A. No.
13 Q. And so even if it is the afternoon, it's not clear --
14 we'll find out from Dr Sands if he can assist us with
15 what time that ward round would have been being
16 conducted. But if it was being conducted at the normal
17 time, then it may have been that the plan to have or the
18 thought of having cardiology involvement might have been
19 formulated earlier than that. But in any event,
20 whenever it was formulated, nobody is recorded as having
21 contacted you. You're not recorded as being involved in
22 any kind of decision that cardiology would be
23 appropriate.
24 A. Yes.
25 Q. And then we see, at 4 pm, that that looks like the note

1 from the cardiologist, and we'll see a reference to that
2 in the nurse's notes. And we see the next entry is the
3 ward round on the 23rd, which is the next date.
4 Dr Stewart has taken it, he has signed it and he's timed
5 it at 12 -- at least timed his note.
6 A. Yes.
7 Q. No reference to you.
8 A. No.
9 Q. So then --
10 A. I wouldn't have been in the hospital on the 23rd.
11 Q. No, but I think you have already helped us by saying
12 that, notwithstanding all of that, if there are serious
13 matters to be undertaken, then even if you are in
14 Cupar Street, you can be reached.
15 A. Yes.
16 Q. And in fact, I think your evidence is not only can you,
17 but you should be reached.
18 A. Yes, I would expect it.
19 Q. Right. So then let's look at 013, which is a nursing
20 note. 22 October. One sees:
21 "Seen by doctor, bloods. Chest X-ray, A&E."
22 That's a reference to an earlier time. And then one
23 sees the 8 am note:
24 "Fed well this morning. For cardiology opinion."
25 That would appear, therefore, to have been something

1 that was being suggested at some time in the morning --
2 A. Yes.
3 Q. -- from that note when you were in the hospital.
4 A. Yes.
5 Q. Then if we see at 2 pm -- we see after that the note.
6 So that's already noted. And then immediately after
7 that, we see in a different hand:
8 "ECG attempted, unsuccessful."
9 If one puts those two things together, it would
10 appear that the view that a cardiology opinion should be
11 sought is something that happened in the morning. They
12 had an unsuccessful try at the ECG and then at 2 pm:
13 "Seen by Dr Mulholland, cardiologist."
14 A. I just find Dr Stevenson's note confusing then.
15 Q. Well, it might be confusing, but the fact of the matter
16 is that a view has been formed to seek a cardiology
17 opinion and you don't seem to be involved in any way.
18 A. No.
19 Q. Nor do we see your name here in the nurse's note as
20 expressing a view, being contacted, having seen the
21 child or anything of that sort?
22 A. No.
23 Q. So that child comes in, there is a concern that what
24 they really need is the view of a cardiologist, but
25 nonetheless you're not involved in that, and then we see

1 the discharge sheet, 011. Admission, 22nd, under you,
2 and discharge on the 25th, it would appear. Do you see
3 that?
4 A. Yes.
5 Q. So although what we're talking about is a very young
6 child, indeed, a baby, really.
7 A. Yes.
8 Q. You don't feature as having had any contact with that
9 child at all.
10 A. No.
11 Q. So if we go to --
12 THE CHAIRMAN: We'll take a break now. We'll sit again at
13 11.40.
14 (11.25 am)
15 (A short break)
16 (11.43 am)
17 MS ANYADIKE-DANES: Dr Steen, before we go on, just to
18 clarify a point that you gave in your evidence earlier.
19 I think you said, I stand to be corrected, that you
20 weren't in the hospital on 23 October.
21 A. I was only in PICU for Claire. I would have been in
22 clinics in the community from 9 to 5.
23 Q. Well, when actually were you in the hospital on the
24 23rd, which is the Wednesday?
25 A. I was in -- obviously I was in overnight with Claire,

1 then I came back after my clinics to do the second set
2 of brainstem results. I would not have been in the
3 hospital during the day.
4 Q. So 4 to 6 you were in the hospital?
5 A. No, probably from 5 right through to 7, 8 o'clock.
6 Q. Well, you arrive at about 4 o'clock in the morning.
7 A. Sorry, I was thinking in the evening. I'm not sure
8 I went home again. I probably went straight to the
9 clinics.
10 Q. Well, we'll clarify that later on. But in any event,
11 I think you accept that at some point, certainly for the
12 brainstem tests, you were in the hospital --
13 A. Yes.
14 Q. -- both in the morning and then at the other end of the
15 day, if I can put it that way?
16 A. Yes.
17 Q. Thank you.
18 So, S4. If we look at 004-002, this is a child
19 admitted on the 21st at 16.05 to Allen Ward, in your
20 name, Dr Steen, and you were on call.
21 A. Yes.
22 Q. If we go over the page, 003, we see the first note in
23 there at 16.30 for 21 October. You see the concerns
24 about the child, which I'm not going to go into. And
25 then towards the bottom of the page you see the results,

1 or what is recorded on the examination of the child.
2 Then over the page again, there's quite a bit of detail
3 there, and then there is a signature of Dr Stewart.
4 A. Yes.
5 Q. Then if we go over the page to what happens on the 22nd,
6 005, that's the ward round on the 22nd, and it says:
7 "Ward round, Dr Sands."
8 A. Yes.
9 Q. This note is taken by Dr Stevenson, the SHO. He
10 describes briefly what the concerns are, the medication
11 that the child is on, and the examination of the child,
12 and the plan.
13 Then if we go over the page, we'll see
14 "23 October 1996, ward round, medical SHO". And then in
15 a different hand, Dr Stewart's hand it would appear,
16 "Well today", and it's signed off by Dr Stewart. No
17 reference to you.
18 A. No.
19 Q. But if we go to page 007, which is the nursing notes,
20 the nursing note for 22 October, you can see what it
21 says there about the observations and so forth. That's
22 7 am I should say. Then the note, 8 am to 2 pm, you can
23 see the concerns:
24 "Wheeziness. Observation: stable."
25 Then it says:

1 "Seen by Dr Steen. To continue regular nebulisers
2 today and steroids."
3 Then at 8 pm:
4 "No change in condition."
5 Then if we work on through the notes, we get to 011,
6 which is the discharge summary. We see that the child
7 comes in on the 21st, discharged on the 24th. That
8 discharge summary is signed off by Dr Stewart.
9 If we look over the page to the typed-up version of
10 what is a little illegible under the comments on the
11 discharge summary, which was typed for the assistance of
12 the inquiry's expert on consultant paediatrics, we see
13 that:
14 "[The child] was admitted with moderate exacerbation
15 of asthma, responding to a short course of oral steroids
16 and was discharged on a double dose."
17 So that's the condition and the passage of care of
18 that child. That is a child that the nursing note
19 records you as having seen. There's no time for when
20 you saw that child, but there is a reference to you
21 having seen that child.
22 A. Between 8 am and 2 pm. And I'm also not sure -- and you
23 probably will be able to elicit it in the rest of the
24 inquiry. That's Nurse Fields, and depending on how the
25 nurses were allocated to the ward, that child might have

1 actually been in room 7, but I don't know. It's just
2 the nurse is usually allocated to four beds.
3 Q. We'll try and see if we can elicit that.
4 A. Yes.
5 Q. You don't recall this child?
6 A. I don't recall any of this, but it does say I saw the
7 child.
8 Q. Can we just pause there for an moment? If you had seen
9 a child, it's not clear when you would have seen the
10 child, except that note is recording what has happened
11 over a passage of time, basically the morning.
12 A. Yes.
13 Q. Is there any reason why you couldn't have seen Claire if
14 you had seen a child as proximate as four beds away from
15 Claire?
16 A. No. That's why I've always felt that I knew what was
17 happening with Claire, but I know there's no
18 documentation, and you can be quite sure that now, if
19 I see a child, I write in the notes the date and time.
20 Q. Sorry, I didn't mean whether you knew what was
21 happening; is there any reason why you couldn't have
22 seen Claire?
23 A. No, I'm not aware of any reason.
24 THE CHAIRMAN: Sorry, doctor, maybe I missed this, but
25 I hadn't picked it up before. Your feeling is that you

1 always felt as if you knew what was happening with
2 Claire?
3 A. It's ... I know that there's no evidence.
4 THE CHAIRMAN: If you'd always known what was happening with
5 Claire, you would have been back in the hospital.
6 A. Well, I phoned. Whatever happened ... I think Dr Sands
7 did keep me informed and I phoned, and whatever I was
8 told, it reassured me.
9 THE CHAIRMAN: But that would mean that you didn't know
10 what was happening with Claire because --
11 A. I thought I knew.
12 THE CHAIRMAN: If you had been told what was actually
13 happening, you wouldn't have been reassured, would you?
14 A. Yes, that the Glasgow Coma Scale was 6 to 7, yes.
15 THE CHAIRMAN: And there was at least one seizure, say,
16 earlier on.
17 A. Yes.
18 MS ANYADIKE-DANES: Just to follow that up, if you had been
19 in the ward where Claire was in the morning and some
20 time after the ward round, or whenever it was, and you
21 had known about Claire's condition as, so far as we are
22 aware, it is recorded during that ward round, you've
23 just said there's absolutely no reason why you couldn't
24 have seen Claire yourself.
25 A. Yes, and my impression always has been that Dr Sands

1 informed me of his examination of Claire and what was
2 happening.
3 Q. No, let's leave that to one side for the moment.
4 You have suggested, although you're hoping that the
5 inquiry will be able to assist with substantiating that,
6 that the child that you are recorded as having seen was
7 in the same ward as Claire.
8 A. Yes.
9 Q. And that's a four-bed ward?
10 A. Yes.
11 Q. In other words, in fairly close proximity to Claire.
12 That was your suggestion.
13 A. Yes.
14 Q. And if that's the case, you've also indicated that,
15 subject to something else turning up, there's no reason
16 why you couldn't have examined Claire yourself and seen
17 her yourself.
18 A. Yes, or discussed it with Dr Sands, he having done the
19 examination.
20 Q. Exactly, exactly. So if you had come into that ward to
21 see another child, would you not have expected to be
22 told, "Actually, there's another one of your patients
23 that was admitted last night and there are some concerns
24 over her"?
25 A. Yes.

1 Q. If all that had happened, it's not a matter of being
2 reassured by the time you get yourself back to
3 Cupar Street. You could have, then and there, examined
4 Claire and, if I can put it that way, integrated your
5 own views and guidance into her care plan.
6 A. Yes.
7 THE CHAIRMAN: Sorry, just to follow on from
8 Ms Anyadike-Danes' questions: without reading out the
9 condition of this child, who we know as S4, it appears
10 to have been an identified condition, an exacerbation of
11 that identified condition, and something which responded
12 to treatment.
13 A. Mm-hm.
14 THE CHAIRMAN: So in terms of priorities, the hierarchy
15 between seeing that child and seeing Claire would have
16 put Claire above S4, wouldn't it?
17 A. Yes.
18 MS ANYADIKE-DANES: Thank you, Mr Chairman.
19 Then if we go to S5. This child is admitted in the
20 early hours of the 22nd. It's 005-002. That's the
21 admission sheet and you see that this child is admitted
22 on the 22nd, the early hours, so you're on call.
23 A. Yes.
24 Q. Admitted under you. And if we go over the page to 003,
25 one sees the first note being made at 1.10. This is

1 also a young child.

2 A. Yes.

3 Q. This child is admitted with febrile convulsions.

4 A. Yes.

5 Q. So then there's quite a lengthy background and we go

6 over the page to 004, which continues, on examination.

7 There's quite a lot of detail there, it would appear.

8 Then there's a CNS examination that's carried out.

9 Over the page again, 005, we see the summary. We

10 come down, ultimately, to the plan:

11 "Start fluids. If oral intake decreases and

12 vomiting increases ..."

13 I presume that's what those signs mean?

14 A. Yes.

15 Q. And the fluid that is suggested is Solution No. 18,

16 50 ml per hour. That's signed off by the SHO,

17 Dr Volprecht.

18 A. Yes.

19 Q. And then a little bit further down that page, you see

20 the note of the ward round, "Ward round, Dr Sands".

21 A. Yes.

22 Q. This note, if one sees over the page, is actually taken

23 by Dr Stevenson, so there is a record of this:

24 "Previous history of seizure."

25 Then there's a reference to meningitis and the age

1 at which that happened, a description of the seizure
2 itself and the examination. Then the plan, which is
3 over page at 006:
4 "Monitor and, if settled, plan for home."
5 Is that right?
6 A. Yes.
7 Q. Then we see at 22 October, "medical SHO". There's
8 a note at 5.30:
9 "Well over this day. Settled. Advice given."
10 And that's signed as well?
11 A. Yes.
12 Q. No reference to you --
13 A. Yes.
14 Q. -- even though it's quite a young child coming with
15 febrile convulsions?
16 A. Febrile convulsions would be a fairly routine --
17 Q. Fairly routine? And then if we just confirm that we see
18 the nurse's note at 008 for the 22nd, the early morning
19 of the 22nd. It says:
20 "To be seen by doctor."
21 And in fact the child is seen by a doctor, at least
22 the record seems to indicate that. Then we see the note
23 carrying on:
24 "Apyrexical [and so forth]."
25 Reference to vomits and so on. And then, over the

1 page:

2 "IV cannula removed this afternoon. Discharged home

3 at 6 pm."

4 And the mother is given certain advice.

5 Then if one sees the discharge sheet, which is

6 signed by Dr Stevenson, that child appears to have been

7 discharged on 22 October, admitted on 22 October under

8 you as the consultant and discharged later on the same

9 day. So in and out, no reference to you at all?

10 A. No.

11 Q. S6, 006-002. This child is admitted on 21 October to

12 Allen Ward under you as the consultant at 17.20.

13 Roughly the same time as Claire or close to. And you're

14 on call.

15 A. Yes.

16 Q. And then if we look at 003, we see the note and why the

17 child was admitted. That goes over the page until 004,

18 where it's signed off by a different SHO, and then we

19 see, just at the bottom of that, the ward round on the

20 22nd, "Ward round, Dr Sands". A note is taken by

21 Dr Stewart. No reference to you.

22 A. Yes.

23 Q. Then if we look at the beginning of the nurse's note at

24 005, you see the reason for admission, which might

25 indicate something or other of the seriousness of it.

1 In fact, if we look at 007, we see that the child is
2 transferred from another hospital. That's noted
3 in relation to 7.35 pm.
4 Then one sees a note for the early morning of the
5 22nd and the later morning, 8 to 10:
6 "Both parents in attendance, seen by Dr Sands,
7 discharged [and so on]. To be reviewed in six to eight
8 weeks."
9 No reference to you.
10 A. No.
11 Q. And then over the page, 008 is a discharge summary, and
12 we see that child came in, 21st, the evening, went out
13 on the 22nd, discharge summary signed by Dr Stewart.
14 You don't feature.
15 A. No.
16 Q. In and out. You don't feature.
17 A. No.
18 Q. S7. Part of this we've seen before, but maybe it helps
19 to see it in this context of going through all the
20 patients for this relevant period of yours. We see this
21 child is admitted on the 22nd and, as has been pointed
22 out, there's "4" in that box 32, which we looked at
23 earlier and "4" indicates the admission type of
24 "booked".
25 A. Yes.

1 Q. And yesterday, you gave evidence that that could be
2 booked in a number of ways. It could be done through
3 a phone call. And then, of course, you are identified
4 as the consultant. Then if one looks at the time, it's
5 13.33, and this child is admitted to Allen Ward.
6 A. And I was no longer on call, but because this was my
7 patient that was admitted under my name because
8 I finished my on-call at 0900.
9 Q. But you would have been on duty?
10 A. Yes, but because it was my patient, it was admitted
11 under my name rather than the on-call paediatrician's
12 name.
13 Q. So this is a patient being assigned to you, if I can put
14 it that way --
15 A. Yes.
16 Q. -- because this is your patient?
17 A. Yes.
18 Q. Does that mean that this is a patient that you have seen
19 before?
20 A. Yes.
21 Q. Many times?
22 A. This child?
23 Q. Yes.
24 A. Yes.
25 Q. So this is patient you know well; would that be fair to

1 say?
2 A. Yes.
3 Q. And the mother you know well?
4 A. Yes.
5 Q. So if one goes over the page to 003, one sees the note
6 of the medical SHO. I was asked to confirm by looking
7 again at the original notes whether there is any
8 assistance from what is redacted above as to indicating
9 anything happening on the 22nd earlier that day. I was
10 unable to do that and I think a letter has gone
11 confirming that. So this is the note made by the
12 medical SHO. That note is made at -- at least the time
13 is recorded at 5 pm.
14 You see the particular condition there of the child.
15 It refers to a recent admission with chest infection, so
16 whatever might be the condition, that is an indication
17 of why the child has been brought in, if I can put it
18 that way.
19 A. Yes.
20 Q. Then if we go over the page to 004, you have the note of
21 what is recorded there for the examination, and this
22 note is signed off by the SHO, Dr Stevenson. Just above
23 that you see there is going to be a little more
24 happening:
25 "Discussion with SALT for a further assessment."

1 Speech and language therapy?
2 A. Yes.
3 Q. And we've redacted who exactly that was going to be.
4 Then the next note is dated the 23rd, "Ward round, SHO".
5 Over the page, if you go, you see that's signed by
6 Dr Stewart. In all of that, there's no reference to you
7 --
8 A. Except --
9 Q. In these notes.
10 A. -- except that I had seen the child prior to admission.
11 In the medical write-up --
12 Q. I beg your pardon, there is. If you go just above the
13 redacted bit -- I'm very sorry -- you see:
14 "Seen by Dr Steen. Admit for further assessment and
15 management."
16 THE CHAIRMAN: And that's on page 003.
17 MS ANYADIKE-DANES: You're quite right, we had looked at
18 this yesterday.
19 And all of that flows on from a note at 5 pm.
20 A. Yes.
21 Q. So then if we go to see if we can get any further
22 guidance from the nurse's notes, we go to 007, and you
23 see -- and we have seen this before -- at 2 pm:
24 "Mum phoned Dr Steen this morning concerning [the
25 problem]. Brought down to Allen Ward at 1.30."

1 And then you see there is a time of 8 pm and the
2 note says:
3 "Seen by doctor. Medication written up. To have
4 [a particular form of medication]."
5 And the reference to you there is simply that the
6 mother had phoned you and the child was being brought
7 down to Allen Ward at 1.30; that's correct, isn't it?
8 A. Yes.
9 Q. If one then looks at the discharge summary at 008, you
10 see that the date of admission is the 22nd, admitted in
11 your name. And you have actually signed this.
12 A. Yes, it's not dated, which means I probably wrote it out
13 prior to the discharge with the junior doctors to date
14 it at the time of discharge.
15 Q. Yes.
16 A. I'm not sure when she was actually discharged.
17 Q. This child was discharged on 1 November. In any event,
18 you haven't dated that.
19 A. No.
20 Q. And the only real reference to you is the note that --
21 so when you do intervene and say something or see
22 a child, Dr Stevenson's perfectly capable of noting
23 that, which is what he did there.
24 A. He didn't note it when I'd seen the child and noted that
25 nebulisers were to be continued.

1 Q. Is a doctor always there when you see a patient?
2 A. Certainly not at the moment because we're quite often in
3 at 8 o'clock.
4 Q. Let's do 1996. In 1996, was a doctor always present
5 when you saw a patient?
6 A. Not always.
7 Q. No. So if you saw a patient and no other doctor was
8 present, it was therefore, was it not, incumbent on you
9 to write in the note that you had seen a patient?
10 A. Yes, and I've already said that the documentation is
11 terrible.
12 Q. I appreciate that, but we're at the moment trying to see
13 what happened. But that is correct?
14 A. Yes.
15 Q. So if that had happened, you should have written a note.
16 A. Yes.
17 Q. What I'm saying is when Dr Stevenson is present and you
18 involve yourself in the care of the child, he's
19 perfectly capable of noting that. He's done it
20 in relation to this child.
21 A. Yes. But that was the history from the parent.
22 Q. Sorry?
23 A. That was the history from the parent he noted.
24 Q. No, he noted, "Seen by Dr Steen. Admit for further
25 assessment".

1 A. I think that's what the parent told him. I don't
2 know --
3 Q. How do you know that?
4 A. Because it's in the history of presenting complaint.
5 THE CHAIRMAN: This is going back to page 3 again?
6 A. Yes.
7 THE CHAIRMAN: So when the note says towards the end of that
8 entry, "Seen by Dr Steen", your best guess at that is
9 that that is Dr Stevenson having been told by a parent
10 that you had seen the child and you had directed the
11 admission for further assessment and management?
12 A. Yes. Dr Stevenson -- this is 5 in the afternoon.
13 I think Dr Stevenson probably got that information from
14 either a nurse or the parent.
15 THE CHAIRMAN: Could we track back on this so I get your
16 understanding and interpretation? If we look at page 7
17 and page 3 together. Page 7 is the earlier nursing
18 entry, which says that the mum phoned you this morning
19 and the child was brought down to Allen Ward at 1.30 for
20 admission. Your best guess is that you would not have
21 been there at Allen Ward at 1.30 for admission?
22 A. No, I would have had to see the child before that.
23 THE CHAIRMAN: And the child isn't admitted to Allen Ward,
24 the child has to be seen, what, in A&E before coming
25 into Allen Ward?

1 A. Or admissions or the treatment room in Allen Ward.
2 THE CHAIRMAN: Okay. So piecing this together, are you
3 suggesting that this should be interpreted to mean that
4 at some time before you left the Children's Hospital on
5 the morning of the 22nd, you saw this child at some
6 location around the Children's Hospital?
7 A. Yes.
8 THE CHAIRMAN: Having been rung by the mother, you then
9 formed the view that the child who you knew well, should
10 be admitted and you effectively admitted the child and
11 then the notes reflect that: first of all, the nursing
12 note at 2 o'clock, and then the history given to
13 Dr Stevenson at about 5 o'clock.
14 A. Yes. I would suspect what I felt was that the child
15 needed to be seen with the thought of admission.
16 Because if the child was just to be admitted, I would
17 not need to see it; the telephone conversation would
18 have been enough.
19 THE CHAIRMAN: Sorry, it would or it would not?
20 A. It would. So if the mother had phoned me and I felt in
21 the telephone conversation there was enough information
22 in that for the child to be admitted, I wouldn't need to
23 see the child. If we had a bed, the child would be
24 admitted.
25 MR GREEN: Sir, could I just clarify please or ask that it

1 be clarified? This was a booked admission, of course,
2 and I wonder if it could be explored whether the child
3 could have been seen at Cupar Street earlier that day or
4 even at home?
5 THE CHAIRMAN: The child could not have been seen at
6 Cupar Street by you on the morning of the 22nd --
7 A. No.
8 THE CHAIRMAN: -- assuming that you were in the Children's
9 Hospital and not in Cupar Street?
10 The other suggestion being floated, to which we'd
11 like your response, is: is it possible that you might
12 have seen the child at home earlier?
13 A. No.
14 THE CHAIRMAN: Okay. So at some point on the morning of the
15 22nd, you believe you were phoned by the mother, the
16 information given to you is enough for you to say the
17 child needs to be admitted.
18 A. Seen.
19 THE CHAIRMAN: Well, the nursing note says, "Brought down to
20 Allen Ward for admission".
21 A. But Dr Stevenson says I'd already seen the child and
22 I wouldn't have needed to see the child if she just
23 needed admitted. The telephone conversation would have
24 been enough to confirm.
25 MS ANYADIKE-DANES: Dr Steen, that presumes a particular

1 interpretation of Dr Stevenson's note.
2 A. Yes.
3 Q. If we look at the admission sheet, the admission sheet,
4 002, records this child being admitted at 13.33.
5 A. Yes.
6 Q. And there is a reference, as the chairman has already
7 taken you to, to the mother having phoned you and you
8 telling the mother to bring the child down to the ward.
9 A. No. The reference says --
10 THE CHAIRMAN: No, that's not --
11 MS ANYADIKE-DANES: "Mum phoned Dr Steen this morning
12 concerning the problem. Brought to Allen Ward".
13 A. The child was brought to Allen Ward.
14 Q. Sorry. There is no record that you have actually seen
15 the child before that happens.
16 A. No, except for what Dr Stevenson wrote at --
17 Q. Just leave Dr Stevenson's note to one side for the
18 moment. There is no record in the nurse's note -- it's
19 not just that the mother has phoned you, but in addition
20 to the mother having phoned you, you've actually seen
21 the child. There's no reference to that at all.
22 A. No.
23 Q. All we have is that she has phoned you, and as a result
24 of that, one might assume, she has brought the child to
25 the ward and that action is recorded at 1.30.

1 A. Yes.
2 Q. The only other document in direct relation to that is
3 the admission sheet, which has the child admitted at
4 13.33.
5 A. Yes.
6 Q. Yes. So there is no actual reference to you having seen
7 the child before the child was admitted.
8 A. Leaving Dr Stevenson aside, yes.
9 Q. So in order for you to assert that you had seen the
10 child before the child was admitted, it depends upon
11 your particular construction of Dr Stevenson's note?
12 A. Yes.
13 Q. Although Dr Stevenson's note is timed at 5 o'clock, when
14 he refers, in the last two lines before we get into the
15 history bit of it, to:
16 "Seen by Dr Steen. Admit for further assessment and
17 management."
18 What in fact he is referring to then is a time when
19 you saw the child prior to admission to effectively
20 authorise and direct admission.
21 A. Yes.
22 Q. But it doesn't have to mean that?
23 A. No.
24 Q. No.
25 THE CHAIRMAN: And you say that you might have had enough

1 information from the phone call with the mother to admit
2 the child --
3 A. Yes.
4 THE CHAIRMAN: -- without seeing the child? But at the very
5 least, you would say that what this shows is that you
6 were contactable that morning --
7 A. Yes.
8 THE CHAIRMAN: -- and you had been contacted.
9 A. Yes.
10 THE CHAIRMAN: So wherever you were that morning exactly,
11 the mother of this child was able to contact you?
12 A. Yes.
13 THE CHAIRMAN: And you would then suggest, I assume, that if
14 the mother of a child was able to contact you, that
15 means that you should have been contactable by the
16 junior doctors who you were working with --
17 A. Yes.
18 THE CHAIRMAN: -- and/or Dr Webb?
19 A. Yes.
20 THE CHAIRMAN: Thank you.
21 MS ANYADIKE-DANES: Just finally, because it's something
22 that has been asked a number of times: if you had, as
23 you suggest, come down to see that child and therefore
24 authorise a child's admission, that wouldn't be a booked
25 admission, would it?

1 A. No. Can I take you back, I'm sorry, to patient 002 --
2 Q. Mm-hm.
3 A. -- which is the child who was admitted from Cupar Street
4 as an urgent admission?
5 Q. Yes.
6 A. Now, that was, "Seen at Cupar Street and advised
7 admission". It has been put in as a 4, as a planned
8 admission, as a booked admission, but it was only booked
9 in so much that somebody told the ward the child was
10 coming. I would suggest that this is the same, that
11 this child had been seen by myself and I told the ward
12 that the child would be coming in, so it was a booked
13 admission in that way.
14 Q. Well, this, if one looks at the letter of S2, is not
15 a matter of the child coming in to be examined and
16 therefore see whether the child should be admitted; this
17 child is to be admitted.
18 A. Yes.
19 Q. If one looks at 013 of Dr Livingstone's note, the
20 discussion led to admission. In other words, whatever
21 was the communication that accompanied this child, the
22 communication was: admit this child and these are the
23 reasons. Your explanation of what might have happened
24 with this particular patient, S7 -- in fact, I think you
25 corrected me when I suggested it -- is not that the

1 child had come down to the ward to be admitted, but the
2 child had come down to the ward to be examined by me and
3 decide whether the child should be admitted.
4 A. The child had come to RBHSC -- because we can't confirm
5 where I saw the child -- for an assessment to be made
6 and then whether she should be admitted or not.
7 Q. Exactly, which is not the same thing as a communication
8 saying the child is to be admitted. When you said,
9 "Wherever I saw the child", where else could you have
10 seen the child?
11 A. I could have seen the child in the Emergency Department,
12 I could have seen the child in one of the outpatient
13 rooms, I could have seen the child in the treatment room
14 on Allen Ward. There were various places that you could
15 bring a child up to be seen.
16 Q. But in any event, when the child is brought, it is not
17 with the certainty that the child would be admitted.
18 That's the whole purpose, according to you, of you
19 seeing the child.
20 A. Yes.
21 Q. So in that case, that's not the same situation as S2.
22 A. No. But it's also not the same as a child coming
23 through the A&E department, which -- it's a coding issue
24 about the 1, 2, 3, 4.
25 Q. Yes. But in any event, I think the chairman has the

1 point so let's go to S8.
2 MR QUINN: This also sounds as though Dr Steen is placing
3 herself in the Royal Belfast Hospital for Sick Children
4 at some time around lunch time on the 22nd. Has that
5 point been established?
6 THE CHAIRMAN: No, I think what I've taken from Dr Steen's
7 evidence about this child, S7, is that the minimum
8 position is that it is established that she was
9 contactable that morning.
10 MR QUINN: That's the minimum position?
11 THE CHAIRMAN: Yes. If a parent of a child could contact
12 Dr Steen, then it would seem odd if junior doctors or
13 nurses or other consultants could not contact her.
14 MR QUINN: Forgive me for saying so, Mr Chairman, but from
15 what I've heard, I've heard that Dr Steen sees this
16 child at the hospital. Because we've asked about home,
17 we've asked about the Cupar Street clinic, so the only
18 other place left is the hospital.
19 THE CHAIRMAN: That's right.
20 MR QUINN: Does that then establish, as a point of evidence,
21 that she's at the hospital at around lunchtime on the
22 22nd?
23 THE CHAIRMAN: I think the doctor said she is not there at
24 1.33.
25 MR QUINN: Yes.

1 THE CHAIRMAN: So you're quite sure you would not have been
2 there at 1.33 so far as you can --
3 A. I would have had to have been away by 1 o'clock at the
4 latest.
5 THE CHAIRMAN: Yes.
6 MR QUINN: What time would she have likely seen the child
7 then? That's the issue.
8 THE CHAIRMAN: The doctor said she would leave before -- she
9 would be away from the Children's Hospital by 1 to get
10 to Cupar Street or to be at Cupar Street. So if she saw
11 this child, depending how we interpret the notes at S7,
12 the child had to be seen before 1 o'clock.
13 MR QUINN: Then this begs the question as to why her senior
14 houseman and registrar were running around looking for
15 Dr Webb and where was Dr Steen --
16 THE CHAIRMAN: I know that.
17 MR McALINDEN: Mr Chairman, one further issue that I think
18 is important to raise at this stage in relation to this
19 patient and that is the timing of the admission that is
20 contained in the nursing records. You'll see at
21 150-007-005, the time of admission.
22 THE CHAIRMAN: What page are you on, Mr McAlinden?
23 MS ANYADIKE-DANES: 005.
24 MR McALINDEN: You'll see that the time of admission is
25 given as 7 pm.

1 A. Could I try to clarify that?
2 THE CHAIRMAN: If you could.
3 A. Yes. The nurses will be able to talk yourselves through
4 it themselves, but if you see the first note in the
5 nursings [sic] was at 2 pm. There is no doubt in the
6 afternoon of -- the Tuesday afternoon that the ward was
7 extremely busy and the staff were extremely busy. This
8 child was admitted under "S Spence" and was followed
9 through by "P Ellison", which suggests that this child
10 will also have been in room 7. And S Spence has noted
11 the first admission; the first note from her is 2 pm.
12 There then needs to be formal documentation of the
13 nursing admission, which is the other papers, as well as
14 the doctor's admission. And it may well be that because
15 the ward was busy, the formal documentation wasn't done
16 by Dr Stevenson until 5 pm and by Nurse Ellison before
17 she went off duty, which is why you have the 7.35.
18 MS ANYADIKE-DANES: On the other hand, doctor, is it
19 possible that actually three documents give us
20 a slightly different interpretation than you've placed
21 on them? If we start with 003 and that Dr Stevenson is
22 right in his note, that you do see the child round about
23 5 pm when you come back from Cupar Street in the way
24 that you have indicated that you might sometimes. This
25 is your patient, a long-standing patient, the mother has

1 already made contact with you, so maybe you do pass by
2 after Cupar. Since you actually can't remember it
3 anyway, maybe you do pass by after Cupar Street and see
4 the child at 5 and Dr Stevenson's note is entirely
5 correct and then what you're doing then is actually
6 confirming, as he records in his note, that this child
7 should be kept in for further assessment and management
8 and that that might fit -- by the time the nurses get
9 round to writing up that confirmation, that's what you
10 see at 005, at 7 pm, and then if one looks at 007, with
11 the note at 8 pm, "Seen by doctor, medication written
12 up". Maybe they're all of a piece and suggest
13 a contrary view that actually you did see the child, but
14 you didn't see the child until some time in or around
15 5 o'clock. That's possible, isn't it?
16 A. Unlikely, because then there's two errors. It means
17 Nurse Spence didn't get the correct time at 2 pm and it
18 also means the admission clerk did not get the correct
19 time at 13.33 for the admission.
20 Q. No, the 2 pm may be that the child actually did come in
21 and those things were done, but the note that
22 Dr Stevenson may be referring to is that the child is to
23 be kept in for those purposes after you have seen the
24 child and given that direction. So that doesn't mean
25 that 2 pm is incorrect reference, but what I'm saying

1 is that it is possible, is it not, that you saw this
2 child at 5 pm?
3 A. That would have meant I would have been back in the
4 Children's Hospital and, much as I would have liked to
5 have been back in the Children's Hospital and much --
6 and when I reflect, it would have helped the
7 situation -- I don't remember coming back to the
8 Children's Hospital. I would love that to be the
9 scenario, but I don't think it is.
10 Q. Precisely, but you don't know that you weren't.
11 A. I don't know --
12 Q. You don't know. With an anxious mother, possibly, who
13 you knew well, a child who was a long-standing patient
14 of yours, you don't know that you didn't actually come
15 back at 5 o'clock after your -- or even slightly
16 truncated your stint at Cupar Street to see that child.
17 You don't know that.
18 A. No, I don't.
19 Q. And that could be an explanation for the records being
20 as they are. It could be.
21 A. It could be.
22 Q. Thank you.
23 THE CHAIRMAN: Let's look at one more page that we haven't
24 looked at yet. Page 9, if you would, for a moment.
25 This is for the same child. There is a record there of

1 four different drugs at G, H, L and M, being
2 administered at 8.30 am on the 22nd. Are those drugs,
3 which would to be administered -- do you see where I am,
4 doctor?
5 MR QUINN: Sir, are you at S7 or S8?
6 THE CHAIRMAN: I'm at S7.
7 A. They were new pages, I think.
8 MR COUNSELL: Mr Chairman, I wonder if I can assist you.
9 I think we will hear evidence from the author of that
10 that when he records regular prescriptions, the 8.30 am
11 would be the following day rather than 8.30 on the 22nd.
12 THE CHAIRMAN: Say that again, Mr Counsell, it would be
13 what?
14 MR COUNSELL: If one looks at line G on this document, where
15 there is a tick against 8.30 am and this patient had
16 first been given the prescription later in the day, then
17 the 8.30 am is intended to denote the following day
18 because this is a chart which shows regular
19 prescriptions.
20 A. Could I take that a bit further? What the nurses do is,
21 when they've prescribed a drug on the next sheet, you
22 see the letter of the drug and the time it was given.
23 So this patient hasn't -- for the 22nd, has no drugs for
24 6, 8.30 am or 12 noon. We're on 010. However, 2.40 pm,
25 it is clearly written "P", and I think that's Nurse

1 Ellison. V, W and X were given, which was the
2 salbutamol, Atrovent and budesonide. So this child was
3 starting to get her medications in the ward from 2.40 in
4 the afternoon, which means the kardex must have been
5 written before 2.40 or else the nurses should not have
6 been administering.
7 THE CHAIRMAN: Right. Just pause for a moment. Mr Quinn,
8 do you have this now?
9 MR QUINN: [Inaudible: no microphone] this morning, so we do
10 have them.
11 THE CHAIRMAN: And do you have the point we are on?
12 Mr Fortune?
13 MR FORTUNE: In order for the nurses to administer the
14 drugs, the drugs must have been prescribed by one of the
15 junior doctors.
16 THE CHAIRMAN: Yes.
17 Let me just get this right, Dr Steen: there's
18 a suggestion advanced by Mr Counsell a few moments ago
19 about how the top half of that page should be
20 interpreted. Are you saying that the entry on the lower
21 half of the page under the second heading "Regular
22 prescriptions" indicates, through the initials of
23 a nurse and a doctor, that there was administration of
24 drugs to this child on the ward from about -- what time
25 did you say, 2.40?

1 A. 2.40 pm. It's written beneath the 12.30 slot. So by
2 2.40 pm, the drugs W, V and X must have been written up
3 for the nurses to be able to administer them.
4 MS ANYADIKE-DANES: Mr Chairman, you can see it at 010. The
5 way that works is that the alphabetical letter that's
6 assigned to the drug is then indicated under a time and
7 the date, and that indicates that it was actually --
8 well, I think from the evidence that indicates it was
9 given, and there is a signature there in a box.
10 THE CHAIRMAN: Okay.
11 A. It's actually ... I'm not sure how the kardex --
12 normally you write the kardex up in a certain time. So
13 I'd have expected all the regular prescriptions on
14 22 October to be done in a, you know, M, N, O, and we go
15 to the 23rd, 24th, 26th and then the 31st. So I don't
16 know why V, W and X are sitting at the bottom rather
17 than up with the rest of the drugs written on the 22nd,
18 but we do know from the signature in the administration
19 sheet, the recording sheet, that V, W and X were given
20 at 2.40 pm.
21 THE CHAIRMAN: Which means she has been admitted and she's
22 on the ward by that time?
23 A. She's on the ward and she has got her drugs written up,
24 the first set of drugs, by 2.40 pm.
25 MS ANYADIKE-DANES: And the signature, so that you see, on

1 009, in the main, certainly for the ones you're
2 referring to, V, W, X, are signed by Dr Stevenson.
3 A. Yes.
4 Q. And since his note is dated 5 pm, there's a potential
5 inconsistency there.
6 A. Um ... Busy ward. The nurses maybe wanted the drugs
7 written up to allow them to administer them while he
8 went on to do other things and he did his note
9 retrospectively. He may be able to help you.
10 Q. In any event, all of that having been said, none of that
11 points necessarily to where you were or at what time you
12 saw the patient?
13 A. No.
14 Q. Thank you. So S8.
15 MR FORTUNE: Before we leave that, perhaps my learned friend
16 might like to go back to this patient and 008 and the
17 discharge summary and ask Dr Steen whether the comments
18 are, in fact, in her writing. And if so, whether my
19 learned friend would like some assistance.
20 MS ANYADIKE-DANES: Are the comments in your writing,
21 Dr Steen?
22 A. Yes.
23 Q. Can you assist with what they say?
24 A. It doesn't photocopy particularly well:
25 "Admitted with feeding and respiratory problems.

1 Really cannot manage [I think it's] any oral feeds and
2 is dependent on tube feeds."
3 I think it's probably:
4 "Continue [or something] Pulmicort, Ventolin,
5 Atrovent, carbamazepine [maybe, I'm not sure], lactulose
6 and Senokot. Review arrangements as needed."
7 Q. Does this mean, although the mother had a concern about
8 her, that the child was not particularly seriously ill?
9 A. No, this mother was always right. If she brought her
10 child -- if she contacted us because her child was
11 unwell, her child was unwell, and that child actually
12 remained in hospital for --
13 Q. Until about 1 November.
14 A. Yes. So this mother knows -- she's a very complex
15 child, but this mother knows when her child is unwell.
16 Q. So she has brought the child in and you have seen the
17 child at some point?
18 A. Yes.
19 Q. Then if we go to S8, this child is admitted on
20 21 October. 11.05. You're on call?
21 A. I'm on call. I think --
22 Q. Can you just help with why it appears in the first
23 instance that the child is assigned to Dr Shields?
24 A. I think it probably is just an administrative error.
25 I suspect Dr Shields was on until 9 am on the Monday

1 morning. He would have been part of Musgrave Ward team,
2 and then I took over from 9 am. So I think it was
3 probably just an administrative error.
4 Q. Yes, that couple of hours --
5 A. They haven't looked at the rota and recognised the
6 change.
7 Q. So then if we go over the page to 003, one sees the
8 initial note at 12 noon, and then one sees "on
9 examination". One goes over the page and the note is
10 ultimately signed by Dr Stewart.
11 Then if you see on the next page, the 22nd:
12 "Ward round, Dr Sands".
13 A. Yes.
14 Q. And then that note seems to have been signed or is
15 signed by Dr Stewart. There's a query: home tomorrow.
16 A. Yes.
17 Q. And because this has been photocopied in colour, one can
18 more easily distinguish Dr Stewart's notation from
19 yours?
20 A. Yes.
21 Q. And in fact, your note appears alongside, in relation to
22 the last two lines of Dr Stewart's, and then the final
23 blank line, and that's your note there, is it, signed
24 with your initials HJS?
25 A. Yes.

1 Q. Can you help us with what that note is adding?

2 A. They were talking about moving the child on to inhalers

3 and I have noted that the child was on immediate dose

4 inhaler, which is a spray, which would be inappropriate

5 for this age group; it's very difficult to use. So I've

6 said that he needs to be moved on to one of the other

7 two types of inhalers, a spacer or a turbohaler, which

8 are easier to use. And I wanted him home, to be going

9 home on Pulmicort, 800 micrograms dose of it, twice

10 daily by a turbohaler, with Bricanyl, 1 to 4 clicks,

11 four-hourly PRN. So it basically is the plan to

12 transfer him on to a different set of inhalers prior to

13 discharge.

14 Q. So what you have done is that's been the note made

15 in relation to the ward round, and you've made some

16 commentary in relation to some parts of that?

17 A. Yes.

18 Q. Essentially, the plan?

19 A. Yes.

20 Q. So that would suggest that you weren't there during the

21 ward round, otherwise you wouldn't need to do that;

22 you'd have made that observation there and then and they

23 would have never queried the matters in that way?

24 A. Or when I was informed that this is what was written,

25 I changed --

1 Q. Yes, but let's start with the ward round. It suggests
2 that you probably weren't there in the ward round,
3 otherwise it wouldn't be written in that way?
4 A. Possibly, yes.
5 Q. Yes. Well, you would have expressed your view as to the
6 appropriateness or otherwise of the inhaler and the
7 change to the medication for going home --
8 A. Yes.
9 Q. -- and that would have all been incorporated in the note
10 and you wouldn't have had to have a correction in your
11 hand?
12 A. Yes.
13 Q. Because it would have never got that far?
14 A. Yes.
15 Q. So that suggests you weren't at that ward round.
16 A. No.
17 THE CHAIRMAN: But at some point after the ward round and
18 after those notes have been written up, you become aware
19 of what has been discussed and projected and, however
20 that comes about, you intervene to adapt it or improve
21 it?
22 A. Yes.
23 MS ANYADIKE-DANES: And do you know, Dr Steen, how it is
24 that you would have been -- and the next note, I should
25 say for completeness, is dated 23 October and is the

1 note that Dr Stevenson takes of a ward round it seems
2 that he took.
3 A. Yes.
4 Q. So there's nothing in between. Can you help with how
5 it is that you would have become aware or had your
6 attention drawn to the medical notes and records of this
7 child?
8 A. I have no recollection. I can only go by what my normal
9 processes would have been.
10 Q. Yes.
11 A. And before I would have left the hospital to go to
12 Cupar Street, I at some stage would have checked what's
13 happening. It might have been a verbal rundown, who's
14 on the ward, what have we done, what needs to be done,
15 et cetera. I can only assume it came to light in that
16 way.
17 THE CHAIRMAN: Did it not come to light the next day?
18 A. Well, I wasn't in the ward the next day and it's written
19 in for the 22nd.
20 THE CHAIRMAN: Yes, but you were back in the hospital
21 because of what happened to Claire on the 23rd.
22 A. But I'm not sure I was on the ward.
23 THE CHAIRMAN: Okay.
24 A. And I'm not sure, if we look at the kardex, whether --
25 MS ANYADIKE-DANES: We'll come to the kardex in a minute.

1 A. One of the drugs is written up for the 22nd.
2 THE CHAIRMAN: But on your explanation, this does seem
3 curious, because it means that you are alerted to the
4 condition of this child.
5 A. Yes.
6 THE CHAIRMAN: And you intervene helpfully and make an
7 improved suggestion about how that child might be
8 treated and discharged home. But again, if that's
9 right, since we are talking about how the child will go
10 home and what type of medication the child will be going
11 home on, in the hierarchy of seriousness this child is
12 not as serious as Claire.
13 A. Yes.
14 THE CHAIRMAN: So if your best guess about how this note
15 comes to be made is correct, it becomes the second time
16 from these records that you have intervened in a child
17 who you didn't see on a ward round and made suggestions,
18 but still have no intervention with Claire.
19 A. It may be that I knew what was happening with Claire and
20 was content with what Dr Sands had written, whereas
21 I was not content with what was written here.
22 MS ANYADIKE-DANES: Sorry, Dr Steen, I think you've already
23 said if you had seen the medical notes or the note
24 that is made of the ward round about Claire and had
25 appreciated that was her condition, those were the

1 concerns, you would have wanted to see her. You have
2 already given that evidence.
3 A. Yes.
4 Q. And then I think just before the chairman was asking you
5 some questions, you had indicated that your normal
6 practice is that before you left for Cupar Street, you'd
7 want to take a sense of what was going on, what were we
8 doing with these children. So if that had been your
9 query and that is what you would have done, then what is
10 the explanation for how you did not come to see Claire's
11 medical notes and records, did not come to note,
12 therefore, what was being recorded in relation to Claire
13 and appreciate how seriously ill a child you might have
14 on that ward, and therefore make your business to go and
15 see her before you left Cupar Street -- for Cupar
16 Street?
17 A. I can only assume that whatever I was informed by
18 Dr Sands -- and again it's not documented -- was what
19 I felt appropriate.
20 THE CHAIRMAN: Sorry, as an absolute minimum Dr Sands would
21 have been telling you that he was going to engage
22 Dr Webb?
23 A. Yes.
24 THE CHAIRMAN: But if he was going to engage Dr Webb, would
25 that in itself not indicate to you, "There's something

1 to be worried about here because we have a child whose
2 condition is not improving and I'm bringing in
3 a sub-specialty"?
4 A. And that would explain why I telephoned at 5 o'clock-ish
5 after the --
6 THE CHAIRMAN: Yes, that might explain why you telephoned at
7 5 o'clock, but surely that would ring more warning bells
8 in your brain than, "What's going on?", what sort of
9 inhaler a child might be discharged home with?
10 A. I don't know what I was told that morning. These are
11 the routine admissions that need things tidied up.
12 MS ANYADIKE-DANES: Sorry, Dr Steen, forget about what you
13 might have been told. What I was pressing you on is
14 what you would have read if you had looked at the note,
15 in the same way as you've clearly seen this note because
16 you have made a comment alongside it. If you had seen
17 Claire's note, quite apart from anything else that
18 Dr Sands might have told you, you would have seen that
19 this is a child who has been on IV fluids, prior to that
20 her serum sodium levels were low; you would have noted
21 that she's pale in colour, there's little response
22 compared to normal -- I'm reading from 090-022-053 --
23 that there was a CNS carried out, her pupils are
24 sluggish to light, difficult to see the fundi. You
25 would have seen all of that, and the impression

1 is: non-fitting status. And, depending on where you saw
2 it, you might have seen added, "query
3 encephalitis/encephalopathy". And you would have seen
4 that the plan was to get her started on rectal diazepam,
5 contact Dr Webb, and find out what the previous medical
6 history is. And you indicated yesterday that had you
7 seen or been told all of that, that's a child you would
8 have wanted to see.
9 A. We don't know when I saw this child, we don't know the
10 timing of the ward round. We know we saw this child at
11 some stage on the Tuesday morning. When Dr Sands made
12 his note, I think was probably about 12 o'clock.
13 I don't know whether I read Dr Sands' note because I'm
14 unsure what was happening for the rest of that morning.
15 Q. Sorry, which child are you now saying you saw?
16 A. 005. And the other child -- sorry, 008.
17 THE CHAIRMAN: We're talking about S8.
18 MS ANYADIKE-DANES: But that doesn't indicate that you saw
19 the child.
20 A. I must have been in the ward.
21 Q. Yes, but that's a different matter.
22 A. Yes.
23 Q. This doesn't indicate that you saw the child at all.
24 A. And there was the child with the nebulised treatment
25 that the nurses record I saw.

1 Q. Yes.
2 A. We don't know what time I saw those children at or what
3 time I intervened.
4 Q. The simple point being, Dr Steen, is that your evidence
5 is, before you go to Cupar Street, you try and get an
6 understanding of who's on the ward and what's happening
7 with them.
8 A. That's correct.
9 Q. Exactly. Now, unless Dr Sands was going to give you
10 information that departed very much from what is
11 recorded in Claire's medical notes and records, if he
12 had told you that, your evidence has already been that
13 you would have wanted to see Claire. So either he
14 didn't tell you that for some reason, he told you
15 something much more reassuring than is recorded in that
16 note, or you didn't have a very effective system for
17 finding out who was on the ward and what their condition
18 is?
19 A. I don't have any recollection. Dr Sands may be able to
20 help further, but I ... I can't answer that. I can
21 only tell you what is due process because I've no
22 recollection.
23 Q. Then if we carry on with S8 and let's see what the
24 nurses say. Their note starts at 009. 11.40 is the
25 history that the mother gives. Then 11.40 am, "Seen by

1 doctor on admission", observations and so on. Then 2 to
2 8. Then the 22nd in the morning:
3 "Ventolin nebuliser on medicine round last night and
4 again at 2 am. 8 am to 8 pm, no audible wheezing.
5 Nebuliser PRN. Observation satisfactory."
6 Then 2 pm to 8, there is no reference to you there.
7 A. No.
8 Q. No. Well, let's look at the kardex that you thought
9 might have assisted. I think your initials refer to the
10 Pulmicort and the Bricanyl; is that right?
11 A. Yes.
12 Q. And so then let's look at the prescription, which is
13 008-006. There you see the Bricanyl. That's K.
14 A. Yes.
15 Q. That is the 23rd.
16 A. Yes.
17 Q. So it is not actually prescribed the next day?
18 A. No.
19 Q. And then we see L, the 22nd. That's Pulmicort?
20 A. Yes.
21 Q. That is signed off by Dr Stevenson. I am not quite sure
22 who the signature is -- maybe it was Dr Stewart, I don't
23 know -- for the 23rd. If we look at the kardex, so what
24 we're looking for is K and L; is that correct?
25 A. Yes.

1 Q. If we look at ... You are more familiar in reading and
2 interpreting this --
3 A. Yes, there's no indication that K was given. K was
4 written up -- or L was written up for the 22nd at 9.30.
5 So the second line down, H was given at 9.30, but L
6 wasn't given. I don't know what H is.
7 Q. In any event, to assist you in answering the chairman's
8 question, which is when you wrote that addition in, if
9 one was trying to correlate that or trying to understand
10 that from looking at when the prescriptions were
11 actually written up, you don't necessarily get a time
12 that has you being involved during the morning on
13 22 October.
14 A. No, but the Pulmicort is written up on the 22nd.
15 Q. Yes, but there's no time for it.
16 A. No.
17 Q. No. So you can't tell from this that that is a response
18 to an involvement that you had on the morning of the
19 22nd?
20 A. No, just on the day of the 22nd.
21 Q. Just on the day of the 22nd? Exactly. Maybe something
22 else at 5 pm.
23 Then if we go to S9 --
24 MR GREEN: Sorry, before we do that, if we go back to
25 150-008-006, please. We can see that under the column

1 "date commenced", at line K, it says:

2 "23/10. Bricanyl."

3 So the Bricanyl was commenced, it would appear from

4 that, on the 23rd. That's followed for some reason by

5 the Pulmicort, saying, "Date commenced 22nd.

6 But then if we go back to the page where Dr Steen's

7 entry is, that's page 005, there is a reference to

8 Pulmicort and Bricanyl. It just might appear to some to

9 be somewhat curious that if this addition was made on

10 the 22nd at all, that the Bricanyl wasn't commenced

11 until the 23rd.

12 THE CHAIRMAN: Do you see the point, doctor? Can you help

13 us with that?

14 A. When you have an acutely wheezy child, you start with --

15 well, if you have to give nebulisers, which are driven

16 by oxygen from the wall, then you step down your

17 treatment prior to them going home. So your first step

18 down is to go to -- well, either four-hourly through

19 what's called a spacer or a turbohaler or something like

20 that. I don't know what -- we have redacted the first

21 two drugs on the drug kardex. The one was stopped on

22 the 22nd. We know on the 22nd that the salbutamol

23 nebulisers -- which may have been regularly done,

24 I don't know -- were then changed as needed. But

25 I don't know if there was anything else written in.

1 MS ANYADIKE-DANES: Dr Steen, could it simply have been an
2 error and the 23rd is actually the right date, the two
3 things were indicated to you at the same time and the
4 dates follow, 21st, 22nd, 23rd, and really Pulmicort
5 should have been the 23rd as well?
6 A. No, I think it's different, different hands, different
7 people have written.
8 Q. Sorry, bear with me, so if the 23rd is the correct date
9 for the Bricanyl, it seems odd after that is written in
10 to be putting in the 22nd for the Pulmicort?
11 A. But that's what's written in.
12 Q. Yes. In any event, none of that really assists with
13 actually when you made that notation.
14 A. No. Except I wasn't in the ward on the 23rd.
15 MR GREEN: I'm sorry, I don't quite understand that answer
16 as yet, because there is, on the face of it, a reference
17 to the Bricanyl being prescribed or commenced on the
18 23rd. That's also consistent with the kardex, and yet
19 it's referred to in a note, which is dated originally by
20 Dr Stevenson on page 5 on the 22nd. It may just be
21 me -- and I'm sure, Mr Chairman, you'll tell me if it
22 is -- but I don't really understand to what extent
23 Dr Steen has assisted the inquiry on this point.
24 THE CHAIRMAN: I think the point is that the notes do not
25 read terribly coherently. I am not sure if we are going

1 to do any better than that, Mr Green. It is yet another
2 example of what the doctor herself has described as
3 terrible record keeping, or it may be another example of
4 that. But the notes do not read coherently and a lot of
5 this is going to come down to my best effort to
6 interpret what is in these records.
7 MR GREEN: If I can put it another way? I'm just wondering
8 if Dr Steen can deal with the possibility that in fact
9 the Bricanyl wasn't commenced until the 23rd and
10 therefore the reference to it on page 5 is in fact
11 something that she has added to the note of the 22nd,
12 but on the 23rd.
13 THE CHAIRMAN: But the doctor said --
14 MR FORTUNE: Was Bricanyl in fact administered on the 23rd
15 if you look at the kardex? You're looking for letter K.
16 MR GREEN: If I may assist Mr Fortune --
17 MS ANYADIKE-DANES: The bottom line, just alongside 96. It
18 looks like a K at 8.30.
19 MR FORTUNE: Well, is that a K?
20 THE CHAIRMAN: Do you see this, doctor, on page 12 on this
21 tab, if you look at it?
22 A. Yes. It certainly looks like a K, doesn't it?
23 MS ANYADIKE-DANES: Yes.
24 A. I don't know what E is. That's the only other thing
25 I could suggest. It is not an L. Then there's -- at

1 12.30, it looks like a K as well. There's no L, so
2 there's no Pulmicort.
3 MR GREEN: If I may assist? If one moves along that row to
4 under the 12, at 12.30, we see what appears to be an L.
5 THE CHAIRMAN: Yes.
6 A. Or a K.
7 MR GREEN: Again, either way, it's on the 23rd.
8 A. But I wasn't in the ward on the 23rd.
9 THE CHAIRMAN: Well, that's the doctor's best answer,
10 Mr Green. Although she was in the hospital, because of
11 issues to do with Claire early in the morning of the
12 23rd and then later on, she doesn't believe she was on
13 the ward.
14 MR GREEN: Thank you, sir.
15 THE CHAIRMAN: That makes her doubt whether that entry on
16 page 5 was written by her on the 23rd. It makes the
17 doctor say that she believes it must have been written
18 on the 22nd. What is really being probed is whether,
19 doctor, it was written before you went to Cupar Street
20 or at some later point when you came back from
21 Cupar Street, maybe around 5 o'clock, but that would
22 only increase the mystery of why you intervened with
23 this child, sorting out the better type of way for that
24 child to get inhalers for asthma at 5 o'clock rather
25 than seeing to Claire.

1 A. Yes. And I've never had an instinct that I came back to
2 the hospital at 5. I've never felt that. I don't --
3 there's no evidence, but ...
4 MS ANYADIKE-DANES: The problem is, without getting into
5 your instincts and so forth, you actually can't
6 remember.
7 A. No, I can't.
8 Q. So it would be better to stick with that.
9 THE CHAIRMAN: Sorry, that's not quite fair on the doctor,
10 Ms Anyadike-Danes, because if she just said, "We'll
11 stick with I don't remember", then a lot of the
12 questioning this morning wouldn't have taken place.
13 MS ANYADIKE-DANES: Sorry, I didn't mean it in that way.
14 I meant it in terms of instincts and so forth.
15 THE CHAIRMAN: Let's move on.
16 MS ANYADIKE-DANES: There is one point which I want to see
17 if we can clarify, which is your presence in the
18 hospital on the 23rd. Do you remember your actual
19 movements in the Children's Hospital on the morning of
20 the 23rd?
21 A. No.
22 Q. You were there because you responded to a call, you saw
23 Claire in PICU and you were there for some time,
24 presumably.
25 A. Yes.

1 Q. Can you say with any degree of certainty that you didn't
2 go on to the ward?
3 A. No. But if I'd gone on the ward, it would have to have
4 been before, say, 8.30 in the morning.
5 Q. Why is that?
6 A. I would have had to be in a clinic in the community by
7 9 am and I would have been out of the hospital from 9
8 until 5-ish.
9 Q. But you could have gone on to the ward. In fact, you
10 might have wanted to go there since what you would have
11 known at that stage was that a very terrible thing had
12 happened in relation to Claire. You might have wanted
13 to go on the ward and just see how people were, what
14 people knew, anything of that sort, to check on your
15 other patients. There might be any number of reasons
16 why you might have taken the opportunity given that you
17 were actually in the hospital to go on the ward.
18 A. If we take that, then anything's possible.
19 Q. Yes. So you can't rule that out?
20 A. No.
21 Q. Thank you.
22 THE CHAIRMAN: To be able to say "I can't rule something out
23 because there's so many things that can't be ruled out"
24 doesn't particularly help.
25 A. No.

1 THE CHAIRMAN: Let's try and get S9 done before the break.
2 MS ANYADIKE-DANES: I think we were about to go on to S9.
3 S9 is a patient who is admitted on 22 October in the
4 early hours of the morning to Musgrave Ward and admitted
5 in your name as a consultant.
6 Then if we go to 003, we see the age of the patient,
7 and this is the first note at 3.20 in the afternoon.
8 That, I think, must be in the morning.
9 MR FORTUNE: It must be in the morning.
10 MS ANYADIKE-DANES: If we carry on through what is redacted
11 over the page, we'll see that it is signed. There's
12 a plan there of close observations signed by
13 Dr Volprecht.
14 Then if we go over to 005, one sees the ward round
15 on 22 October is taken by Dr Sands. The note of it is
16 signed by Dr Stevenson and there's a plan, and there is
17 no reference to you in any of that.
18 A. No.
19 Q. Just in ease of Mr Fortune's comment -- and I think this
20 must be right because if you look at 006, when it says,
21 "Date and time", it says, "2.30 am". If one looks on
22 in the nurse's note at 007, there you have the
23 description of what is happening. Then 8 am to
24 12 midday, the observations. At that stage:
25 "Awaiting to be seen by medical staff. Query home."

1 At 2 pm:
2 "Seen by doctor from Allen Ward for discharge home.
3 Advice given to mother."
4 Which, if we just go back to 005, that seems to
5 accord with the plan.
6 A. Yes.
7 Q. But there is nothing in there that refers to you; that's
8 correct, isn't it?
9 A. Yes.
10 Q. And if we see on the discharge summary, 008, this child
11 is admitted in the early hours of the 22nd, discharged
12 on the 22nd, signed off by Dr Stevenson. So this is
13 another of those children who comes in and out, and
14 there is no reference to you at all --
15 A. No.
16 Q. -- although it's your patient.
17 A. Yes.
18 MS ANYADIKE-DANES: Mr Chairman, those are the patients that
19 were Dr Steen's patients. As Dr Steen was describing
20 yesterday, she was on call and expected to be contacted
21 if consultant guidance was necessary for any of the
22 other consultants' patients. I'm not going to go
23 through those in that detail, but the ones that we have
24 that were on the ward at the relevant time -- I think
25 there are two patients of Dr Webb's, I think there's one

1 of Dr Hill's and one of Dr Reid's and, I believe, five
2 of Dr Redmond's. I have been through them all -- and
3 I'm sure the other counsel here have -- and I can't see
4 any reference at all to you being involved or contacted
5 in relation to any of them.
6 A. No.
7 Q. And you would accept that?
8 A. Yes.
9 Q. And there are notes of ward rounds that were being done.
10 Some of those ward rounds were done by the junior
11 paediatric staff. But nonetheless, there is no
12 reference to you. Some of them are done by the
13 consultants themselves. Dr Redmond seems to do her own
14 ward rounds.
15 A. It was the cystic fibrosis multidisciplinary team grand
16 round at 11 o'clock on a Tuesday. We normally would
17 have had the ward round done and then we would all have
18 been to it. And that is why you have the five AR
19 patients where there's a different doctor noting what
20 happened on the round.
21 Q. Yes. But that having been said, the ward rounds that
22 weren't being carried out by Dr Redmond, but related to
23 those other consultants' patients, you're not involved
24 in those.
25 A. No.

1 Q. Nor is your guidance apparent in anything that happens
2 there.
3 A. Yes.
4 MS ANYADIKE-DANES: Thank you very much indeed.
5 THE CHAIRMAN: We will leave it for this morning. Can you
6 come back tomorrow morning at 10 o'clock again?
7 A. Until Christmas.
8 THE CHAIRMAN: Thank you. We'll resume at 2 o'clock with
9 Dr Stevenson.
10 (1.00 pm)
11 (The Short Adjournment)
12 (2.00 pm)
13 (Delay in proceedings)
14 (2.08 pm)
15 DR THOMAS ROGER STEVENSON (continued)
16 Questions from MS ANYADIKE-DANES (continued)
17 MS ANYADIKE-DANES: Good afternoon, Dr Stevenson. Can I ask
18 you: were you here during the evidence that was being
19 given this morning by Dr Steen?
20 A. Yes, I was.
21 Q. The reason I ask you that is because a number of things
22 were said about some medical notes and records, and
23 I would like to take you to the ones that affect you
24 directly in relation to Dr Stevenson's patients.
25 A. Dr Steen's?

1 Q. Sorry, Dr Steen's patients. If we can go to S4. If
2 you have the file there, you'll need to look at 004-005.
3 That's the actual page, but just to familiarise yourself
4 with it, the admission sheet appears on 002. Do you see
5 that, the admission sheet?
6 A. Yes.
7 Q. Then because that child comes in on the 21st, there are
8 entries in relation to that on the 21st, and then we get
9 to your entry, which is on 005.
10 A. Yes.
11 Q. You note the ward round by Dr Sands. The first thing
12 I want to ask you is: do you have any recollection of
13 any of this?
14 A. No.
15 Q. Okay. So is this as present or absent from your mind as
16 your recollection of Claire?
17 A. Yes.
18 Q. You have no better or worse recollection of any of these
19 other children?
20 A. Yes.
21 Q. Do I take it therefore that you're as good as your note
22 and as good as what you recall your practice was likely
23 to have been in 1996?
24 A. That's true.
25 Q. Thank you. If you see there what you record and you

1 sign it, and then if we go to page 007. You can see
2 that's the nurse's entry.
3 A. Yes.
4 Q. That's an entry that's written in relation to the 8 am
5 to 2 pm slot, if I can put it that way, or shift. About
6 halfway down that, slightly more, you see:
7 "Seen by Dr Steen. To continue regular nebulisers
8 today and steroids."
9 Do you see that?
10 A. Yes.
11 Q. Were you aware of -- well, you have no memory, so let me
12 put it another way. Did it sometimes happen that you
13 had done your ward round or you had accompanied the
14 registrar, whomsoever it was doing the ward round, taken
15 your note and at some other time the consultant might
16 see a child, with you not present, if I can put it that
17 way?
18 A. That could happen, yes.
19 Q. That could happen?
20 A. Yes.
21 Q. If that did happen, what normally happened about
22 recording such a fact?
23 A. Well, that would possibly have been referred to me if
24 there was a change in management or there was a change
25 of treatment that needed to be written up or bloods had

1 to be taken following on from that consultant's visit.
2 Q. If that was the case, how would you indicate, if you
3 would do it at all, that that resulted from an
4 examination by the consultant?
5 A. My practice at that stage, as best as I can recall,
6 would be "seen by" or "SB" the relevant consultant,
7 Dr Steen, Dr Hill.
8 Q. And then you would note whatever you had to do?
9 A. Whatever the changes that were recommended or advised by
10 that consultant.
11 Q. And anybody reading that thereafter would appreciate not
12 only was there a change, but that change was effectively
13 being authorised by whomsoever is the named doctor?
14 A. Yes.
15 Q. And then you'd sign that?
16 A. Yes.
17 Q. So that's what you think your practice would have been.
18 A. Yes.
19 Q. If it didn't result in anything that you had to do, so
20 you had to be alive to it, so let's say a consultant had
21 seen the child, you're not present, you're off doing
22 other things, then what would you expect to happen about
23 recording the fact, if it's done at all, that the
24 consultant had seen the child?
25 A. In this example, the nurses would record it in their

1 nursing notes.

2 Q. And does the consultant put any record themselves as

3 to --

4 A. Well, yes. Yes, certainly consultants would write in

5 their own notes.

6 Q. Certainly?

7 A. That's dependent on the individual consultant --

8 Q. Yes.

9 A. -- and their own practice.

10 Q. In your experience, what would the consultant do

11 typically?

12 A. Typically, most consultants ... It's hard to quantify

13 exactly what every consultant would do. But most

14 consultants would write in their notes or, if not, they

15 would refer to you to write in their notes on their

16 behalf.

17 Q. So there'd be some sort of record of the fact that the

18 consultant had seen the child?

19 A. Yes.

20 Q. Is that what you would regard as good practice?

21 A. Yes.

22 THE CHAIRMAN: Was that current practice in 1996?

23 A. It would be in my experience at that time.

24 THE CHAIRMAN: Okay.

25 MS ANYADIKE-DANES: Thank you.

1 So if then we can go to S7 because I think the other
2 child that you're involved in, if I can put it that
3 way -- if you look at 007-002, that's the admission
4 sheet, just to locate you.
5 A. Yes.
6 Q. The child is admitted on the 22nd, timed at 13.33. Then
7 you see over the page is your note.
8 A. Yes.
9 Q. And that's timed on the 22nd at 5 pm.
10 A. Yes.
11 Q. "Medical SHO." That's you, is it?
12 A. It is.
13 Q. So you're seeing the child?
14 A. It would indicate that, yes.
15 Q. And then you refer to it being a recent admission and so
16 on. And then you write down in the last two lines:
17 "Seen by Dr Steen. Admit for further assessment and
18 management."
19 Doing the best you can -- and if you really can't
20 help, then please say so -- how do you interpret that
21 note of yours?
22 A. To the best of my memory, it would indicate that
23 Dr Steen had been involved in that child prior to the
24 child coming on to the ward.
25 Q. Well, let's go to the other reference that we have,

1 which might help.
2 THE CHAIRMAN: I think actually we can do this quite
3 directly because you'll have heard the evidence this
4 morning, and the question is: does that mean that you
5 knew that Dr Steen had seen the child or, as Dr Steen
6 suggested, this would be part of the mother's history,
7 that Dr Steen had seen the child?
8 A. To the best of my memory, this is the history obtained
9 from the child's parent.
10 THE CHAIRMAN: So do you agree, insofar as you can
11 reconstruct this from 1996, that the way in which this
12 note is written means that the parent told you -- and
13 you recorded -- that Dr Steen had seen her child?
14 A. Yes, to the best of my memory, according to that record.
15 MS ANYADIKE-DANES: And does the timing of that note mean
16 the first time you were able to get to see the child was
17 5 pm?
18 A. Yes.
19 Q. Or that whenever it was you saw it, your note of when
20 you --
21 A. Was made at 5 pm.
22 Q. Does it necessarily mean that you saw the child at 5 pm?
23 A. It's more likely that it was at 5 pm that I actually saw
24 this child.
25 THE CHAIRMAN: Because it would be hard -- if you saw that

1 child at, say, 2.30 or 3 --
2 A. And then to recall what the history indicated in the
3 notes --
4 THE CHAIRMAN: It'd be very hard, wouldn't it?
5 A. Well, two, three hours later, amongst what else was
6 going on that day would have been difficult.
7 MS ANYADIKE-DANES: Thank you. There's just one last one in
8 this set of patients' medical notes and records.
9 That relates to S8. Once again, if you look at 008-002,
10 that's the admission sheet. That tells you the child
11 comes in on the 21st at 11.05. And then the intervening
12 pages are the initial notes. If you then go to 005,
13 you will see a ward round note, which is taken by
14 Dr Stewart, who was an SHO who was with you on duty that
15 day; is that right? Are you at 008-005?
16 A. Sorry, that's the next child.
17 Q. I'm so sorry, it's S8.
18 A. Yes.
19 Q. Do you see that?
20 A. I do.
21 Q. Okay. So then if you see at the top left-hand corner,
22 that's the 22 October:
23 "Ward round, Dr Sands. Well today [et cetera]."
24 Do you see that?
25 A. Yes, I do.

1 Q. That appears to be a note taken by Dr Stewart.
2 A. That's true.
3 Q. Do you know anything about the notation by Dr Steen that
4 she has initialled in relation to the child's treatment?
5 A. No.
6 Q. And if that's a note that Dr Stewart made, is it likely
7 that you wouldn't have had anything further to do with
8 that child unless you yourself made a note?
9 A. Yes.
10 Q. Thank you very much indeed.
11 In fact, it is your note on the 23rd; isn't that
12 right?
13 A. Yes, that's right.
14 Q. Yes. So you do -- and it says, "Ward round". It looks
15 like it says "Dr Sands" underneath and it seems to be
16 corrected to say "Dr Stevenson"; is that right?
17 A. That's true, yes.
18 Q. So that's your ward round?
19 A. It would be, yes.
20 Q. And would you have been looking at the previous note?
21 Would it have been part of what you would do in
22 preparation to see whether any of what had been
23 prescribed before had actually been carried out; is that
24 part of what you'd be looking at before a ward round?
25 A. Yes, it could be because there could be a change in the

1 treatment plan based on previous notes or entries,
2 sorry.
3 Q. Because you don't recall this in the way you said you
4 don't recall anything really, so you can't help us with
5 when Dr Steen might have added her notation, but if you
6 go over the page --
7 THE CHAIRMAN: Just pause there. What Dr Steen appears to
8 have done is added to the note of the 22nd October in
9 two respects. One is by identifying a specific type of
10 inhaler --
11 A. Yes.
12 THE CHAIRMAN: -- which is preferable for this child, and
13 the second is by then adding Pulmicort.
14 A. Yes.
15 THE CHAIRMAN: Your note on the 23rd refers specifically to
16 the turbohaler and Pulmicort, doesn't it?
17 A. Yes, it does.
18 THE CHAIRMAN: Piecing it together as best we can and
19 realising that none of this is perfect, would that
20 support an interpretation that Dr Steen's addition to
21 the note above was there when you came to do your plan,
22 and that's where you got the turbohaler and Pulmicort
23 from?
24 A. It could be, yes.
25 THE CHAIRMAN: Is it likely to be, do you think, or not?

1 A. It would be likely because the consultant has come and
2 written a note, and therefore at my level of experience
3 I wouldn't have queried that and I would have followed
4 on from that.
5 THE CHAIRMAN: That's what I'm thinking. Let's suppose by
6 the time you did the ward round on the 23rd that
7 Dr Steen hadn't added the bits on the top half of the
8 page about the turbohaler and Pulmicort.
9 A. Yes.
10 THE CHAIRMAN: There wouldn't be anything in the top half of
11 the page to guide you --
12 A. No.
13 THE CHAIRMAN: -- on either of those, sure there isn't.
14 A. That's true, yes.
15 THE CHAIRMAN: For you to come up with turbohaler and
16 Pulmicort, given your limited paediatric experience,
17 would be unlikely?
18 A. It would be unlikely, yes.
19 MS ANYADIKE-DANES: Just following on, that means whenever
20 it was put on, it was put on perhaps some time between
21 the end of the ward round on the 22nd and the start of
22 the ward round on the 23rd.
23 A. Yes.
24 Q. If the plan had come from a discussion that you had had
25 with Dr Steen because nothing was written down there

1 more detailed from the 22nd, then is that something that
2 you would have noted?
3 A. Yes, again, like my practice would have been "seen by"
4 or "discussed with".
5 Q. Yes. "D/W" or something?
6 A. Yes.
7 Q. So that would have identified where you got that
8 prescription from --
9 A. Yes, that's right.
10 Q. -- if I can put it that way? And then if one goes over
11 the page to 006, you see that the Bricanyl, which is
12 something that is in the earlier part added by Dr Steen,
13 "1 to 4 clicks, four-hourly", you can see that the
14 Bricanyl is K and the date -- not your date -- is the
15 23rd. And then the Pulmicort and so forth is L, the
16 22nd, and that's your signature.
17 A. It is.
18 Q. For you to be signing that as a regular prescription on
19 the 22nd, does that mean you saw that child on the 22nd?
20 A. It would indicate that, yes.
21 Q. And if you saw that child on the 22nd, wouldn't you have
22 added that to your note or made a note to that effect?
23 A. Not necessarily, because it was a change in the
24 medication, but it would have been better if I had made
25 a note to indicate that I had amended and changed the

1 prescription.

2 Q. Well, could you have made that amendment to the

3 prescription on the 22nd without seeing the child?

4 A. It could have been because it could have been

5 highlighted by a nurse to change the medication, you

6 know, if a consultant had seen that child.

7 Q. And if that's what you're doing on the 22nd, why would

8 you put an entry of the 22nd that seems to follow an

9 entry of the 23rd?

10 A. It could be an error on my part to write down the 22nd

11 instead of the 23rd.

12 Q. So you could have been doing that on the 23rd actually?

13 A. Yes, that's another possibility.

14 Q. And the 22nd is just the wrong dating and you mean the

15 23rd?

16 A. Yes.

17 MR FORTUNE: While we're considering possibilities, could

18 Dr Stevenson actually have seen the entry made by

19 Dr Steen on the 22nd and indeed have correctly entered

20 the prescription for the 22nd, albeit after Dr Stewart's

21 entry being dated the 23rd? Because we're dealing in

22 possibilities.

23 MS ANYADIKE-DANES: We are.

24 THE CHAIRMAN: Yes, that's if Dr Steen saw this patient on

25 the 22nd, which is an unknown.

1 MR FORTUNE: It's the same problem --
2 THE CHAIRMAN: It is.
3 MR FORTUNE: -- with the prescription chart, sir.
4 MS ANYADIKE-DANES: Thank you.
5 If we can go back to where we were with your
6 evidence yesterday. I had been asking you about
7 phenytoin --
8 A. Yes.
9 Q. -- you may recall.
10 One of the questions that I wanted to ask you is not
11 specifically about phenytoin, but about whether at that
12 time a cardiac monitor was running in situ during the
13 infusion.
14 A. I'm unable to remember that.
15 Q. Well, Dr Webb in his witness statement at 138/1,
16 page 23, in answer to question 16(f), which we don't
17 need to pull up, says that it would be routine practice.
18 And here's one that I will pull up. That's Dr Aronson,
19 who's the inquiry's expert, 237-002-012 at (r). The
20 question he's being asked is to comment on whether an
21 EEG, a heart rate monitor, should be required
22 before/following the administration of IV phenytoin
23 in October 1996. And he says in relation to the heart
24 rate monitor:
25 "During the intravenous administration of phenytoin,

1 continuous monitoring of the electrocardiogram is
2 essential."
3 Were you aware of that?
4 A. At my level of experience at that time, I'm not certain.
5 Q. Well, I think the nurses record that it's being
6 monitored in the afternoon. The cardiac monitor is at
7 2300 hours if we go to 090-040-138. So there you see it
8 at 11:
9 "IV phenytoin erected by doctor and one over one
10 hour. Cardiac monitor in situ throughout infusion."
11 So it is at 11 pm. But in fact you have phenytoin
12 being administered before then, in the afternoon.
13 A. Yes.
14 Q. So is there any reason why you would not have done what
15 Dr Aronson says is essential and what was done later on,
16 which is to ensure that there was a cardiac monitor in
17 situ?
18 A. I don't recall, you know, if there was or was not
19 a monitor in place.
20 Q. There was not one recorded. Did you know if there
21 should be one in 1996? I appreciate you may have
22 knowledge since. But in 1996 did you know that?
23 A. Again, I think I did.
24 Q. Not only did you know there should be one, did you know
25 it was essential?

1 A. I knew there should be one. How essential, you know ...
2 Again, that's a point that I'm not entirely certain on.
3 Q. If there was to be one and you knew that, how would you
4 record that that is what should happen? Where would you
5 record that?
6 A. It should have been recorded in my notes.
7 Q. In your notes?
8 A. Yes. Well, and the nursing notes because it would have
9 been --
10 Q. Because you would have directed the nurses if that is
11 what was to happen?
12 A. We could arrange that, yes.
13 Q. But it's not there?
14 A. It's not there.
15 Q. Dr Stevenson, yesterday I had asked you about the BNF
16 and you said that there was a BNF for use. I don't
17 think you could specifically remember whether you had
18 yourself used it on that day, but you acknowledged that
19 there was one there, you knew what it was and you would
20 consult it.
21 A. To the best of my memory, yes.
22 Q. Can we pull up 311-028-014? It's quite a poor copy and
23 I'm sorry for that, but if you go right down to the
24 bottom left-hand side:
25 "Dose: by slow intravenous injection or infusion

1 (with blood pressure and ECG monitoring)."

2 Then for status epilepticus it gives you the 15

3 which we went to yesterday:

4 "... at a rate not exceeding the loading dose."

5 Then it says in the brackets, as I read out to you,

6 about the ECG monitoring.

7 So it has how you calculate it roughly, the dose,

8 the rate and it tells you that there should also be

9 blood pressure and ECG monitoring.

10 A. Yes.

11 Q. Correct me if I'm wrong, but I think you said that you

12 were not particularly familiar with prescribing these

13 anticonvulsants.

14 A. No, that's true.

15 Q. So if you, not being familiar, had consulted your BNF --

16 which would have been a prudent thing to do, would it

17 not?

18 A. It would have.

19 Q. Not only would that have helped you with the 15 amount

20 per kilogram which you indicated yesterday might have

21 prompted you to ask Dr Webb about that --

22 A. Yes.

23 Q. -- given that he had mentioned 18, but you would also

24 see that there should be some monitoring?

25 A. That's true.

1 Q. Did you have any experience in erecting an ECG?
2 A. Yes.
3 Q. So you could have done it?
4 A. Well, for adults.
5 Q. Did you know how to do it for Claire?
6 A. I could have done, yes.
7 Q. Had you ever done one for a child before Claire, so far
8 as you're aware?
9 A. I may have done, but I just can't remember.
10 Q. So it's not that there necessarily would have been any
11 problem in doing it?
12 A. It's technically more difficult in a child because
13 they're restless or depending on their age, but no, you
14 could do it.
15 Q. And if you were unsure, you could have got some help?
16 A. Yes.
17 THE CHAIRMAN: Claire wasn't particularly restless, was she?
18 A. No, but I'm using --
19 THE CHAIRMAN: According to the records, I know you don't
20 remember.
21 A. There's another child in folder 150 who I was asked to
22 do an ECG on and it wasn't easy to do it. That's a very
23 different child.
24 THE CHAIRMAN: Yes.
25 A. It's just to highlight that it's not always easy.

1 MS ANYADIKE-DANES: Claire was quite the contrary, actually.
2 That's exactly the point. She wasn't restless; she was
3 in coma, effectively.
4 A. Yes.
5 Q. But there's no note of it, and given the way the nurses
6 have recorded the note for later on, is a reasonable
7 interpretation that it simply wasn't up?
8 A. That could be an assumption, yes.
9 Q. If we look at the end prescription you have for this
10 loading dose of 635, Dr Aronson has commented on that.
11 I'll take you to it, at 237-002-009. At the bottom of
12 it, under (h):
13 "Please explain what effect on Claire you consider
14 the administration of 635 mg of IV phenytoin rather than
15 432 would have had, particularly in terms of her level
16 of consciousness."
17 The 432 is based on the calculation of 18 by her
18 body weight as opposed to what the BNF and the
19 prescriber suggests of 15. But leaving that part aside,
20 he says:
21 "I would have expected some adverse reactions to
22 have occurred since the dose given was about 50 per cent
23 more than was indicated."
24 Then he goes on to say:
25 "The most common adverse reactions of this drug

1 affect the central nervous system, including decreased
2 coordination, slurred speech, mental confusion,
3 somnolence, drowsiness."
4 But then he goes on to say:
5 "Claire was unconscious and when she was given the
6 phenytoin, most of these effects, if the occurred, would
7 not have been detectable. The drug would also have
8 reduced Claire's GCS score and would have made it more
9 difficult to assess Claire's progress and the extent to
10 which Claire's neurological impairment was due to
11 a primary illness."
12 That's effectively what he's saying there. Would
13 you accept that? Or did you not in 1996 know sufficient
14 to know whether that was accurate or not?
15 A. In 1996 I would not have had the level of experience to
16 go into the detail of the expert witness here.
17 Q. But if you had looked up phenytoin, you might have been
18 able to find out what some of the risks, adverse
19 reactions and so on would be.
20 A. Yes.
21 Q. And then you would have known that.
22 A. Yes.
23 Q. In fact, I think it already says that, where we were
24 before at the BNF, which I'm not going to take you to
25 again, but that's how the BNF works: it talks about

1 adverse reactions, it talks about optimal prescription
2 rates and what the drugs' characteristics are and so on.
3 A. Yes, that's true.
4 Q. So if you were unfamiliar with phenytoin, which you say
5 you were, and you had looked it up, which would have
6 been a prudent thing to do, as you have said, you'd have
7 known not only the business about the monitoring that
8 should go on and the advised amount and rate, but you
9 would also have known some of these adverse reactions.
10 A. Yes.
11 Q. If you'd known that, would you have been keeping
12 a lookout for them?
13 A. Yes.
14 Q. And would you have been guiding the nurses as to
15 something that they might be looking for because this
16 might happen?
17 A. Yes.
18 Q. The other thing is that when that phenytoin amount is
19 given, shortly thereafter there's a seizure. If we were
20 to pull up 310-001-001, we can see the 635 milligrams of
21 phenytoin, you can see when that is administered. And
22 then you can see that in relation to the seizure.
23 A. Yes.
24 Q. If you want to see the original note, it's in the record
25 of attacks. This document just pulls together original

1 documents. It is our compiled document. At
2 090-042-144, there you are, this is the record of
3 attacks that is maintained for Claire. You see right up
4 at the top:
5 "3.10 pm. Lasted ... frequently. Strong seizure at
6 3.25. Duration: 5 minutes. State afterwards: sleepy."
7 And that's signed by Claire's mother.
8 A. Yes.
9 Q. Dr Aronson was asked about that seizure and his response
10 to that can be seen at 237-002-011. He says:
11 "Toxic concentrations of phenytoin can be associated
12 with seizures, paradoxical seizures, but it is
13 impossible to say in Claire's case whether the seizure
14 at 3.25 was due to phenytoin toxicity, an underlying
15 infection, hyponatraemia, some other cause or a
16 combination of any of these."
17 But at that stage, none of you actually know what is
18 the cause of Claire's presentation.
19 A. That's true.
20 Q. Isn't that correct?
21 A. Yes.
22 Q. So you're looking for a whole range of things to try and
23 see if any of them, in combination or by themselves,
24 might provide some sort of explanation and might allow
25 you therefore to develop a more effective treatment plan

1 to address that diagnosis. That's the course you're
2 on --
3 A. Yes.
4 Q. -- almost from the moment that you have the ward round
5 with her; isn't that right?
6 A. That's right.
7 Q. So trying to assess what is the effect of the drugs
8 being given is one of those ways to try and pinpoint to
9 see cause and effect of any of your other hypotheses, if
10 I can put it that way; isn't that right?
11 A. That's true.
12 Q. So isn't the sum total of it that what Claire really
13 needed is somebody to take control over her situation
14 and pay fairly close attention to what was happening
15 across a fairly broad spectrum, both from the general
16 paediatric case to the neurological; isn't that right?
17 A. That would be true, yes.
18 Q. And in your view, who did you think was the person on
19 the spot, if you like, who should be charged with taking
20 control of that and seeing where all these things are
21 leading us?
22 A. Well, I was the trainee doctor on the ward at that time,
23 so --
24 Q. Did you feel you had the experience to do that?
25 A. I can't remember exactly, but at that stage I probably

1 didn't have the experience.

2 Q. No. Did you hope that you would be guided in that by

3 the registrar or even by the consultant?

4 A. Yes.

5 Q. Did it occur to you at the time that Claire needed some

6 more senior guidance on the paediatric front?

7 A. I don't recall if I considered that.

8 Q. I understand.

9 THE CHAIRMAN: This may be dangerous, but my assumption

10 would be that, at that time, you were in your third

11 month in paediatrics.

12 A. That's true.

13 THE CHAIRMAN: And this was a girl, a young girl, who was

14 not -- it wasn't just that she wasn't responding well,

15 she wasn't responding favourably to treatments. Her

16 condition was getting worse. It seems to me that it

17 must have occurred to you that "I need help here".

18 A. Yes, but I -- in the process of ... As best as I can

19 recall, Mr Chairman, in the process of doing the things

20 that I was advised or recommended to do by more senior

21 colleagues, I was busy doing what I was asked to do and

22 I maybe didn't reflect on the seriousness of Claire's

23 condition.

24 THE CHAIRMAN: Okay, well, you hadn't been advised at any

25 point by Dr Steen so far as we can establish.

1 A. Yes.
2 THE CHAIRMAN: You had been on the ward round with Dr Sands?
3 A. Yes.
4 THE CHAIRMAN: And you had had, or had you had direct
5 engagement with Dr Webb? Do you remember that?
6 A. I don't remember direct engagement with --
7 THE CHAIRMAN: But you knew that Dr Webb had been engaged
8 and you had had direct contact with Dr Sands. So
9 there's a question then of whether you followed the line
10 that they were going down or whether you sought help.
11 A. At my level of experience, I would have deferred to the
12 more senior clinicians, and that would have been
13 Dr Webb, because he had seen Claire and then put down
14 the instructions for the phenytoin.
15 THE CHAIRMAN: Right.
16 MS ANYADIKE-DANES: In fairness, Dr Aronson has expressed
17 the views that I put to you, but we do have two other
18 experts who also have views on that. Just in fairness,
19 there's Professor Neville, who's the paediatric
20 neurology expert for the inquiry. He deals with it at
21 232-002-009. His first point is that he doesn't think
22 that giving IV phenytoin was appropriate at all at that
23 stage, irrespective of how much. And the reason for
24 that is that he believes that before you embarked on
25 treatment of that nature, you would need proof that

1 non-convulsive status epilepticus was present, and that
2 is the whole point about requiring an EEG and so forth.
3 So that's his starting point: that this was not
4 appropriate at all.
5 Leaving that aside, and addressing what was the
6 likely consequence of giving that, he didn't think that
7 that overdose is likely to have materially affected the
8 outcome. What he does think is the overdose might have
9 reduced the consciousness level, but doesn't think it's
10 likely to have had a major effect on diagnosis or
11 management.
12 As for Scott-Jupp, he touches on it very briefly and
13 he doesn't think it takes us very much further forward,
14 noting that. But in any event, what you are engaged in
15 is calculating and administering quite a powerful and
16 important drug.
17 A. That's true.
18 Q. And that you should have been alive to its possible
19 effects, adverse and not, and also how you monitor
20 a patient while that drug is being administered; would
21 you accept that?
22 A. I would.
23 Q. And you don't appear, on the face of it, to have
24 followed the guidance in the BNF; would you accept that?
25 A. I would.

1 Q. Thank you. If we're moving forward in roughly
2 chronological time, if you like, the next time really
3 we have is Dr Webb's attendance at 1500 hours. Let's go
4 to your note at 090-022-055. Just above that, you have:
5 "Seen by Dr Webb."
6 Do you see that?
7 A. Yes.
8 Q. And that's your note, is it?
9 A. It is.
10 Q. That's your note, you note that Claire is still in
11 status, status epilepticus.
12 A. Yes.
13 Q. Was that your view or are you here recording what
14 Dr Webb's view is when he sees her?
15 A. To the best of my memory, I think it will be Dr Webb's
16 view.
17 Q. And if you are writing "Seen by Dr Webb" and making the
18 note, although again I appreciate that you don't have an
19 independent recollection of it, but does it indicate to
20 you that you were present when Dr Webb was examining
21 Claire?
22 A. I don't recall if I was present.
23 Q. I know you don't, but would that be a reasonable
24 indication from looking at the way you have written
25 "seen by Dr Webb, still in status", which you think is

1 something he's likely to have said, and you make this
2 note?
3 A. I think from ... It seems from the way I've documented
4 it, that it would have been that Dr Webb has seen
5 Claire, but I wasn't actually with him at the time, and
6 I was maybe somewhere else on the ward and he came then
7 to say, "I've seen Claire and this is what I want you to
8 arrange".
9 Q. In any event, whether it is because you're literally
10 there when he examines Claire or whether it's because he
11 then comes to you, at some point there has been an
12 exchange between you about Claire, either at his
13 examination of her or following his examination of her;
14 would that be how that reads to you?
15 A. That's how I would read it, yes.
16 Q. Okay. What you're writing down then is, to the best of
17 your recollection, what he would have told you?
18 A. Yes.
19 Q. And he would have told you that there's to be a stat
20 dose of midazolam. And all those figures there that he
21 gives you, "0.5 milligrams per kilogram stat dose",
22 is that what he would have told you or would he have
23 said -- well, what would he have said?
24 A. I don't recall exactly what he said, but it's the way
25 I've documented it. It would appear that that's what

1 was passed to me.
2 MR SEPHTON: If I could help here: Dr Webb's recollection
3 is that he had to go away to consult his notes that
4 he had from Vancouver in order to find out what the
5 midazolam dose was; do you remember that?
6 A. No.
7 MR SEPHTON: He came back and said to you that, "The dose in
8 my notes is 0.15 milligrams per kilogram".
9 A. I don't remember that.
10 MR SEPHTON: Okay, thank you.
11 MS ANYADIKE-DANES: Just a point of clarification,
12 Mr Chairman, because that was a bit of evidence. I'm
13 not aware that we've actually received that by way of
14 a witness statement at any stage. Maybe Mr Sephton can
15 help.
16 MR SEPHTON: I believe not.
17 MS ANYADIKE-DANES: So that is Dr Webb's view as to what
18 happened, but it's not included in any statement to
19 date?
20 MR SEPHTON: That's correct.
21 THE CHAIRMAN: Well, how are we going to get that? Because
22 you'll understand that if, in effect, your client is
23 saying that Dr Stevenson mistakenly misunderstood
24 something and gave triple a dose of midazolam, but
25 I don't have a statement before the inquiry to that

1 effect, then I obviously should have something before me
2 to that effect from Dr Webb.
3 MR SEPHTON: That's right, sir, you should.
4 THE CHAIRMAN: Can that be arranged?
5 MR SEPHTON: I can certainly go about that and I will do it
6 as soon as we can.
7 THE CHAIRMAN: Thank you.
8 MR GREEN: Sir --
9 THE CHAIRMAN: Sorry, just for the record, Mr Sephton,
10 I understand that Dr Webb has serious health problems,
11 which I will not go into any further, save to say they
12 are serious health problems, and that is more
13 unfortunate for Dr Webb than it is for anyone else here.
14 I don't want to intrude on him, but that fact makes the
15 conduct of this hearing rather more complex than it
16 might otherwise be. It becomes even more complex again
17 if we are to receive interventions such as the one
18 you've just made in the absence of written statements.
19 Okay?
20 MR SEPHTON: I understand, sir. Perhaps I can have some
21 guidance. You appreciate there are logistical
22 difficulties in getting instructions.
23 THE CHAIRMAN: Yes.
24 MR SEPHTON: The alternatives are either not to put the
25 point at all --

1 THE CHAIRMAN: That doesn't help.

2 MR SEPHTON: No. Or alternatively to put the point and try

3 and raise the matter in a statement in due course.

4 THE CHAIRMAN: Yes, but this is a particularly significant

5 intervention --

6 MR SEPHTON: Yes.

7 THE CHAIRMAN: -- because it goes to the drugs which Claire

8 received, which has always been one of the major

9 concerns of the Roberts family. I'm not so worried at

10 all about peripheral issues, but if there is an

11 intervention on such an important issue as this, then

12 I think we have to have it in writing from Dr Webb.

13 Mr Green, did you want to say anything beyond that?

14 MR GREEN: I was simply going to put a marker down because,

15 of course, Dr Sands is going to be next, and if

16 Mr Sephton has instructions on such critical issues,

17 perhaps it would be helpful if we could have, in some

18 form, written notice of what those interventions are

19 likely to be. Otherwise this becomes inquiry by ambush.

20 THE CHAIRMAN: I hope I've made the point clear.

21 MR GREEN: You have indeed, thank you.

22 MS ANYADIKE-DANES: Mr Chairman, maybe I can help with that?

23 Dr Webb's second witness statement, 138/2, says at

24 page 13, if we pull that up and you look at

25 question (d):

1 "Please explain why you recommended the
2 administration of midazolam in Claire's case:
3 "I recommended midazolam because Claire had had
4 a positive response ..."
5 This witness statement, Mr Chairman, was provided on
6 18 September of this year. And the answer to that
7 question is:
8 "I recommended midazolam because Claire had had
9 a positive response to diazepam ... short-acting, to be
10 given as a continuous infusion. I had been using it
11 intravenously during his paediatric neurology fellowship
12 in Vancouver with good results."
13 And so on:
14 "It had been used intravenously at the time, but has
15 since been superseded."
16 And so forth. But there's absolutely no reference
17 to an exchange that he might have had with Dr Stevenson
18 where he would have told Dr Stevenson that in fact what
19 he should be using was 0.15 milligrams per kilo.
20 THE CHAIRMAN: If you go on to the next page, page 14,
21 please, there was opportunity at page 14 --
22 MS ANYADIKE-DANES: Yes.
23 THE CHAIRMAN: -- to raise this. Because he was being asked
24 about the miscalculation of midazolam at question 15,
25 wasn't he?

1 MS ANYADIKE-DANES: Yes.

2 THE CHAIRMAN: I'm very interested to see what Dr Webb is

3 now saying and the sooner I see it, the better.

4 MS ANYADIKE-DANES: Thank you, Mr Chairman.

5 MR FORTUNE: Sir, can I also put down the marker, bearing in

6 mind what appears in 15(b), in case anything affects

7 Dr Steen?

8 THE CHAIRMAN: Yes.

9 MS ANYADIKE-DANES: I beg your pardon. We were at your note

10 at 090-022-055. You are saying that you would have got

11 that from Dr Webb, you don't recall him giving you

12 anything other than what you have recorded there,

13 I understand, as a 0.5 milligrams per kilo stat dose.

14 A. Yes.

15 Q. And you've got that as 12 milligrams IV. I think I had

16 taken you yesterday to the references in the BNF,

17 indicating that it should actually be 0.15. And in

18 fact, the intervention that you have just heard

19 indicates that Dr Webb is of the view that that is what

20 it should have been. Not only is of the view now,

21 he was of the view in 1996. So 0.5 is just wrong,

22 according to him.

23 A. Yes.

24 Q. Yes. But that's not something you were aware of?

25 A. No.

1 Q. And I can't remember if I had asked you whether you had
2 prescribed midazolam before. Had you?
3 A. I don't recall if I've prescribed it.
4 Q. If you had, it's not likely to be something that you
5 commonly prescribed?
6 A. In paediatrics or general medicine, in my experience,
7 no.
8 Q. No, at that stage, I mean. You might have done it
9 subsequently.
10 A. At that stage, no.
11 Q. In fact, you might not have prescribed it before at all.
12 A. Yes, that's true.
13 Q. This is another one of those that you didn't go and
14 check and look "What exactly am I prescribing, what is
15 the recommended amount, calculation, what are the
16 adverse effects?". You didn't do any of that.
17 A. Yes.
18 Q. Why? Because you were simply following along what you
19 believed Dr Webb had told you?
20 A. Again, I was likely to be deferring to someone with more
21 clinical experience.
22 THE CHAIRMAN: If you take that note at the top of page 55,
23 is the left-hand side of the screen what you understood
24 Dr Webb to be telling you to give and the right-hand
25 side of the screen is your mathematical calculation of

1 it?
2 A. Yes, under the "Clinical history, examination and
3 progress", Mr Chairman.
4 THE CHAIRMAN: Sorry, on the left screen there's the
5 first --
6 A. Yes, that's my calculation.
7 THE CHAIRMAN: And points 1 and 2 on the left-hand side are
8 your note of what you believed Dr Webb told you to
9 administer?
10 A. Yes.
11 MR QUINN: Mr Chairman, if I can give some information to
12 the tribunal? If you look at WS138/1, page 32. It's
13 Dr Webb's statement. You may recall that I opened the
14 case on the basis of that information. Halfway
15 down, (b)(ii). And then the last sentence of the next
16 paragraph where he says:
17 "The administration of intravenous treatment for
18 status epilepticus routinely involves the administration
19 of an intravenous loading dose followed by a slow
20 infusion. The loading dose should have been given at
21 0.15 milligrams per kilo --"
22 THE CHAIRMAN: Okay, thank you very much.
23 MR QUINN: "-- and I do not know how a dose of
24 0.5 milligrams per kilo was charted."
25 We seem to know how it was charted, but it was

1 always in the papers that the dose should have been
2 0.15.
3 THE CHAIRMAN: From Dr Webb?
4 MR QUINN: Yes.
5 THE CHAIRMAN: Thank you very much.
6 MS ANYADIKE-DANES: Sorry, the bit that remains unclear was
7 actually what the intervention was, which is that he had
8 had an exchange with Dr Stevenson, specifically to tell
9 him that it was 0.15. That particular bit had been
10 known from his witness statement. What we hadn't known
11 is that he had had a specific or claims to have had
12 a specific exchange with Dr Stevenson, where he told him
13 that it was 0.15. And I think that if he is going to
14 maintain that -- because obviously it has an impact on
15 Dr Stevenson on others -- then I am grateful,
16 Mr Chairman, for your indication that we should have
17 that in writing other than from Mr Sephton.
18 THE CHAIRMAN: Let me come back to that after the break,
19 okay?
20 MS ANYADIKE-DANES: So if we go back to your note, then,
21 090-022-055. Is there anything in your note that
22 indicates the rate at which that loading dose, that stat
23 dose as you call it, should be administered?
24 A. No.
25 Q. Then how would anybody know that it should have been

1 administered slowly or over any particular period of
2 time? In fact, if you had looked at the BNF, leaving
3 aside what Dr Webb has then said in his statement, he
4 says:
5 "Slow intravenous. Initially 30 to 300 micrograms
6 given over five minutes and then successively ..."
7 But in any event, the BNF prescribes for how that
8 should actually be administered. So yesterday we looked
9 at another indication, where the BNF had recommended by
10 slow push, and you said you knew about slow push and so
11 forth. If we are dealing with this, what would indicate
12 to anybody how that dose had been given?
13 A. It wouldn't indicate the rate that the intravenous
14 injection -- based on my notes.
15 Q. You can't tell that?
16 A. No.
17 Q. Just for the sake of completeness, 311-028-020, which is
18 the BNF. There you see right in the middle of the top
19 left paragraph, quite apart from "slow intravenous
20 injection", you can then see:
21 "Child [in capital letters]: over 7 years,
22 150 micrograms per kilo, that is 0.15 induction."
23 Okay? So back again to your note of 090-022-055.
24 Is it therefore the 0.5 may simply have been an error on
25 your part?

1 A. It could have been, yes.

2 Q. When you're dealing with these very important drugs that

3 have quite significant effects, is there any sense that

4 you should maybe get these things checked by somebody

5 when you've done your calculation? Because a decimal

6 point in the wrong place or the wrong basis used for the

7 calculation can, as we've actually seen in this case,

8 have quite -- in terms of the calculation, maybe not

9 necessarily the outcome -- significant effects --

10 A. Yes.

11 Q. -- and in another case, could have very serious

12 consequences. Is there any indication that these things

13 should be looked over by a more senior doctor?

14 A. It would have been certainly, on reflection, good

15 practice, you know, to check my calculations with

16 another colleague.

17 Q. Did it occur to you that you just might do that? If

18 you're not familiar with having prescribed them and

19 thinking, "Okay, I'm not entirely sure what these drugs

20 do, but I know they're anticonvulsants and I know this

21 is a very sick child that we're dealing with and I'm

22 under direction by the paediatric neurological

23 consultant, maybe I'll just make sure that I've got

24 everything correct before I actually start to administer

25 this"; did that thought cross your mind?

1 A. I don't recall if I thought like that.
2 THE CHAIRMAN: I just want to be clear I understand what
3 you're saying.
4 If Dr Webb tells you, "This is the dose of midazolam
5 which you should give to somebody", to Claire, to
6 whoever else, what would make you go to another doctor
7 to check your calculations? Because on one view, you do
8 your arithmetic and then you double-check it. If you
9 then went to Dr Stewart or Dr Sands to say, "Would you
10 check my arithmetic?", they might look a bit askance at
11 you surely.
12 A. Yes.
13 THE CHAIRMAN: Particularly on what looks to have been
14 a very busy day when you, Dr Sands and Dr Stewart were
15 running round a lot of patients.
16 A. It would be unlikely in the context of our busyness
17 to -- if you're sort of -- if you feel confident in your
18 own abilities, you go on ahead because you know
19 everybody else is busy and you've got a job to do.
20 THE CHAIRMAN: It emphasises the need for you to get it
21 right and then to double-check it, but going off to ask
22 someone else to double-check unless you're really quite
23 unsure would be a very unlikely scenario.
24 A. It would be, or could be, sorry.
25 MS ANYADIKE-DANES: If you're not checking the outcome -- so

1 you're given, as you understood it, a formula, if you
2 like. So you're not told, "Administer X amount of
3 midazolam as a stat dose". As I understand it, what
4 Dr Webb gives you is a formula and you go away and
5 calculate that.
6 A. Yes.
7 Q. And he does that both for the stat does and the
8 continuous infusion; is that right?
9 A. That's right.
10 Q. So if you're not familiar with the drug, when you have
11 the amount you are proposing to actually administer, if
12 you're not wishing to trouble another colleague who may
13 not be easily obtained doing other work, do you not at
14 least check and say, "Does that actual amount to
15 administer tally with anything that's in the reference
16 works that I have to guide me on this?", and the two
17 that seem to be available were the BNF, which you've
18 already acknowledged, and the prescriber which may have
19 been about, and any textbook which might have been
20 there.
21 A. Yes, it certainly would have been good practice to have
22 done that.
23 Q. I don't mean checking your arithmetic because that's
24 always good practice, but when you have the amount
25 you're just about to administer or direct somebody else,

1 in the case of a nurse, to administer, it would have
2 been good practice to check that that amount tallies
3 with amounts that you can see in the guidance works
4 available to you?
5 A. Yes, it would have.
6 Q. That would have been?
7 A. Yes.
8 Q. And that could easily have been done?
9 A. It could have.
10 Q. If you'd done that, you might have appreciated that that
11 stat dose was a very, very high dose --
12 A. Yes.
13 Q. -- to be administering? Then if we look at the actual
14 prescription sheet, 090-026-075. If we pull that up.
15 So then you see the midazolam, second from the bottom.
16 This is the stat dose?
17 A. Yes.
18 Q. And we see "120". Having written down "12", have you
19 any idea how you could possibly have written down 120?
20 A. I can't explain or recall why I wrote down 120. Well,
21 a possibility is it was down as "12.0". But again,
22 I can't ...
23 Q. It doesn't look as --
24 A. No, it doesn't.
25 Q. It just looks like 120, doesn't it?

1 A. It looks like 120, yes.
2 Q. That's one of the reasons I'm putting to you how
3 familiar you were with these drugs you're dealing with
4 in relation to Claire. Because anybody who's expressed
5 a view about that instinctively would know you couldn't
6 be prescribing, for a child of that age, 120 milligrams
7 of midazolam as a stat dose. You just couldn't.
8 A. Yes, I would accept that.
9 Q. So as you were physically writing that down, that's not
10 something that leapt up to you and said: hang on
11 a second, there must be a mistake here, what on earth
12 have I done here? You just simply wrote that down. Not
13 only did you write it down, but you carried along
14 apparently that line and you signed it.
15 A. Yes.
16 Q. So you couldn't have been sufficiently familiar with
17 midazolam to recognise that that just could not be
18 right.
19 A. But if you're making the midazolam up, the number of
20 vials that you'd have needed to bring it up to
21 120 milligrams --
22 Q. We'll get to that in just a second. This is your
23 prescription, you're signing it, actually writing it
24 down.
25 A. Yes.

1 Q. As you physically wrote it down, it couldn't have jarred
2 you and said "That cannot be right"?
3 A. I don't recall if it did.
4 Q. Why is it not signed under "given by" and initialled?
5 A. I can't explain what.
6 Q. Does that mean you didn't give it?
7 A. I just don't remember.
8 Q. When you say the amount of vials it might have taken to
9 actually reach 120, do you actually recall making this
10 up?
11 A. No.
12 Q. Professor Neville has given evidence to say that even
13 the 12 milligrams was a big dose and there is no
14 evidence that Claire actually required that dose. Where
15 was the midazolam if you were going to get it, to make
16 it up?
17 A. It's medication that likely to be kept within the ward
18 drug cabinet.
19 Q. So that would be accessible to you?
20 A. If I had to go and get the medication, I'd have to get
21 the keys from the nurse who held the keys.
22 Q. Do you know who that was in those days?
23 A. No, I don't.
24 Q. Would that be the ward sister? The most senior nurse.
25 A. It'd be the most senior nurse, I presume.

1 Q. Does that mean that you could have instructed somebody
2 else to go and make that up and give it, or is that
3 something that you would have to give?
4 A. No, it's medication. I don't think a nurse would have
5 been asked to --
6 Q. So you would actually have to give it?
7 A. Yes.
8 Q. But you could have asked a nurse to go and get it for
9 you?
10 A. Yes.
11 Q. Well, what are the drugs that you have to give as
12 a doctor and the nurses can't give?
13 A. In 1996?
14 Q. Yes.
15 A. I can't exactly recall all the different drugs.
16 Antibiotics ...
17 Q. What does the signature indicate? That indicates who
18 was given by, doesn't it?
19 A. On the kardex?
20 Q. Just as we're looking at it now, yes. That column that
21 says, "Given by". Does that actually mean whoever is
22 signing that has physically given that medication?
23 A. Yes.
24 Q. Is that what that indicates?
25 A. Yes.

1 Q. So you're saying a nurse couldn't have given the
2 midazolam --
3 A. No.
4 Q. In 1996? Or the phenytoin?
5 A. No.
6 Q. Or the diazepam?
7 A. No.
8 MR FORTUNE: Can I assist?
9 MS ANYADIKE-DANES: Sorry, if you bear with me one moment,
10 please.
11 If a nurse couldn't have given the diazepam, why
12 does it appear as if Nurse Linsky has signed for the
13 diazepam?
14 A. Sorry, because that's a PR, the diazepam and method of
15 administration is written down. That's a rectal --
16 Q. She could give rectal diazepam?
17 A. Yes, but intravenous would always, in my experience,
18 have been a doctor's role.
19 Q. Okay. So although the nurse could have got this
20 medication for you -- maybe helped you make it up, could
21 she have or is that your responsibility?
22 A. That would generally be our responsibility.
23 Q. That's your responsibility and you to administer it?
24 A. Yes.
25 Q. And is the only place that one would expect to find that

1 it had been administered this card, where it's signed,
2 or do you expect to see that in any other note?
3 A. In my experience, it would generally be written in this
4 "drugs once only" prescription sheet.
5 Q. So we can't tell from this alone whether it actually was
6 or wasn't given, whether it's inadvertent that you
7 hadn't signed it or whether it's not signed because you
8 didn't give it?
9 A. Yes.
10 Q. In fact, we know if we look at the notes coming
11 afterwards, there are references to a loading dose
12 given, particularly by Dr Webb afterwards. But in any
13 event, from this, you can't tell?
14 A. That's true.
15 Q. And the references that I'm speaking of are, if you look
16 at the nursing note at 090-040-141. Then you see the
17 "Stat IV Hypnovel". That's midazolam, isn't it?
18 A. It is.
19 Q. At 3.25. There you see it, "Stat IV Hypnovel" at 3.25.
20 A. Yes.
21 Q. "Continuous infusion running" and so on. So the "stat
22 IV Hypnovel" suggests in that note that the stat dose
23 was given, although it doesn't say what it was?
24 A. That's true.
25 Q. Sorry, what I mean is the amount it was, but it

1 certainly indicates that a loading dose was given.
2 A. That's true.
3 Q. And then if we see Dr Webb's record in Claire's notes,
4 090-022-055. There we are. You see that Claire has had
5 a loading dose of phenytoin. That's okay. And a bolus
6 of midazolam.
7 A. Yes.
8 Q. Would that indicate that's a stat dose, that reference
9 to bolus?
10 A. Yes, it would.
11 Q. So although you haven't recorded it or signed for it,
12 it would seem that the other notes suggest that a stat
13 dose or loading dose of midazolam was given, although
14 none of them indicate exactly what that amount would be,
15 and in fact if you wanted to find out what that amount
16 is, the only place is the prescription, which takes you
17 to the 120, which would be very unhelpful for anybody
18 trying to see what happened to Claire --
19 A. Yes.
20 Q. -- if that's incorrect?
21 A. Yes.
22 Q. Because then you're left not entirely knowing what was
23 given.
24 A. That's true.
25 Q. Maybe there had been some suggestion to move away from

1 the 12, but nobody knows what it is.

2 A. That's true.

3 Q. So if we look now at your continuous dose and you

4 calculate that out, and you get to the 69 milligrams.

5 Is there any suggestion of when it was prescribed that

6 the loading dose should actually start? We know when it

7 seems to have been, but did Dr Webb indicate to you when

8 you should actually get that up and running?

9 A. I don't have any --

10 Q. There's no note to that?

11 A. There's no note to that effect.

12 Q. Would it not have been a good idea to include that?

13 A. Yes.

14 Q. So when one is looking at the notes, one's looking at

15 one continuous narrative of what is to happen as opposed

16 to having to dive off and look at what's recorded in

17 these other supporting documents, if I can put it that

18 way. It would have been helpful?

19 A. It would.

20 Q. In 1996 -- I don't want to say anything by today's

21 standards -- would that have been good practice?

22 A. It would have been, yes, seen as good practice.

23 Q. Thank you. So what about when the continuous infusion

24 should start? Is that clear from your note as to when

25 that should actually commence?

1 A. No, it's not.

2 Q. Is there any notion as to whether there needs to be some

3 sort of break between when the stat dose has been fully

4 administered and when you can start the continuous

5 infusion?

6 A. There doesn't appear to be.

7 Q. Did you know whether the literature would suggest that

8 that's what should happen instead of immediately

9 concluding the stat dose and then immediately erecting

10 the continuous infusion. Did you know whether there was

11 any literature about that?

12 A. At that time, no.

13 Q. You simply didn't know?

14 A. No.

15 Q. That may have been an appropriate thing or not, you

16 didn't know.

17 A. Yes.

18 Q. How would you get the 69 milligrams? That's going to be

19 a continuous infusion, isn't it?

20 A. It would be, yes.

21 Q. How does it actually work?

22 A. You draw up 69 milligrams of the drug.

23 Q. From where?

24 A. From the vial, from the medication that would have been

25 given on the ward.

1 Q. So you collect up a whole load of vials of midazolam.
2 Syringe it out, is that how it would be, the 69?
3 A. Yes, syringe it out and that would go into an infusion
4 pump, which was then set at the rate they give it.
5 Q. You have queried whether there could have been as much
6 as 120 accessible on the ward, but it would seem there
7 must have been at least 69. In fact, there would have
8 to be more than 69 because there was going to be
9 a loading dose and the 69.
10 A. Yes, if the 120 was --
11 Q. No, no, sorry, I was unclear. When I was asking you
12 about the 120, quite apart from the fact that you
13 thought that it must have been an error, but in any
14 event, in support of that, you were saying effectively
15 that: I couldn't have got my hands on 120, that's an
16 awful lot of midazolam.
17 A. Yes.
18 Q. What I'm suggesting to you is that you'd have had to get
19 your hands on the 69 --
20 A. Yes.
21 Q. -- and at least more than that -- because forget about
22 the 120 -- there was going to be at least 12 of the
23 loading dose.
24 A. That's true.
25 Q. So that's still quite a bit.

1 A. It is.
2 Q. So you're saying there would have been enough for that,
3 but there's unlikely to have been as much as 120? And
4 how do you know that?
5 A. I can't recall other than what was the -- you know, the
6 quantities of the actual medication that was kept in the
7 store cupboard or in the drug cabinet on the ward.
8 Q. So it may not be quite correct to say, "The chances of
9 me actually having written down 120 and meaning 120 are
10 slim because I'm unlikely to have had 120 available to
11 me". There might have been that amount?
12 MR COUNSELL: I hesitate to interrupt, but we know in fact
13 that there would have been 100 from a letter which the
14 inquiry should have. I can give you the reference.
15 MS ANYADIKE-DANES: Thank you.
16 MR COUNSELL: 302-085-001.
17 THE CHAIRMAN: Thank you.
18 MS ANYADIKE-DANES: Thank you very much indeed.
19 You saw that, doctor?
20 A. I did.
21 Q. Obviously, that's something that we will pursue with
22 others who can better assist the inquiry about that.
23 From your point of view, you don't know, your sense was
24 that it was a lot and you thought that was an error you
25 had made and you didn't mean 120?

1 A. Yes.
2 Q. In any event, if we go back to where we were with your
3 note. We're still talking about quite a bit of
4 midazolam there.
5 A. Yes.
6 Q. And that's all going to syringed out, and, what, put
7 into an IV bag; is that how it works?
8 A. Yes.
9 Q. And then the rate of which is controlled?
10 A. It is, by an electronic machine that --
11 Q. So nobody has to do anything about that. Once it's set,
12 it's going to go at that rate?
13 A. Unless it's changed by the nursing staff, depending on
14 the prescriptions.
15 Q. If you want it to continue at that rate, you simply set
16 it. It's not the sort of thing that anybody has to keep
17 checking backwards and forwards, "Is it truly running at
18 that rate?", or whatever it is. It's set and that's it.
19 A. To my knowledge, that would be the case, yes.
20 Q. Thank you very much. If we keep that up there for the
21 minute and go to Dr Webb's attendance now at 1700 hours.
22 I think in your witness statement -- it's at 139/1,
23 page 22, question 32(b) -- you say:
24 "I recall that Dr Sands and I were present on the
25 ward at the time of Dr Webb's third attendance [which is

1 this one]."

2 A. Yes.

3 Q. "I do not recall if I was present at his third

4 examination and other discussions regarding further

5 treatment for Claire's condition."

6 And then you say in your second witness statement at

7 139/2, page 10, in answer to question 16(b):

8 "To the best of my recollection, Dr Webb passed on

9 to Dr Sands his thoughts on Claire's condition and his

10 advice on further treatment following on from his third

11 review and examination. This may have been a verbal

12 discussion following Dr Webb's attendance and

13 examination."

14 How do you know that's what was happening on that

15 second observation of yours, that to the best of your

16 recollection Dr Webb passed on to Dr Sands his thoughts

17 on Claire's condition? Were you there?

18 A. I was on the ward, but I don't exactly recall the two

19 individuals meeting and discussing Claire's case.

20 Q. You've couched it in terms that, to the best of your

21 recollection, that's what's happened or that's what

22 happened, if I can put it that way. So how do you know

23 that? Did Dr Sands speak to you about it?

24 A. No, but I think it reflects on what the chairman

25 mentioned. I'm trying to remember as best I can, but

1 I've been asked questions and that has been on the basis
2 of looking back at the records.
3 Q. That's what seems logical to you?
4 A. Yes, that's how I've tried to approach this.
5 Q. I understand. Then if we look at the note, which is up
6 there now, 090-022-055, item 2, there's a plan there.
7 A. Yes.
8 Q. If we look at item 2, it says:
9 "Check viral cultures, stool, urine, blood."
10 [Inaudible: no microphone.] Whose responsibility
11 was it to do that?
12 A. Well, some of those tests, to my knowledge, would have
13 been a blood test, and the others would have been urine
14 samples, stool samples from Claire.
15 Q. Yes, but whose responsibility was it to respond to that
16 plan of Dr Webb's and make sure those things were
17 carried out?
18 A. Those would be SHOs' and nurses' roles.
19 Q. That's you?
20 A. Yes.
21 Q. So that's effectively a direction to you?
22 A. And to the nurses.
23 Q. Yes. But in terms of the second thing, the things that
24 required a doctor, that would be you who had to do that?
25 A. Yes.

1 THE CHAIRMAN: What time were you due to finish at on that
2 afternoon?
3 A. Well, our shifts were 9 to 5.
4 THE CHAIRMAN: Right. So if a plan is put in place at 5
5 o'clock by Dr Webb, do you stay on shift to do it or
6 does that become part of the handover to the incoming
7 SHO or registrar?
8 A. Your ward work was not fixed so that at 5 o'clock that
9 you walked off.
10 THE CHAIRMAN: I understand that, but there are other people
11 who are walking on.
12 A. Yes, there'd be other people who would be taking over
13 the overall cover for your Allen Ward and then
14 Musgrave Ward as part of your on-call rota.
15 THE CHAIRMAN: How do you balance between the people who are
16 finishing soon after 5 o'clock and the people who are
17 coming on? If there's a plan which is set out at
18 5 o'clock, about 5 o'clock, by Dr Webb, how do you
19 decide between yourselves who's responsible for
20 activating it?
21 A. That is part of your handover, which we may get to, but
22 it's an informal: these things need done. This is
23 what -- this is the work ... Generally, you didn't want
24 to leave work for someone who's coming on because they
25 would be covering more wards than their own. Therefore

1 you tried to get things as cleared up as best as you can
2 on that particular day.
3 MS ANYADIKE-DANES: Does that mean, in fairness to your
4 colleagues coming on, who will have more beds to cover
5 than you would, that you would, if there were these last
6 minute, if I can put it that way, directions, you would
7 try and carry those out before you left?
8 A. If that's practically possible, yes.
9 Q. And if it is not possible, then is this one of things
10 that you drew to somebody's attention that Dr Webb has
11 said this will need doing fairly soon?
12 A. Yes.
13 Q. That sort of thing?
14 A. Yes.
15 Q. You have no idea whether you did it or whether you
16 brought it to the attention as part of your handover for
17 anyone else to do?
18 A. I have no memory of that.
19 Q. Is this the sort of thing that you would try and put in
20 train before you left?
21 A. Generally, you would want to clear up and leave as
22 little work for someone coming on call when generally it
23 was a busy --
24 Q. You wouldn't get the results, but you might have taken
25 the bloods and sent them off?

1 A. Exactly.
2 THE CHAIRMAN: It's also trickier, isn't it, because at that
3 time, at 5 o'clock, we know from file 150 that you were
4 examining another patient.
5 A. That's true.
6 THE CHAIRMAN: The patient who had come in, at least in
7 part, by her mother contacting Dr Steen earlier that
8 day.
9 A. Yes. And another child who I was asked to see. I was
10 also asked to see another child in preparation for that
11 child to go home.
12 MS ANYADIKE-DANES: So quite a busy 5 o'clock for you.
13 A. Sorry?
14 Q. So quite a busy 5 o'clock for you.
15 A. 5 o'clock is always busy for a doctor.
16 Q. I understand. If we now go to item 3 on Dr Webb's plan:
17 "Add IV sodium valproate. 20 milligrams per kilo IV
18 bolus followed by infusion of 10 milligrams per kilo IV
19 over 12 hours."
20 Just on that same point about trying, so far as you
21 can, to clear up things and not leave work for others to
22 do on the patients that you've been looking after during
23 the day, this would be junior doctors' responsibility,
24 would it, an SHO?
25 A. Generally, yes, it was the SHO.

1 Q. So the issue is whether it's one of those things that
2 you would try and do before you left or you would be
3 pointing out in a handover to the SHO coming on duty?
4 A. Yes. There would be -- because there's two of us on the
5 ward, so between the two of us, you'd try and clear up
6 all the patients and, in this case --
7 Q. So between you and Dr Stewart, who was the other SHO,
8 you'd try and sort out these sorts of things?
9 A. Yes, and you would have been assisted if the registrar
10 was around and was helping out.
11 Q. It seems that the bolus was administered by Dr Sands,
12 but the infusion doesn't really seem to have started.
13 If we go back to the prescription sheet -- this is
14 something to be taken up by others -- but if we look at
15 090-026-075, there you see the sodium valproate right
16 at the bottom, the once only; do you see that?
17 A. Yes.
18 Q. That's been calculated out. Whose signature is that?
19 A. It looks like Dr Sands.
20 Q. That is Dr Sands' signature. So he's signing and he's
21 initialled it, so he's given that at 5.15.
22 A. That is what you'd assume from that.
23 Q. If you look above on the regular prescriptions there's
24 also an entry for sodium valproate, and that was going
25 to be the continued infusion, which was going to be

1 running over 12 hours; do you see that?

2 A. Yes.

3 Q. And that's struck out. Then one can see the rewritten

4 prescription at 090-026-073. There we are. If we pull

5 that up a little bit. Does it appear there?

6 A. I don't see it.

7 Q. So it seems to have been struck out there, I think

8 probably by Dr Hughes, from the signature. And it

9 doesn't appear on the rewritten prescription. It's

10 a little bit cut off at the top, but it was rewritten at

11 9.30 that evening. Dr Hughes was on duty then.

12 A. Yes.

13 Q. You may not be able to help with this because I know you

14 really don't remember anything at all, but do you have

15 any explanation at all for why Dr Webb's plan, if I can

16 put it that way, didn't get put into effect in the way

17 that he had directed?

18 A. I don't recall why.

19 Q. Okay. Then can we go to acyclovir and cefotaxime.

20 If we look at the prescription sheet, 090-026-075, we

21 see the regular prescriptions for cefotaxime there and

22 just below it is acyclovir.

23 A. Yes.

24 Q. And you have signed for those?

25 A. That's true.

1 Q. Does signing mean they're erected? Sorry, what is the
2 significance of your signature there?
3 A. Well, it's the dosage and the regime of those particular
4 drugs.
5 Q. So it doesn't necessarily indicate that you know that
6 has commenced?
7 A. No.
8 Q. What it indicates is you have given that prescription,
9 that direction that that is to happen, that amount, that
10 frequency, if I can put it that way, in that way?
11 A. Yes.
12 Q. And that's what that means?
13 A. Yes.
14 Q. I understand. It's the one below it, that's the once
15 only, so you can physically give that, or a doctor can?
16 A. Yes.
17 Q. So we see then when it is intended that those drugs
18 should be given. And given when all this is happening,
19 the ones that refer to the morning time, what you're
20 indicating is that's the time in the following morning
21 we should be giving more of that drug?
22 A. Yes, so in this case it'd be the 23rd.
23 Q. So the first drug, the cefotaxime, what you've indicated
24 there, should be given at 5.30; is that correct?
25 A. Yes. That's the --

1 Q. And then you've indicated that the next amount should be
2 given at 9.30 and then there should be two more amounts
3 given the next day; is that correct?
4 A. Yes.
5 Q. If we see the acyclovir, you've indicated that the first
6 amount should be given at 9.30.
7 A. Yes.
8 Q. Is there any reason for that? Why don't you start both
9 of them at the same time?
10 A. Because the normal practice would have been that you
11 would have given medication spread out throughout the
12 24-hour period. And for that acyclovir, to the best of
13 my knowledge, it was three times a day, and you put it
14 down for 8.30, 12.30, 9.30.
15 Q. Is there any indication by Dr Webb as to when he wants
16 you to start?
17 A. I have no memory of that, and based on the notes --
18 Q. Sorry, on his notes. Well, let's look back at the
19 medical notes and records. Just where we were at --
20 I think it was 090-022-055. Is there any indication
21 there of when Dr Webb actually intends you to start this
22 plan? If we pull up that plan a bit to highlight it.
23 A. The way I would read that is that there's no exact
24 indication of when this was to be given or started.
25 THE CHAIRMAN: Would you not then take it that it was to

1 start pretty much straightaway? If a doctor puts a plan
2 in place for a child who's not responding well to the
3 treatment she's already receiving and this plan is
4 different from what had been done before, do you not
5 then work on the assumption that unless he says, "Try
6 this in 2 or 4 hours, if there's no improvement", that
7 you start it straightaway?
8 A. Yes, you could take that to be the case.
9 THE CHAIRMAN: What I'm really saying is: is there anything
10 else you would take other than that?
11 A. I suppose it's a ... When you're writing this up, it's
12 the practicalities. I wouldn't necessarily have been
13 aware of the medication that was actually physically
14 present on the ward.
15 THE CHAIRMAN: Okay. So there's actually tracking down the
16 medication, putting it together and so on.
17 A. Yes.
18 THE CHAIRMAN: That might always be the position.
19 A. Yes, but I think, from my practice, you'd have to take
20 that into consideration because I wouldn't necessarily
21 have been aware of acyclovir or cefotaxime was actually
22 in the drugs cabinet at that time, that I could have
23 started at that time, you know, because of the
24 seriousness, as you've indicated, Mr Chairman.
25 MS ANYADIKE-DANES: Some of the reason why you might not

1 have prescribed it to start at the same time is because
2 it might not have actually been available.
3 A. That may well have been the case, yes.
4 Q. Well, if you want a drug to be started at a given time
5 and you can't because it's not available, is that
6 something you should make a note of because that's
7 getting in the way of the plan of the child's care?
8 A. Yes, it would have been good practice to document "not
9 available".
10 Q. Not only good practice, it might actually have been
11 extremely helpful because that might have altered
12 practices. People might have realised that we need to
13 maybe change the amount of stock we keep of certain
14 drugs because we can't have a situation where the
15 consultant has directed something, the junior doctor
16 wants to prescribe it and he can't do it because it just
17 doesn't happen to be there. Maybe we have to review why
18 don't we have it there? So it would have been good to
19 have recorded that fact, if that was the case?
20 A. Yes.
21 Q. Did you actually know what these drugs were for?
22 A. Yes, because cefotaxime, from my experience, would have
23 been -- it's an antibiotic and acyclovir's an antiviral.
24 Q. So this was, as the chairman indicated to you, a form of
25 medication that hadn't actually yet been given to

1 Claire?
2 A. No.
3 Q. Because as of that stage, all the medication that at
4 least you've had anything to do with has all been
5 anticonvulsant --
6 A. Yes.
7 Q. -- from the diazepam to the phenytoin to the midazolam.
8 It's all anticonvulsant.
9 A. It is.
10 Q. Sodium valproate. It is all anticonvulsant. This is
11 the first time that the consultant has indicated:
12 actually, maybe introduce a different form of therapy
13 here.
14 A. Yes.
15 Q. So if that's the case, is it not all the more important
16 that either you start it immediately or you confirm with
17 somebody more senior, preferably the person indicating
18 it as his plan, as to whether it's important that it is
19 started immediately?
20 A. It would.
21 Q. I wonder if you could help with this: when you do the
22 ward round, do you indicate status epilepticus?
23 A. Yes.
24 Q. And also that there's going to be a discussion with
25 Dr Webb? Probably not involving you, but Dr Webb is

1 going to be consulted, if I can put it that way.

2 A. Yes.

3 Q. And also there's a plan that she should be given rectal

4 diazepam.

5 A. Yes.

6 Q. And thereafter, I think in Dr Sands' hand, is added

7 "encephalopathy/encephalitis". And that's added.

8 A. Yes.

9 Q. And that brings with it a notion of some viral effect

10 going on.

11 A. That's true.

12 Q. Do you have any knowledge of when that got added to the

13 medical notes?

14 A. I've no memory.

15 Q. Was that ever discussed with you?

16 A. No, not to my knowledge.

17 Q. You don't remember it in particular?

18 A. I don't remember it in particular.

19 Q. Well, you don't remember it at all in fact.

20 A. Yes.

21 Q. The rectal diazepam, though, was something that, between

22 Dr Webb and Dr Sands, Dr Webb seems to have approved of

23 and the rectal diazepam was administered and was

24 administered some time between 12 and 1 o'clock.

25 I think it's 12.30 it's administered. If all those

1 things were being discussed with Dr Webb, would that
2 suggest to you that some time before then the
3 differential diagnoses of encephalopathy and
4 encephalitis have been added?
5 A. It could have been, yes.
6 Q. It could have been. And could you therefore have been
7 aware all through the afternoon that there is a concern
8 that there is something viral, something bacterial,
9 going on with Claire --
10 A. Yes.
11 Q. -- if you'd read the notes?
12 A. Yes. You would take that from that.
13 Q. You would take it from that. And you may say you were
14 too junior to ask the question, but if you'd had any
15 discussions at all with Dr Sands, might you have asked,
16 "What are we doing about the other stuff that is thought
17 to have been perhaps contributing to her condition?".
18 You're the person actually carrying out the plan in
19 terms of medication. You would have seen that there was
20 no medication that you're being asked to address that
21 has anything to do with -- other than effectively the
22 anticonvulsant, the neurological signs?
23 A. But I think at my level of experience in paediatrics at
24 that time, I'm not certain if I would have had the
25 confidence. And maybe I should have asked, you know, as

1 a learning point, "What other options do we need to
2 consider here?", from someone who's more experienced.
3 Q. That's actually one of the things I'm trying to get at.
4 Here you have a child where nobody's entirely sure
5 what's happening and -- well, they do know what's
6 happening, but why it's happening. And you are
7 learning, you're halfway through your rotation in
8 paediatrics. Would you not have regarded that as an
9 opportunity to try and understand for yourself what is
10 happening as, as you put it, a learning point?
11 A. But at the time you're trying to manage Claire in the
12 way that has been advised by more senior colleagues. So
13 it would be -- if you wanted to make a learning point
14 from it, then you would, on reflection back, you know,
15 review what was done, how it was done, why it was done.
16 Q. Did you ever think to do that afterwards when you knew
17 that, unfortunately, this had a terminal end for Claire?
18 Did you ever think to go back to Dr Sands or any of the
19 consultants, as a learning point, to understand what had
20 happened and how it had happened?
21 A. I don't recall if I personally went back to any of the
22 more senior doctors to discuss it.
23 Q. Has it ever occurred to you to do that in other
24 circumstances?
25 A. In the basis of other clinical --

1 Q. Yes.

2 A. Yes.

3 Q. So it's not that it would be a completely alien thing to

4 do?

5 A. No.

6 Q. Is it that at the time when you were dealing with Claire

7 that you were just so busy that you didn't have time to

8 think about actually what you were doing or why you were

9 doing it, you were simply responding to the directions?

10 A. I believe that's probably the case, yes.

11 THE CHAIRMAN: We'll break until 3.50.

12 (3.40 pm)

13 (A short break)

14 (3.51 pm)

15 MS ANYADIKE-DANES: Dr Stevenson, I have been asked to, just

16 before we get too ahead with the chronology, to put to

17 you some matters that come from further back. One of

18 them was quite further back. Can we pull up

19 090-022-052?

20 This is a note or at least part of a note that

21 Dr O'Hare makes, and so she's on in the night shift, if

22 I can put it that way. After she has got her plan for

23 IV fluids, she's got a suggestion of "IV diazepam, query

24 seizure activity". Then she says:

25 "Reassess after fluids."

1 It may be that you've already covered this point as
2 to the extent to which you would look at the notes
3 preceding, but I think what you suggested that you would
4 do or indicated you would do, although you can't
5 remember, is you'd be getting everything together for
6 the ward round to make sure all was in order?
7 A. Yes.
8 Q. In the course of that, would you actually be reading the
9 notes themselves?
10 A. Yes.
11 Q. So you would have seen that? What does that mean to
12 you, "reassess after fluids"?
13 A. Once the fluids that had been run through --
14 Q. Reassess what after fluids?
15 A. "Reassess the patient" is how I would have read that.
16 Q. What would that have involved in that context? There's
17 going to be a ward round at some stage, but there's
18 a specific reference to "reassess after fluids"?
19 A. Review the history and presenting complaints and then
20 examination findings, and then ... You know, on the
21 ward round.
22 Q. So reassess that indication of what should be happening,
23 the IV fluids, whether there should be IV diazepam?
24 A. Yes.
25 Q. Reassess all of that?

1 A. All of that as part of the ward round to review, and
2 then to formulate a working diagnosis and then
3 a management plan accordingly.
4 Q. And then you see, at 12 midnight, there is a bit of
5 a reassessment, or at least there appears to have been.
6 A. Yes.
7 Q. "Slightly more responsive. Observe and reassess in the
8 morning."
9 A. Yes.
10 Q. Do you see that?
11 A. Yes.
12 Q. What is being reassessed? Her overall condition, her
13 overall presentation or anything more specific than
14 that?
15 A. From my opinion -- and I can't speak for Dr O'Hare whose
16 entry I believe this is -- it would be all of the
17 clinical history and the presenting symptoms and
18 Claire's condition at the time of the ward round.
19 Q. Particularly, maybe, because it says there, "Has been
20 slightly more responsive", her responsiveness, that sort
21 of thing?
22 A. Yes.
23 Q. In addition to her vital signs and so forth?
24 A. Yes.
25 Q. Just her presentation?

1 A. Well, at the ward round you sort of review everything
2 rather than just take --
3 Q. That's why I'm wondering. If you're going to do that on
4 a ward round anyway, is this being emphasised in any
5 particular way that there should be reassessment? Does
6 it indicate maybe there should be some reassessment
7 perhaps before the ward round or at least early in the
8 ward round when there has been two references to
9 reassessment, the last of which says, "Reassess AM".
10 Presumably both Dr O'Hare and Dr Volprecht would be very
11 well aware of the fact that there will be ward rounds in
12 the morning.
13 A. Yes.
14 Q. But is a way of interpreting that that what they really
15 meant is somebody should be looking at this child fairly
16 early in the morning, not at the end of a ward round,
17 for example?
18 A. Yes.
19 Q. Is that how you might have interpreted that?
20 A. No, the way I would have interpreted it is this is to be
21 reassessed at the time of the ward round.
22 Q. But I understood you to say that, in any event, that you
23 reassess anyway at a ward round?
24 A. Yes.
25 Q. So this is completely unnecessary?

1 A. Well, I can't speak for what Dr O'Hare meant by that.
2 The way I would have understood it to mean is, as part
3 of your ward round, then that was a reassessment.
4 Q. Yes. So then, in a handover, when one sees that
5 a registrar has put "reassess" twice in that way in the
6 morning, is that just the sort of thing that you might
7 want to clarify with a registrar, whether there's any
8 particular reason I'm being directed to this -- not you
9 personally, but maybe Dr Sands -- since I'm going to
10 obvious reassess her in the ward round? Is it
11 indicating she should be seen first thing or with some
12 level of priority? Is that not the sort of thing one
13 would hope to have, an exchange between the moving on
14 registrar and the incoming?
15 A. Yes, but that would be for the registrar in this case to
16 pass on to the relevant people coming on.
17 Q. But if you'd seen it as you're gathering together the
18 notes, might it not be something that you might have
19 suggested or prompted Dr Sands and said, "I don't
20 exactly know what that means, you normally reassess
21 anyway, but since it has been put in twice, maybe you
22 want to think about priorities"?
23 A. Yes. That could have been the case.
24 Q. Could have?
25 A. Yes.

1 Q. If we go to 090-022-053, I have referred to this
2 a couple of times with varying degrees of success or
3 pronunciation. "Impression, non-fitting status."
4 That's you?
5 A. Yes.
6 Q. Thereafter, "encephalitis/encephalopathy". And you're
7 not entirely sure when that was added?
8 A. No.
9 Q. You can't remember any of this, so you definitely can't
10 remember any discussion about when that ought to be
11 added or might have been added?
12 A. No.
13 Q. Then if we go further on in the medical notes, we see at
14 090-022-054 -- so that's your next note. That's after
15 Dr Webb has seen her and that's a note at 2.30.
16 A. Yes.
17 Q. And the purpose of that note seems to have been to
18 record these things that you have to do in terms of the
19 phenytoin prescription, which is that part of the plan,
20 item (i), and then checking the levels.
21 A. Yes.
22 Q. You don't recall anything else there?
23 A. No.
24 Q. So you are not seeking to summarise where we are at that
25 stage in terms of the differential diagnoses?

1 A. No.

2 Q. You're simply recording what it is that you're going to

3 do?

4 A. Yes.

5 Q. If you go over the page again then to 022-055. There

6 we are. "Seen by Dr Webb." That's your note, we were

7 just looking at it earlier. You see that that's "Still

8 in status"?

9 A. Yes.

10 Q. That's a mini history, a sort of "Where are we now since

11 previously?".

12 A. A very poor summary, but just a summary.

13 Q. But that's what it's intended to be.

14 A. Yes.

15 Q. And then you go on and deal with the main thing you have

16 to do, which is to organise the calculation and

17 administration of the midazolam.

18 A. Yes.

19 Q. But if you take that first line as at least trying to

20 summarise where we are now or where Claire is now,

21 there's no reference in that to

22 encephalitis/encephalopathy.

23 A. No.

24 Q. So according to the note that's added, although we don't

25 know when it is, presumably if you were doing a kind of

1 a mini history, you'd be looking back at the notes,
2 would you not?
3 A. Yes.
4 Q. So she's still in status. That was one part of what the
5 notes apparently said. There's these two other bits,
6 which are completely different.
7 "Encephalitis/encephalopathy." There's no record of
8 that?
9 A. No.
10 Q. Is there any reason why, if you were doing, admittedly
11 the most truncated of summaries, if you were trying to
12 put one part of where Claire's current condition is, you
13 wouldn't have added, if you had seen it, encephalitis
14 and encephalopathy?
15 A. No.
16 Q. No reason?
17 A. No.
18 Q. Because that's all part of her picture as we understand
19 it to be.
20 A. Yes.
21 Q. Then you were looking through her notes. Have you seen
22 any evidence to the encephalitis/encephalopathy anywhere
23 other than there?
24 A. In the previous page?
25 Q. Yes.

1 A. I don't recall seeing anything.
2 Q. But if you were going to carry out Dr Webb's plan
3 in relation to the midazolam and so forth, still
4 hanging, if that had been identified at that stage, was
5 the encephalitis/encephalopathy, would you not have
6 needed a treatment plan for that?
7 A. Well, yes, it would follow on then from the next entry,
8 timed at 1700.
9 Q. So if that had already been there, you would have been
10 seeking guidance on: okay, I see this is what I have to
11 do about the fact she's still in status; what is it that
12 I'm to do about the fact that somebody has included in
13 her differential diagnoses
14 'encephalitis/encephalopathy'?" You'd be looking for
15 a treatment plan for that as well, wouldn't you?
16 A. Yes, from a -- well, in this case a more experienced
17 clinician.
18 Q. It's not something that you're going to devise yourself,
19 is it?
20 A. No.
21 Q. So you need some guidance on what is the treatment plan
22 for that?
23 A. Yes.
24 Q. And that's what you'd have been looking for.
25 A. Yes.

1 Q. And if you had got one, you'd have recorded it.
2 A. I would have.
3 Q. One last point to take up with you, and that is,
4 you have said, I think, it's part of the junior
5 doctor/SHO's role to take the bloods and that sort of
6 thing. I think you've already said it was fairly normal
7 to have bloods taken as part of the follow-on from the
8 ward round.
9 A. Yes.
10 Q. Well, why weren't any bloods taken for Claire?
11 A. I can't recall why. I can make assumptions, but I can't
12 recall why.
13 Q. Wouldn't it have been particularly important to do that
14 since, the previous evening, she had had a low sodium
15 result?
16 A. Yes.
17 Q. And she was on IV fluids, and you actually hadn't
18 reassessed her IV fluids, you simply carried on with the
19 IV fluids, as I understand your evidence yesterday, from
20 what had been given her before.
21 A. Yes. It would have been better to have done the bloods.
22 Q. But not only would it have been better, would it not
23 have been -- I understood what you were saying was that
24 it was fairly standard practice to have done the bloods
25 after the ward round.

1 A. If it was clinically indicated at the time of the ward
2 round. If the directions came at the ward round to do
3 bloods, we would have done the bloods.
4 Q. Leaving aside that, how often did patients on the ward
5 typically have their bloods checked?
6 A. I don't recall how often. It depends on the clinical
7 cases.
8 Q. So it wasn't anything that was done routinely?
9 A. Well, there's generally bloods done every day on some
10 patient or other, but the exact number and if it was
11 a routine --
12 Q. Admitting your limited experience, but on a patient like
13 Claire, could even you see that having the blood tests
14 for her was appropriate?
15 A. Yes.
16 Q. Just on the acyclovir and cefotaxime, I was asking you
17 about those: Dr Webb has, in his witness statement, said
18 138-1, page 41, in answer to question 24 -- this is the
19 very question that the chairman was asking about what
20 would you have anticipated that Dr Webb would have meant
21 about starting time, and he says:
22 "I recommended that Claire received cefotaxime and
23 acyclovir at 5 pm. I would have expected this to have
24 started within an hour or two. There was no delay in
25 the administration of cefotaxime to Claire and I do not

1 know why there was a delay in administering the
2 acyclovir."
3 So from Dr Webb's point of view, there was no
4 suggestion, as I think you were wondering -- although
5 you don't remember -- whether the reason why the
6 acyclovir might not have been administered fairly
7 promptly was actually because you were trying to spread
8 it out at three times a day or whatever it is. The
9 evidence of Dr Webb doesn't indicate that at all. Quite
10 the contrary. He wasn't seeking to have you spread it
11 out; he was anticipating that you would start that
12 fairly soon, within a hour or two, time to arrange it
13 and so forth, and he doesn't understand why it's not
14 done. You can't help us with that, except to confirm
15 that the records indicate that it wasn't done?
16 A. No, not within the time frame that Dr Webb's indicated.
17 Q. So the upshot of that might have been, if there was
18 something that this medication could have addressed that
19 related to the encephalitis/encephalopathy or any other
20 thing to do with her condition, it's not something that
21 had been started fairly early, and even if the
22 consultant identified that maybe something like that
23 could be beneficial, there is delay there?
24 A. There is.
25 Q. So there's a very long period of time when whatever

1 it is that that medication thought might help is simply
2 not being addressed?
3 A. That's true.
4 Q. Okay. I would like to ask you now about the
5 neurological observations. If we go to 139/1, page 27,
6 in answer to question 37(e). This is where you talk
7 about the Glasgow Coma Scale:
8 "State the Glasgow Coma score that you consider to
9 reflect the onset of coma."
10 And you say:
11 "A Glasgow Coma score of less than 8 is considered
12 severe, 9 to 12 moderate, and less than 13 mild.
13 I would feel a score of less than 8 indicates the onset
14 of coma."
15 We had produced a schedule for the coma scores to
16 try and assist. If I pull that up alongside
17 310-011-011. I may have got the wrong number. Bear
18 with me. (Pause).
19 I have just seen it come up. There we are. So if
20 one looks at the left side of that, you can see Claire's
21 modified GCS scores for the 22nd; do you see that?
22 A. Yes.
23 Q. And the scores are in on the three different bases of
24 calculating them with the totals along the bottom. That
25 total you were saying, of 8, that's where one finds

1 that. The rest of the information is simply to indicate
2 how that is arrived at and shows you the differences
3 between the three of them and where the more or less
4 serious presentations in those three different
5 sections -- and you see the passage over time. The red
6 indication is the observation that Dr Webb makes during
7 his examination of Claire at 2 o'clock in the afternoon.
8 The rest of it comes from the records that the nurses
9 maintain.
10 This is something that you'd have had available to
11 you?
12 A. It would be a modified copy, but it would be very
13 similar.
14 Q. Yes, the one that the nurses are maintaining?
15 A. Yes.
16 Q. And you knew how to interpret that --
17 A. Yes.
18 Q. -- as to its significance?
19 A. Yes.
20 Q. And you knew that Claire was on hourly obs?
21 A. Yes.
22 Q. Is that something that you would have been looking at
23 just to keep a check on how she is going?
24 A. Yes, and also be guided by the nursing staff who are
25 doing the tests.

1 Q. Exactly. If we look along the bottom, I should say that
2 what is in brackets is -- I think it's Dr Webb's
3 calculation. He has a sort of a re-modification as to
4 what the figures should be.
5 A. Okay.
6 Q. But then if you look along the bottom, you can see
7 those. Are those results that would have concerned you,
8 had they been brought to your attention?
9 A. Yes, and also the change.
10 Q. Yes. Of course, there's now an element of subjectivity
11 in it because some people may --
12 A. There is.
13 Q. -- reflect things slightly higher or less and sometimes
14 one might detect that in a change of handover or
15 something. But broadly speaking, I think there was only
16 one handover change over that period. But broadly
17 speaking, they are all fairly serious, aren't they?
18 A. Yes.
19 Q. Even Dr Webb's slight modification, which has the
20 benefit of raising it by one point, nonetheless has that
21 all at the level, when I just read out your statement
22 there, which would be something of concern to you. And
23 not only concern, but you would have considered that
24 severe.
25 A. Yes.

1 Q. Because you have got, even if you take Dr Webb's,
2 you have got a severe score at 4, 5 o'clock, and
3 bordering severe at 6 and 7.
4 A. Yes.
5 Q. And then severe again, not that you'd have been there at
6 9. But the ones for when you would have been there,
7 if we take you to 5 o'clock. You would have been at the
8 one at 9. I think you have described that as moderate,
9 9 to 10. That's the first one for during your shift.
10 That's moderate. The 8 to 9, that's verging on moving
11 between severe to moderate.
12 Then the next one at 3 o'clock -- well, that is
13 severe. That's severe even by Dr Webb's calculation.
14 And it becomes even more severe at 4 o'clock. Then it's
15 still severe, same level, at 5 o'clock. So towards the
16 latter half of that afternoon when you were on duty and
17 the person of contact on that ward, Claire's Glasgow
18 Coma score was what you yourself have acknowledged was
19 severe?
20 A. Yes.
21 Q. Well, what did you do about it? Or what do you think
22 you should have done about it?
23 A. I should have reviewed Claire myself and, if there was
24 concerns that was highlighted to me, the changes in the
25 Glasgow Coma Scale, I should have sought help or advice

1 from a more senior colleague.
2 Q. Leaving aside whether the nurses thought there was
3 concern, on your own interpretation, there is a concern.
4 She has gone down, in fact she's going down -- that's
5 one thing that's presumably of concern. Not only that,
6 it's what she goes down to.
7 A. Yes.
8 Q. She goes down to something at 3 o'clock that you
9 consider to be severe and she goes down again to -- this
10 is on Dr Webb's -- 7. Even more severe at 4.
11 A. But in the space of that afternoon, Dr Webb saw Claire
12 three times. It's not a justification for my failings
13 by any means, but at my level of a trainee in
14 paediatrics, I would be referring and deferring to
15 Dr Webb and his level of experience.
16 Q. Dr Stevenson, I entirely understand that. But you're
17 part of the paediatric team. This patient's consultant
18 is your consultant, if I can put it that way, Dr Steen.
19 A. Yes.
20 Q. You would have known then whether, in your estimation,
21 Dr Steen had been anywhere near Claire throughout that
22 day. So leaving aside the fact that your registrar has
23 got in a specialist neurological opinion about this, did
24 it occur to you that this is something that your
25 consultant really ought to know about?

1 A. No, because I would have been still deferring to
2 a senior colleague, whether it was a neurologist, and in
3 this case I probably did refer more to Dr Webb's
4 management rather than considering contacting Dr Steen.
5 Q. Do you think it's something that Dr Steen should have
6 known about? Irrespective of whether you felt the
7 obligation was yours to advise her, do you think it's
8 something that she should have known about or been
9 alerted to?
10 A. Well, yes, if you follow on from her evidence this
11 morning --
12 Q. No, forget her evidence this morning. From your view.
13 Step back into 1996.
14 A. I still recall -- all I can say is that I probably would
15 still refer to Dr Webb, but yes, it would have been
16 better for Dr Steen to be informed since she was
17 Claire's consultant.
18 Q. I'm not suggesting that you were the person to do it,
19 but what I'm seeking to ask you is if this state of
20 affairs something that you would have thought Claire's
21 consultant paediatrician or consultant ought to know
22 about?
23 A. Yes.
24 Q. Thank you.
25 THE CHAIRMAN: So if Dr Steen rang from Cupar Street or if

1 somebody rang from Allen Ward to Cupar Street, one of
2 the ways in which she would have been advised that
3 Claire's condition was causing concern was by reference
4 to the Glasgow Coma Scale?
5 A. It would be certainly one of the observations that you
6 would want to pass on.
7 MS ANYADIKE-DANES: And although we've been looking at the
8 total, if you were to look a little higher than that,
9 there's no vocal response at all all the time you're
10 there.
11 A. No, that's true.
12 Q. Isn't that right?
13 A. Yes.
14 Q. And all the time you're there, there's no eye opening at
15 all recorded. Sorry, I beg your pardon. There's two
16 3s. At 1 pm and 2 pm, there's an eye opening to speech.
17 A. Yes.
18 Q. And at 2, which has decreased, the eye only opening to
19 pain. That's a deterioration as well. Part of those
20 deteriorations which leads to the deterioration in the
21 total that we see.
22 A. Yes.
23 Q. So if one was going to put Dr Steen in the picture, as
24 it were, what she'd be knowing is that you've got
25 a deteriorating Glasgow Coma Scale, and what I have to

1 tell you is that there has been no vocal response
2 recorded and her eye-opening response has deteriorated
3 so that she's really opening her eyes, as far as
4 3 o'clock, to pain and, by 4 o'clock, she's not opening
5 them at all.
6 Just a few more things that I would like to ask you
7 about. We're sort of almost in there with
8 communications with senior doctors. As we've gone
9 through, you have tried to touch on that. I just want
10 to make sure that for the benefit of those who are
11 seeking that we have all your evidence on that ...
12 Leaving aside the consultant, who's several removes
13 from you, if I can put it that way, although I think
14 you've conceded that, if it was necessary, you knew that
15 you could contact a consultant.
16 A. Yes.
17 Q. And Dr Steen has given her evidence to say if it was
18 necessary, she would expect you to contact her. Let's
19 deal with the people more closely connected to you and
20 that is the registrar. In 1996 -- because it might now
21 be different -- what did you regard as your duty, your
22 role, in keeping in contact with your registrar about
23 the condition of a patient?
24 A. It was to keep them up-to-date and if you had any
25 concerns, to seek their advice, you know, in regard to

1 those changes, in regard to -- well, in this case,
2 Claire.
3 Q. I will stand to be corrected, but I think there is only
4 one reference to Dr Sands being in and about when
5 Dr Webb is there. I think it was that latter one
6 we were looking at.
7 A. Yes.
8 Q. So it would seem that Dr Webb saw Claire three times and
9 it may be that Dr Sands was only around once or
10 thereabouts. Is that the sort of thing that you feel
11 you should keep Dr Sands appraised of, that Dr Webb has
12 actually come and this is the view that he has and this
13 is his management plan and this is what I'm doing about
14 it?
15 A. But I think at that time I probably would have again
16 referred to the consultant.
17 Q. No, no, no, I mean keeping your registrar up to speed
18 with what's going on. He's the most senior paediatric
19 person, if I can put it that way, apart from the
20 specialist who is --
21 A. But I would have jumped, if you put it in those terms,
22 the line management ... in the sense that if the
23 consultant has been involved, I may not have -- and
24 obviously I didn't indicate that I've contacted Dr Sands
25 to keep him up to speed.

1 Q. So you might not have kept Dr Sands up to speed?
2 A. No, because the consultant was involved already in
3 Claire's case.
4 Q. What did you think Dr Webb was actually brought in to
5 do?
6 A. To give a further opinion into the reasons why Claire
7 was so unwell.
8 Q. Well, maybe you can help me with that. Do you think
9 he was being brought in primarily as the neurologist to
10 deal with her neurological presentation?
11 A. Well, that would be the prime reason to bring him in,
12 for advice, to clarify your diagnosis or your
13 uncertainty of the diagnoses, and to get maybe
14 clarification on how to manage this.
15 Q. And did you think then that once Dr Webb was engaged, if
16 I can put it that way, that in fact what he was then
17 doing was dealing with all her condition, not just the
18 neurological aspect?
19 A. As far as I can recall, that's what I took to be the
20 case.
21 Q. So are you saying that you thought that, effectively,
22 Dr Webb had taken over her management?
23 A. Yes.
24 Q. Are you sure about that?
25 A. I'm not privy to how consultants discuss amongst

1 consultants at my level, but that would be my experience
2 in the previous years.
3 THE CHAIRMAN: If Dr Webb saw Claire three times on the
4 Tuesday afternoon, which he appears to have done, and
5 Dr Steen wasn't around, as she appears not to have been,
6 is that why you, looking back on it, think that that
7 supports a view that Dr Webb had, for whatever reason,
8 taken control because he was the only consultant around?
9 A. De facto he was giving me advice as a very junior
10 trainee and I took that to be that he, yes, had taken on
11 the responsible ...
12 THE CHAIRMAN: You know there's something of a debate -- not
13 only between the consultants, but also between the
14 experts in Claire's case -- about whether, in fact, that
15 was the case, whether Dr Steen retained primary
16 responsibility or whether Dr Webb had taken it over, or
17 whether they had shared responsibility. When you give
18 us your view, is that on the basis of the physical
19 presence and interventions of Dr Webb and the absences
20 of Dr Steen for whatever reason?
21 A. Yes, because I was the one who was dealing with the
22 practicalities of the medication as we've already been
23 asked [sic] upon. So that's where I've taken my
24 guidance from: it is the consultant who's given me those
25 responsibilities.

1 MS ANYADIKE-DANES: As the chairman has just indicated, this
2 issue as to who actually had control over the care and
3 management of Claire has become, not surprisingly,
4 a rather important one, partly because, at some stage,
5 there seems to be no evidence of Dr Steen's involvement,
6 but there is some evidence of Dr Webb's involvement.
7 The inquiry put together a schedule, trying to
8 compile in one place everybody who had given evidence in
9 their witness statements on that issue as to who they
10 thought was in charge of Claire. If I can pull it up,
11 it's 310-005-001.
12 There it is. It's literally, as it says:
13 "Who was the consultant with responsibility for the
14 management, care and treatment of Claire from
15 approximately 1400 hours on 22 October [which happens to
16 be the time when we have the first note of Dr Webb's
17 involvement] to 23 October?"
18 One goes through a number of people. Obviously
19 Dr Steen and Dr Webb have their views.
20 If we go over the page to 002, Dr Sands is asked
21 that, and he expresses his view.
22 If we go over the page again to 003, we have your
23 view. You see the first one:
24 "I believed Claire was under Dr Steen as her named
25 consultant between her admission and up to the time of

1 my leaving the ward at the end of the shift. I am
2 unable to recall if there had been a formal transfer of
3 responsibilities to Dr Webb or if he was providing
4 advice in managing Claire's condition."
5 So that's your first witness statement, page 28, in
6 answer to question 40:
7 "I believed Claire was under Dr Steen."
8 Then it says the basis of your belief that Dr Steen
9 was responsible for Claire's care on 22 October was:
10 "... on hearing the next morning that Claire had
11 died in PICU and he knew that Dr Steen was the duty
12 consultant for Allen Ward at that time."
13 That is made reference to in your second witness
14 statement. But certainly when you were asked about it
15 previously, your view seems to suggest that the
16 consultant is Dr Steen. Now, it may be that you can
17 reconcile those things.
18 A. Yes, because it would be seen that the admitting
19 consultant was Dr Steen, but from my -- from the
20 practical aspect of being the junior doctor on the ward,
21 the person who has given me the lead is Dr Webb in the
22 sense of what treatments needed to be done for Claire
23 over the course of the afternoon.
24 Q. For Claire in her entirety or for Claire on the
25 specialist issues about which his advice had been

1 sought? That's actually the point that I'm getting at.
2 You may not know that because you may say, "I have no
3 idea what Dr Sands and Dr Webb discussed between them".
4 A. I wasn't privy to that, so I can't make any comment on
5 what.
6 Q. But your sense now seems to be, when you just answered
7 the chairman and myself, that you thought, effectively,
8 Dr Webb was in charge of her entire presenting
9 condition.
10 A. Yes, because he was giving me the lead in the practical
11 issues that I needed to do that afternoon.
12 Q. I had been asking you really about keeping Dr Sands up
13 to speed, if you like, and I think what you had then
14 said is actually you jumped a rung in the hierarchy and
15 you were receiving plans and directions directly from
16 Dr Webb and Dr Steen wasn't involved and effectively
17 Dr Sands had been bypassed; is that what you were
18 saying?
19 A. Well, yes.
20 THE CHAIRMAN: Be careful. I think that's slightly putting
21 words in his mouth. He doesn't know if Dr Sands was
22 bypassed because he doesn't know what Dr Sands had been
23 discussing with Dr Webb, if anything. I'm not sure
24 we can get really much further with Dr Stevenson on
25 this.

1 MS ANYADIKE-DANES: Well, from your point of view, in terms
2 of who you thought you should keep up to speed, my
3 understanding -- and please correct me if I'm wrong
4 because I certainly do not want to put words in your
5 mouth, that's not at all helpful -- is it that you
6 didn't feel it was so important to keep Dr Sands
7 appraised of what was happening because you were seeing
8 Dr Webb or receiving the plans from Dr Webb? That's
9 actually what I'm trying to get at.
10 A. Yes, because Dr Webb was involved in the directions that
11 I was being asked to do.
12 Q. Did you think it was relevant to keep anyone appraised
13 of what was happening other than the notes you made
14 in the medical notes and records?
15 A. On reflection, I should have involved Mr and Mrs Roberts
16 and their family, and I've ... Unfortunately, I have
17 not documented that and that's a failing on my part.
18 Q. You say you've not documented it. Does that mean you
19 don't know whether you did or not or --
20 A. Yes, I don't know whether I did or not. I don't recall.
21 Q. They don't recall it.
22 A. I don't know.
23 THE CHAIRMAN: Well, let's assume for the moment that
24 they're right, that Mr and Mrs Roberts are right in
25 saying that you didn't communicate with them and there

1 is certainly nothing in the records which contradicts
2 that. Can I take it -- and, more importantly, can they
3 take it -- that that's a matter of regret on your part
4 that you didn't?
5 A. Absolutely.
6 MS ANYADIKE-DANES: Just finally, in retrospect -- and
7 hindsight is a wonderful thing and we all wish we had
8 it -- would you have thought it to be better practice to
9 have been keeping, if you weren't doing it -- and nobody
10 knows whether you were or not -- keeping Dr Sands
11 appraised of what was going on, who was the next person
12 in the paediatric team ahead of you?
13 A. If you followed the chain of command, yes.
14 Q. Thank you. I think I did ask you about communications
15 with Claire's parents before, and I'm very conscious of
16 the fact that you actually have no independent
17 recollection of any of this, but I think you've given
18 your evidence about that, about the significance of
19 keeping in touch with them and you have just now made
20 the statement that you made now, so I'm not going to ask
21 you any more about that.
22 But I would like to ask you about the handover.
23 When you were giving your evidence, you were talking
24 about the handover at the top end, if you like, which is
25 when you were coming in, and you were saying that

1 sometimes that would happen and sometimes it didn't. It
2 rather depended at the SHO-to-SHO level, where that SHO
3 was going on to, as to whether they were literally
4 there, available to have a handover with you and whether
5 you subsequently contacted them depended on whether that
6 was relevant, given what those higher up were doing and
7 informing themselves.
8 But can we go down to when you're going off duty?
9 That handover may be a little more important, might it
10 not, because whoever is coming on is now going to deal
11 with many more patients?
12 A. Well, it would be the reverse of the person -- you know,
13 it's the reverse of the morning, so it's important that
14 you passed on the important patients and the things that
15 needed to be done to the person coming on because they
16 may not have been attached to Allen Ward -- in this case
17 obviously that was the case -- so they're completely,
18 you know ... They weren't aware of what had been going
19 on.
20 Q. Yes, that's the point. When you come in in the morning,
21 you are attached to Allen Ward and there's more of you,
22 if you like.
23 A. Yes.
24 Q. So although, of course, communication is always good,
25 but it may be that it's even more important when you're

1 doing it at the end of your shift because whoever is
2 coming on is going to deal with many more patients and
3 may not be particularly familiar with any of those on
4 Allen Ward who are the patients that you've been dealing
5 with during the day; would that be fair?
6 A. Yes.
7 Q. And I think that the SHO that you might have been handed
8 over to -- I'll be corrected if I'm wrong -- was
9 probably Dr Joanne Hughes; would that be right?
10 A. On the basis of the records, yes.
11 Q. And can I just find out from you what a handover like
12 that would involve?
13 A. It sometimes is a face-to-face handover with discussions
14 and a list of patients, or things that needed to be
15 done. Sometimes it was done through the telephone
16 through to Musgrave Ward where the other SHO was maybe
17 based.
18 Q. Well, I know you don't remember it, but given the
19 condition that Claire was in and we've just been looking
20 at her Glasgow Coma Scale chart and the times involved
21 and you have seen the timeline and what was going on and
22 the records, what is the sort of thing that you'd be
23 wanting to point out or alert the incoming SHO to?
24 A. Well, Claire's clinical condition and the level where
25 she was when we left the ward and also then what other

1 clinical management plans had to be done, whether that
2 was to give antibiotics or acyclovir.
3 Q. And the other drugs that had yet to be administered and
4 that were going to be started at some point, would that
5 be the sort of thing?
6 A. Yes.
7 Q. What was actually running at the time, might that be
8 something?
9 A. Yes.
10 Q. So you didn't have to do it face-to-face, but you think
11 that it would have been appropriate to have some sort of
12 exchange about it?
13 A. It would.
14 Q. Dr Stewart was also an SHO on that evening. How did it
15 work? Did you just try and get one and have a word with
16 one, did you try and have a word with both, or wasn't
17 there any particular practice at all?
18 A. It varied from day-to-day, depending on the busyness and
19 what rotas, you know, on-call duties that you as
20 individuals had.
21 Q. If there are any outstanding tests that you hadn't yet
22 been able to -- in fact, I think there would have been
23 actually. If you had done them yourself, you would have
24 been doing them on the cusp of you going off duty. You
25 certainly wouldn't have time to get the results. Would

1 you have been alerting them that there's something they
2 might want to be chasing up, that sort of thing?
3 A. Yes. Yes, to expect results to come through at some
4 stage that evening.
5 Q. So leaving aside the fact that you can't actually
6 remember this, would it have been your intention that
7 when you left, whoever the SHOs were that were going to
8 come on duty, they would be under no misunderstanding
9 that Claire was a very sick child?
10 A. Yes.
11 Q. If I can just, in terms of how these things are done,
12 see whether you agree with this: this is Dr Stewart's
13 view as to what happens in a handover of that sort.
14 Witness statement 141/2, page 2, in answer to question
15 1(a):
16 "Describe the normal procedure for the handover."
17 Then the answer is:
18 "Normally, the retiring senior house officer gave
19 a verbal report to their colleague coming on duty. This
20 report covered all relevant information that we would
21 need to continue the patients' care through the night.
22 Such a report might include ..."
23 And then there are details being given:
24 "Information regarding current ward patients whose
25 condition was causing particular concern."

1 Would that have been Claire? Firstly, sorry, if
2 I just finish at the end and then you can see whether
3 you accept that this is an appropriate categorisation of
4 what you would be saying:
5 "Important test results to check before the morning
6 ward round, a list of outstanding tests, a list of
7 outstanding urgent test results that might need to be
8 chased up personally."
9 Does that capture the sort of thing that would be
10 conveyed during a handover?
11 A. It would.
12 Q. It would. Thank you for that. If we go back to that
13 then, "Information in relation to patients whose
14 condition was causing particular concern". Would that
15 have been Claire in your view?
16 A. It would.
17 Q. It would. "A list of outstanding tests." They'd be the
18 blood tests?
19 A. Yes.
20 Q. And, "A list of urgent test results". Would that still
21 be the blood tests? Would they be considered urgent, to
22 get those back?
23 A. Yes.
24 Q. And would you want to alert them to the fact that
25 Dr Webb had suggested that if she didn't wake up, she'd

1 be having an EEG the next morning? Might that be
2 something they would need to know?
3 A. It would be beneficial for them to be aware that they
4 would need to monitor Claire overnight. The EEG would
5 have to be organised on the following day.
6 Q. Yes. Anything about her fluids, that she's been on IV
7 fluids for quite some time now and there's been no blood
8 test result back at that stage?
9 A. Well, again, that would follow up on the bloods, you
10 know, that need to be followed up on.
11 Q. And that she was on hourly observations?
12 A. Yes.
13 MS ANYADIKE-DANES: Thank you very much indeed.
14 Mr Chairman, I wonder if you'd just give me one moment.
15 THE CHAIRMAN: Yes. (Pause).
16 MS ANYADIKE-DANES: I think Mr Quinn has some questions that
17 he would like to ask. I'm happy if you would wish to
18 rise for a minute to see if we can accommodate them.
19 THE CHAIRMAN: Well, I've accommodated some very, very
20 limited questioning, Mr Quinn, before, but I am not
21 going to get into a routine in Claire's case of
22 everybody standing up at the end of a witness and
23 putting questions. Okay?
24 MR QUINN: I haven't asked any questions yet and I'm quite
25 happy to go through my learned friend.

1 THE CHAIRMAN: If you can resolve what needs to be asked --
2 I will rise for five minutes to try and arrange for this
3 to be sorted out and then, before we finish, I'm going
4 to come back to Mr Sephton's point that arose earlier on
5 this afternoon.
6 MR COUNSELL: [Inaudible: no microphone] ask one or two
7 questions of Dr Stevenson?
8 THE CHAIRMAN: Could you liaise with Ms Anyadike-Danes? You
9 won't have known this before, Mr Counsell, but what
10 we've tried to do is liaise as much as possible for the
11 questioning to go through Ms Anyadike-Danes. So
12 Mr Quinn doesn't ask it from the family's angle, you
13 then ask it from another angle, somebody asks it from
14 another angle. It becomes unhelpful.
15 MR COUNSELL: I understand that. I only ask that given
16 that, of course, I am counsel for Dr Stevenson.
17 THE CHAIRMAN: I understand. What has happened before is
18 that when inquiry counsel's finished asking her
19 questions, we have given an opportunity, but I do
20 restrict it, and if it is necessary to start, we'll
21 start with counsel for the family, Mr Quinn.
22 Dr Stevenson, you're almost finished, just wait for
23 a few minutes, please.
24 (4.41 pm)
25 (A short break)

1 (4.53 pm)
2 THE CHAIRMAN: Where are we?
3 MS ANYADIKE-DANES: If we could please pull up 090-022-055.
4 Right down at the bottom is Dr Webb's plan. You are
5 made aware of that plan because you seek to put some of
6 it into effect; isn't that right?
7 A. That's true.
8 Q. What happened about 2? Was all of the plan carried out
9 at 5 o'clock?
10 A. I can't recall.
11 Q. Well, where would you see the evidence of all that plan
12 being carried out? Would you have put a note just
13 before you go -- we see Dr Webb's note at 1700 hours.
14 I know you're about to go off or maybe about to see
15 another patient. But since that's a plan that you see
16 and do start to put into effect because you start to put
17 it into effect item number 1, do you -- I don't think
18 you do 3, Dr Sands does 3, I think at least from the
19 prescription. But do you not think it would have been
20 appropriate to have added a note immediately after that,
21 as to what you are doing, what's left to be done or
22 something of that sort?
23 A. Yes, it would be normal practice for me, you know, if
24 there was a request for a blood done to tick that so
25 that I've indicated that I've done it.

1 Q. Yes. Well, she's already got intravenous access, hasn't
2 she? Would it have been very difficult to have taken
3 blood?
4 A. The practicalities -- you know, you certainly could have
5 done it.
6 Q. Sorry?
7 A. Yes.
8 Q. You easily could have done it?
9 A. Yes.
10 Q. Is there any are reason why you didn't?
11 A. I can't recall now why.
12 Q. If I can take you further back to 090-022-053, and that
13 addition of "encephalitis/encephalopathy". I think when
14 I was asking you before, you noted that you hadn't made
15 any reference to that when you do your mini history
16 later on in the notes. I think you said that if you had
17 been there, then you think you would have addressed that
18 in some way because you'd have needed some sort of plan
19 to deal with it. Is it possible that it actually wasn't
20 there before you left the ward?
21 A. I'm not certain of your question.
22 Q. That addition of "encephalitis/encephalopathy", as
23 further differential diagnoses, is it possible that that
24 actually wasn't added to the notes before you left the
25 ward?

1 A. That's a possibility.

2 Q. Because you don't refer to it anywhere in anything that

3 you do or engage in.

4 A. Yes, that would be true.

5 Q. So it is possible that it just wasn't there?

6 A. It could be true, yes.

7 Q. Thank you.

8 THE CHAIRMAN: That must be so. We don't have a time when

9 it was added. We don't have a day when it was added.

10 MS ANYADIKE-DANES: No. Or a year.

11 Then if I can ask you something about your

12 experience on the ward. You have said that you were

13 three months into your paediatric rotation.

14 A. Yes.

15 Q. What was your experience on Allen Ward?

16 A. Well, I would have started -- well, that would be three

17 weeks of that two-month block.

18 Q. So where would you have been for the previous three

19 months?

20 A. It's a six-month period, so the first two months I was

21 in A&E in the hospital. And then we would have moved or

22 rotated around the medical ward for two months and then

23 in the surgical ward for two months. So this is part of

24 that first three weeks of being on Allen Ward.

25 Q. Actually on Allen Ward would have been three weeks, is

1 that right, roughly?
2 A. Roughly, yes.
3 Q. And are you aware, as you were going round, of getting
4 an induction at all, as to how things get done on
5 Allen Ward?
6 A. I don't recall specifically an induction for Allen Ward.
7 From my past experience on other units, you would have
8 got an induction within the first week of starting that
9 new position.
10 Q. Then I want to take you to one of the patients, the
11 other patients, not Claire, with which you had some
12 involvement. If we go to file 150, it's patient S7.
13 It's at 007-003. Is that your note at 5 o'clock?
14 A. It is.
15 Q. It says, "Medical SHO"; was there anybody with you there
16 so far as you're aware?
17 A. That was only myself.
18 Q. That's you?
19 A. Yes.
20 Q. So if one goes through that up until 004, that seems to
21 be quite a lengthy note. I know you can't remember
22 this, but if you can just cast your eye over the sort of
23 thing that you're recording and, in particular, if you
24 look at 004, the type of examination that you would have
25 conducted to have produced that information, if I can

1 put it that way. How long does that sort of thing take?
2 A. Well, it depends on the child and your co-operation and
3 your engagement with the child and its family. You
4 could take 20 minutes, half an hour, but that would vary
5 depending on the clinical situation.
6 Q. So it's not five minutes?
7 A. No.
8 Q. If I then take you to a schedule that I had shown you
9 before. Sorry, I beg your pardon. Can we stay with
10 that? There was another question I needed to ask you.
11 007-003. "Seen by Dr Steen"; do you see that?
12 A. Yes.
13 Q. And then if you go to the nursing note, 007, there's
14 a reference to:
15 "Mum phoned Dr Steen this morning and brought the
16 child down to Allen Ward."
17 So there seems to have been some indication of
18 a conversation between the mother and Dr Steen.
19 Then if you reflect again on your note "seen by",
20 when I asked you about that, you thought it indicated
21 that Dr Steen, I think, had been involved prior to the
22 child coming to the ward. And I wondered if that was
23 a very careful use of words "had been involved" as
24 opposed to "had seen".
25 MR FORTUNE: Sir, how many times must the question be

1 allowed to be asked, even if it's put in a slightly
2 different way? You have been quite strict in the past.
3 THE CHAIRMAN: And I will be again, but if somebody has
4 raised an issue about whether the oral evidence given is
5 consistent or indicates some moving away from the
6 written note, I would like to hear if there's an answer
7 to that question. And I think that is the effect of the
8 question, whether, when Dr Stevenson said earlier that
9 there's an indication that Dr Steen was involved,
10 whether that's moving away from the note. Is that the
11 point?
12 MS ANYADIKE-DANES: That's exactly the point.
13 THE CHAIRMAN: Do you understand? I think earlier this
14 afternoon you referred to Dr Steen appearing to have
15 been involved, whereas this note -- as I now
16 understand it -- is your note of the parent telling you
17 that the child had been seen by Dr Steen.
18 A. It would be my note of what the patient's parents had
19 told me.
20 MS ANYADIKE-DANES: Can you help with that? If you look
21 back at the note the nurses took, what appears to have
22 happened is the mother telephoned Dr Steen. There's
23 certainly no reference in the nursing note to the mother
24 saying that her child has seen Dr Steen. If you look at
25 that and then if you look at your note and think about

1 the answer you gave to me earlier, is there a different
2 way in which you want to interpret your note, your
3 record that you made at the time?
4 MR FORTUNE: Sir, can we --
5 THE CHAIRMAN: I'm not sure he can beyond his note at the
6 time. I know this isn't your question you're asking,
7 but if the note which Dr Stevenson made in 1996 says
8 that a parent told him that the child had been seen by
9 Dr Steen, then I don't know how Dr Stevenson can go
10 beyond that in the absence of any specific recollection.
11 MS ANYADIKE-DANES: I think, Mr Chairman, the point is that
12 what Dr Stevenson might have been told is that the
13 parent had -- he might have been given the information
14 that is recorded in the nurse's note and Dr Stevenson
15 might have assumed that that meant, rather than
16 a telephone call, that Dr Steen had actually seen the
17 child and he's put "seen by" as opposed to "spoken to on
18 the telephone". It might have been his
19 misunderstanding. That's the only issue, so far as
20 I understand it, whether it is possible for that to have
21 been the case.
22 THE CHAIRMAN: I don't understand how the doctor could
23 possibly comment on that 16 years later.
24 MR FORTUNE: I'm hoping that Dr Stevenson is not being
25 pushed to answer that question.

1 THE CHAIRMAN: I don't see how he can answer it.
2 MR FORTUNE: Thank you.
3 THE CHAIRMAN: We're 16 years on. We are parsing notes in
4 a way, written at a different time, for very, very
5 important reasons. But I think we should all be very
6 careful about the extent to which we try to analyse or
7 interpret notes which were written when the people who
8 wrote them cannot remember them. We will do our best,
9 but I'm anxious that we deal with the major issues
10 rather than trying to overanalyse what was written
11 16 years ago.
12 MS ANYADIKE-DANES: I understand that, Mr Chairman. This is
13 a query that came directly from Dr Stevenson's counsel,
14 and when I'm faced with something like that, I have no
15 idea whether that comes from anything else --
16 THE CHAIRMAN: Sorry, I'm not criticising you,
17 Ms Anyadike-Danes, about raising it; I am just making
18 a general point. I deliberately didn't ask who had
19 raised the point because I think it's one of general
20 application. We can try too hard to work out what these
21 notes mean.
22 MR COUNSELL: Sir, I'm quite content to leave it there. It
23 is just that having taken instructions earlier, I felt
24 it right that the inquiry should be given that
25 information, if the inquiry felt it was helpful. If you

1 don't, then let's leave it there.

2 MS ANYADIKE-DANES: Sorry, does that mean that instructions

3 have been taken since Dr Stevenson gave his evidence?

4 THE CHAIRMAN: I assume not.

5 MR COUNSELL: No.

6 MS ANYADIKE-DANES: Right. If we move on from that and pull

7 up 310-005-003. As I took you to that before, the

8 question is: your account in your witness statement does

9 not seem to accord with what you were saying before.

10 There is a real issue to be determined by the chairman

11 in this inquiry as to who was the consultant in charge

12 of Claire's care or, more to the point, who should have

13 been. You have expressed a certain view there, which

14 doesn't seem to quite tally with what you said in your

15 oral statement today. Is there anything that has

16 happened that has caused you to change the view that

17 you have recorded there in your statement?

18 A. Again, my perception at that time is that Dr Steen was

19 the consultant who Claire came under, but from a point

20 of view of then the practicalities of who took over and

21 instructed me and advised me, therefore I saw that role

22 as being Dr Webb.

23 Q. Maybe we had better go to the question because it's

24 unfair to be putting a snapshot without the question,

25 although you'll see that what is headed up here is the

1 consultant with responsibility for the management, care
2 and treatment of Claire. That's what being addressed,
3 not who's the name consultant necessarily on the
4 admission sheet.
5 The witness statement is 139/1, page 28, and I think
6 the question is question 40:
7 "Identify the consultant whom you believed to be
8 responsible for Claire and her management, care and
9 treatment between her admission on 21 October 1996 [so
10 it's a longer period than is in that schedule] and her
11 death on 23 October and explain the basis for this
12 belief."
13 So that's the question which should have captured
14 the point that you were making earlier as to whether --
15 well, she might have been the named consultant on the
16 admission sheet, but actually it was Dr Webb who was
17 seeing her and was managing her direct care.
18 A. I may have misunderstood and misread the sentiments of
19 question 40.
20 Q. You didn't understand the question?
21 A. Well, not in the context of --
22 Q. So what you're meaning to say then is to distinguish,
23 am I right, in the consultant who is the named
24 consultant, if I can put it that way --
25 A. Yes.

1 Q. -- and the consultant who is actually providing the
2 guidance and management and care of her at the relevant
3 times?
4 A. Yes.
5 Q. And would that mean, given the way that -- I understand
6 that you might not have entirely appreciated what the
7 question was getting at. But given that that question
8 goes from between her admission on the 21st until her
9 death on the 23rd, does that mean that what you should
10 really have been indicating is that, "Well, she may have
11 at some point. I believe the responsibility for her
12 care or the person guiding her care and treatment
13 changed"? Would that have been a more expansive answer
14 there?
15 A. Yes.
16 Q. Is that what you mean?
17 A. Well, yes.
18 Q. And in a practical sense, not necessarily in a formal
19 sense, you're not suggesting that you know anything
20 about, in a formal, legal way --
21 A. In my experience at that time, the formal allocation of
22 patients to the consultants wouldn't have been something
23 I would have been involved in.
24 Q. No, but if Claire's care had actually changed in that
25 way so that now you were expected to and regarded

1 yourself as looking to Dr Webb as the consultant, as
2 I think you indicated earlier -- if that had happened
3 would you not have expected Dr Webb to have noted that
4 at any of the times he makes his notes in her medical
5 notes and records?
6 A. He may have done.
7 Q. But we've just seen the notes he made.
8 THE CHAIRMAN: Sorry, I think the witness meant he may have
9 done in the sense that that is something he might have
10 done, not something that, from looking at the records,
11 he appears to have done.
12 MS ANYADIKE-DANES: Sorry.
13 MR FORTUNE: The word "now" also appeared in the question.
14 MS ANYADIKE-DANES: Would you have expected in 1996 if there
15 had been that taking over, if I can put it that way, of
16 a patient's care, for the consultant doing that to have
17 recorded that in the patient's notes and records?
18 A. At that time, it may well have been the case that
19 consultants would document that, yes. I don't recall.
20 THE CHAIRMAN: Do you know the answer to the question?
21 A. "No" would be the honest answer.
22 THE CHAIRMAN: Okay.
23 MS ANYADIKE-DANES: You said that you kept in touch with the
24 nurses and so forth. Do you know what the general view
25 was as to who was the consultant people were to look to?

1 A. Well, it would be Dr Steen because she was part of
2 Allen Ward consultant staff.
3 THE CHAIRMAN: I think the point's gone as far as it helps
4 me.
5 MS ANYADIKE-DANES: I accept that, Mr Chairman.
6 Thank you.
7 THE CHAIRMAN: Okay. Is there anything outstanding?
8 Mr Quinn? Anybody else before I come to Mr McAlinden,
9 before I come to Mr Counsell? No?
10 Okay, Dr Stevenson, is there anything more you want
11 to say before you leave the witness box?
12 A. I just want to address Mrs Roberts in the sense that I'm
13 very sorry for my part in Claire's care, amongst the
14 others who were present on that day. I haven't had an
15 opportunity to do that, and this is the first time I've
16 had an opportunity. I'm very sorry.
17 THE CHAIRMAN: Thank you very much. Thank you for your
18 time, Dr Stevenson. You may leave.
19 (The witness withdrew)
20 We're not going to start Dr Sands now, so we'll
21 resume with Dr Steen tomorrow morning and then move on
22 to Dr Sands.
23 Let me come back, Mr Sephton, to the issue that
24 cropped up this afternoon. On reflection, I've looked
25 through previous statements by your client and I'm

1 increasingly unhappy about this. Could you bring up,
2 please, 091-008-043, which is your client's statement
3 for the inquest. It's a statement he made, I think at
4 some point -- the one we have isn't dated; it's almost
5 certainly at some point in 2005.
6 If you see the screen in front of you, Mr Sephton,
7 you will see the reference in the last few lines on that
8 page to the notes which Dr Webb prepared the statement
9 from. It goes on to document the calculations
10 undertaken to prescribe midazolam as a bolus and then as
11 a low dose infusion.
12 This wasn't your responsibility at the time, but at
13 that point there's nothing in this statement to the
14 inquest to indicate that your client advised a coroner
15 that there was any mistake in the calculation of
16 midazolam.
17 MR SEPHTON: I think, sir, he says in terms in his statement
18 that he didn't realise that there had been a mistake.
19 THE CHAIRMAN: Yes, well, there could have been no more
20 obvious case than Claire's in which the coroner would
21 have expected the consultants to take extra care and
22 provide all possible information in 2005/2006 because
23 this was an inquest which was already taking place
24 10 years late. Right? Your client has gone through
25 those records and has provided a witness statement,

1 which does not raise an issue about any mistake in the
2 prescription of midazolam. Right?
3 MR SEPHTON: Yes.
4 THE CHAIRMAN: He then comes to make his first statement to
5 the inquiry, and it's witness statement 138/1, page 32,
6 and in that statement he says for the first time that
7 we're aware of, in answer to question 2(b), the last
8 sentence:
9 "The loading dose should have been given at
10 0.15 milligrams per kilogram and I do not know how
11 a dose of 0.5 milligrams was charted."
12 He leaves it at that. In other words, he does not
13 assist the inquiry by going on to provide any more
14 information.
15 I now understand from what you said earlier that he
16 does have some more information which he is willing to
17 give. But if we then turn up on today's transcript,
18 what you said, which is I think is at page 125
19 [draft] -- if you can bring it up at 125, because I'm
20 not sure, Mr Sephton, that the transcript actually
21 captures quite correctly what I think you said to me.
22 On page 125 [draft], you are noted from line 6, as
23 interjecting and saying:
24 "If I could help here. Dr Webb's recollection
25 is that he had to go away to consult his notes that

1 he had from Vancouver in order to find out what the
2 midazolam dose was."
3 And you said to Dr Stevenson:
4 "Do you remember that?"
5 And Dr Stevenson said no.
6 Then you continued:
7 "That dose in my notes is 0.5 [sic] milligrams per
8 kilogram."
9 Now, I assume that that's been picked up incorrectly
10 on the transcript, has it, that the transcript should
11 say --
12 MR SEPHTON: 0.15.
13 THE CHAIRMAN: What you're saying is that, just to get it
14 clear -- maybe you can clarify this. Is Dr Webb now
15 saying for the first time that he told Dr Stevenson
16 anything about checking his notes from Vancouver or is
17 he simply saying that he had raised an issue about
18 midazolam and came back and told Dr Stevenson that the
19 dose was to be 0.15?
20 MR SEPHTON: My instructions are that Dr Webb reached the
21 conclusion that midazolam should be prescribed. He
22 didn't know what the appropriate dose was, so he had to
23 go to his office to look at what the appropriate dose
24 was in his notes that he took when he was practising,
25 when he, Dr Webb, was practising in Vancouver.

1 I abbreviated what should have been put. He then
2 telephoned Dr Stevenson and told him that the
3 appropriate stat dose was 0.15 milligrams per kilogram.
4 THE CHAIRMAN: Right. I would certainly like a written
5 statement from Dr Webb on that. It's unfortunate that
6 it's coming out in that way. It is potentially quite
7 significant because it adds potentially important detail
8 and changes the picture to some degree in terms of -- on
9 this issue at least -- excusing Dr Webb from any
10 responsibility which may arise as to the wrong dose
11 being prescribed. So it's potentially significant.
12 MR SEPHTON: I will ensure that a statement is provided as
13 soon as possible.
14 THE CHAIRMAN: Thank you very much. Mr Fortune raised this
15 on Monday morning when Dr Steen started to give her
16 evidence and she was asked about a number of questions
17 in which she had given a pro forma answer in her written
18 witness statement. From now on, I will expect people to
19 co-operate fully. I will expect people who are asked
20 for witness statements not to shy away from giving
21 relevant information and to volunteer information which
22 they're not specifically asked for, if it arises
23 directly or indirectly from the questions which are
24 raised with them. This inquiry is difficult enough
25 without people either withholding or not providing as

1 much information as they have. And that's not a point
2 directed at you, Mr Sephton, or you Mr Fortune, but it's
3 a point of general application for the rest of the
4 inquiry. I hope that's clearly understood.
5 We'll adjourn now and we'll sit tomorrow morning at
6 10 o'clock.
7 MR GREEN: Sir, before you do, obviously Dr Sands is giving
8 evidence tomorrow. It would be helpful if, before he
9 goes into the witness box, Mr Sephton and/or anybody
10 else who has matters that they wish to raise with him
11 through your counsel in questioning, which doesn't
12 emerge in the evidence, before the inquiry and before
13 the parties at the moment, could provide details of that
14 in writing to me and/or Mr McMillan so we can take
15 instructions before he goes into the witness box and
16 then becomes incommunicado with us for however long.
17 THE CHAIRMAN: I'm sure inquiry counsel would second that.
18 That's even on the basis that it's a preliminary note
19 which will be followed by a proper statement signed by
20 Dr Webb, or anybody else for that matter.
21 MR GREEN: Just on the basic principle of fair notice.
22 THE CHAIRMAN: Absolutely. I agree.
23 MS WOODS: Mr Chairman, if I could raise a small point of
24 timetabling. The timetable has slipped ever so
25 slightly. I'm looking forward to Thursday afternoon,

1 when Dr O'Hare is due to give evidence by video link
2 from Malawi. I just want to know whether we can
3 reassure her that there will be a link between Belfast
4 and Malawi, assuming no technology problems, at 2 pm
5 on Thursday.
6 THE CHAIRMAN: We have to do Dr O'Hare by video link on
7 Thursday afternoon and we have to do Dr Volprecht, who
8 I think is lined up to give evidence by video link, on
9 Friday afternoon at 2 o'clock. Before you and your
10 solicitor leave today, I think the inquiry staff still
11 don't have the full details of the link-up. We are very
12 anxious to tidy that up today because -- I might be
13 entirely wrong -- but there's perhaps more potential for
14 things to go wrong between here and Malawi than there is
15 in some other places we could easily connect to. We'd
16 like to make sure we get those details today or, at
17 worst, tomorrow morning.
18 We are a little behind. I hope that we can make
19 some time up tomorrow and, if needs be, to get through
20 these essential witnesses this week, it might be that
21 we'll continue to sit late. I don't particularly want
22 to sit until 5.30 in the evening, having started at
23 10 o'clock, but if we have to, we have to for this week
24 at least.
25 MR GREEN: Sir, two matters. First of all, Dr Sands has

1 a professional commitment on Thursday at Altnagelvin
2 Hospital, a paediatric cardiology clinic. If it were
3 possible to finish his evidence tomorrow, even if that
4 meant sitting significantly later than normal, I know
5 that he would be grateful for that.
6 The second reposition would be, if that is not
7 possible, if things could be juggled about a bit so that
8 he can come back and finish his evidence on Friday.
9 That would be better than the third alternative, which
10 is for him to try and re-arrange the clinic; I don't
11 know how easy that's going to be. There will no doubt
12 be children expecting to see him with their parents on
13 Thursday.
14 THE CHAIRMAN: So he's not available on Thursday but he
15 could be -- sorry, he's more easily available on Friday
16 than he is on Thursday?
17 MR GREEN: Quite right.
18 THE CHAIRMAN: Dr Bartholome, as I understand it, who's
19 scheduled to give evidence on Thursday, is then moving
20 into an overnight shift on Thursday night/Friday
21 morning.
22 MR GREEN: You're ahead of me, yes.
23 THE CHAIRMAN: So she wouldn't be in any shape to give
24 evidence on Friday if she wasn't finished on Thursday.
25 MR GREEN: You have the point exactly.

1 THE CHAIRMAN: Between tonight and tomorrow morning, I'll
2 work with inquiry counsel to do everything we can to
3 make sure that we stick as closely as we can to this
4 timetable and fit in within the restrictions which
5 you've indicated the people whose evidence we want to
6 hear.
7 MR GREEN: That's very helpful and I'm obliged to you.
8 THE CHAIRMAN: Thank you very much, ladies and gentlemen.
9 Tomorrow morning at 10 o'clock.
10 (5.30 pm)
11 (The hearing adjourned until 10.00 am the following day)
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1 I N D E X

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DR HEATHER STEEN (continued) 1

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Questions from MS ANYADIKE-DANES 1

4 (continued)

5 DR THOMAS ROGER STEVENSON 101

(continued)

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Questions from MS ANYADIKE-DANES 101

7 (continued)

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