Monday, 15 October 2012

(10.00 am)

(Delay in proceedings)

(10.08 am)

THE CHAIRMAN: Good morning. Ms Anyadike-Danes?

Housekeeping discussion

MS ANYADIKE-DANES: Thank you, Mr Chairman.

Just very quickly to bring people up to speed, in addition to the files that were released to you the last time we were here, some queries were raised about other documents within that original set. You should have received those other pages out of the medical notes and records, which I think have literally just been popped into the original file. If there's anything missing again, let us know.

In addition to that, you should have four other medical notes and records. One was the one that I had mentioned before that was missing from the original 15; there were only 14. And then there were three further ones. The upshot is that none of those files relate to Dr Steen's patients. There's a Dr Redmond's patients. In fact, I think there are three for Dr Redmond and one for Dr Webb.

So far as I can see, the ward rounds that relate to those patients do not involve any of the clinicians that

are witnesses here for Claire's case. But in any event, you can work your way through those and, if there's anything that you wish to raise, then of course you can do that with me in the break. But I don't propose to go through them in any detail. You'll have understood the format as I was going through them last time; it's the same pattern of documents that we have provided to you, redacted as appropriate.

So Mr Chairman, I wonder if we could call Dr Steen then.

THE CHAIRMAN: Yes, please. Dr Steen.

DR HEATHER STEEN (called)

Questions from MS ANYADIKE-DANES

MS ANYADIKE-DANES: Dr Steen, before I go any further, just one quick question: do you have your curriculum vitae there?

A. Yes.

Q. Dr Steen, you've made a number of statements. You made a statement for the coroner, which is dated 15 March. For reference, it's 090-050-154. You also provided a deposition on 25 April 2006. That's 091-011-067. And then you have made three statements to the inquiry. The first is dated 6 March -- all of this year I should say -- that's 143-1. There's one dated 10 July, 143-2. And then there is another one dated 20 September, 143-4.

There was intended to be a 143-3, but for various reasons we reduced the number of questions in that, and that has therefore appeared as 143-4.

Have you seen all those statements?

A. I have.

Q. And do you adopt those statements as your evidence, subject to anything you might say to the inquiry?

A. I do.

Q. Thank you. Then if I could just pull up your first statement, 143-01. If we can go to page 11 of that statement. You'll see in answer to question 18(a), you say:

"As a witness of fact at this inquiry and not an expert witness, I am prepared to give factual evidence about my involvement in the treatment of the deceased, and, where appropriate, to interpret and explain entries in the notes and records. As a witness of fact, I do not consider it appropriate for me to comment on, to explain, to justify or to criticise the acts or omissions of other clinicians or members of the nursing staff involved in the care of the deceased."

In large part, those questions to which you have responded in that way were seeking your comment, your views, your assistance on a variety of matters. Very often to do with your junior doctors and what your

expectations of them were. You don't have to take it from me, but there are over 100 questions that you have responded to in that way, which occur on 46 pages. And sometimes the entire page is comprised of answers of that sort. There's an example of this sort of thing if we go to page 17.

That is:

"State whether you would have expected Dr Sands to have asked you to attend and examine Claire between her admission and 4 am on 23 October."

That's your expectation of what you would have expected. And you answer it in that way. There are a number of others to do with your own view as to the diagnosis or the concerns being expressed about Claire. I don't propose to go through them all. Is there any reason why you didn't feel you could assist the inquiry by providing your view?

MR FORTUNE: Before Dr Steen answers, my learned friend and I have spoken about this situation, sir. At the time this statement was completed, Dr Steen was represented by solicitors for the Trust. In fact, the advice that was given to Dr Steen came from leading counsel. We were not representing Dr Steen at the time. In the circumstances, sir, any question of this nature may provoke Dr Steen to consider waiving her privilege.

We would resist such a situation.

THE CHAIRMAN: Well, can you say what Dr Steen's current position is about the appropriateness of answering these questions?

MR FORTUNE: Yes, we can, and Dr Steen will willingly answer such questions.

THE CHAIRMAN: Right. So insofar as we need to go into these currently unanswered questions, in at least some cases, Dr Steen will give oral answers to questions which you say, on advice, she did not give written answers to?

MR FORTUNE: Absolutely.

THE CHAIRMAN: Thank you very much.

MR FORTUNE: You can draw whatever conclusions you wish.

MS ANYADIKE-DANES: Well, then I wonder if we could pull up your CV? That's to be found at 311-017-001. Then if we see right at the bottom, slightly after the period with which we are concerned, between 1999 and 2010 you took over management roles, including the clinical director for paediatrics; that's correct, is it?

A. Yes, that's correct.

Q. If we go over the page to 002, we can see you were consultant paediatrician for the Northern Belfast Health and Social Services Trust. That appointment actually spans the period of concern in relation to Claire. In

other words, that's what you were when Claire was admitted on 21 October 1996; is that correct?

A. That's correct.

Q. You say that that was a combined post. How did that work as a combined post?

A. That was a new post. Two posts were put in at that time by the Commissioners, one to North and West Belfast Community Trust and one to South and East. Eight of the sessions -- we had ten three-and-a-half hour sessions in our jobs. Eight of the sessions were in the community dealing with neurodisability, child development clinics, children with complex needs, especially in schools, chronic disease management and child protection. And then two sessions were provided to the acute sector and the idea was to provide closer liaison should any of those children with complex needs be admitted to hospital, to support the acute on-call rota and, I think -- and I'm sorry we don't have my job plan, and I have difficulty recollecting exactly what I was doing. But I think one of my two sessions was also to run a rapid-access clinic, a clinic to facilitate urgent referrals to the Children's Hospital.

Q. And what were the days when you were expected to be at the Children's Hospital?

A. I can't be certain. The Tuesday morning was a definite.

I think the other may have been a Friday morning.

Q. And when you were carrying out your role at the hospital, what was it that you were expected to be doing?

A. We delivered a consultant-led service where we had a responsibility, if we had been on call, to see the admissions and the Allen Ward team admissions to Children's Hospital. So at least one of the sessions was tied up with seeing inpatients, be they my own inpatients or my colleagues' inpatients, and that was usually the Tuesday morning. I also tried to attend the cystic fibrosis ward round on the Tuesday morning because I did some inpatient management of those children, and then my understanding is the other morning was to develop a clinic.

Q. During this time, did you have a private practice at all?

A. No, I don't have private practice at all?

Q. Have you ever had one?

A. No.

Q. We have been provided with a job description for you. I'm not entirely sure that it entirely relates to the period that we're talking about, but in any event it's at 302-031-016. That deals with the hospital as summarising the type of hospital it is and so forth. If

we go over the page to 017, you see "university". Did you have --

A. This is -- the Trust found this job description. This is incorrect. This is the job I moved to on 1 April 1997. This was where I moved from the Community Trust into a combined post where I did eight sessions in the hospital and two in the community. I swapped it round.

Q. Yes, that's why I said I wasn't entirely sure it was the correct one.

A. And I had informed the Trust that it was the wrong one.

Q. I'm very grateful to you for that. In any event, I wonder if you might help us with this and see whether this is any different to the one that would have been your actual job description. If we go to page 020, if you see the duties of the post, under (a):

"The post holder will be expected to work with professional colleagues in the care of patients referred to him/her and to keep up-to-date with innovative change and development within the specialty, profession and the Health Service."

Were you expected to do that also?

A. Yes, I think that's what any consultant would be expected to do, no matter what post you're in.

Q. And irrespective of whether it was eight-to-two or

two-to-eight, did you also have university duties?

A. The university duties were usually undergraduate teaching. We were a teaching hospital, so there were always students around and that's I think what it refers to as "university". So it would be on the ward teaching or students coming to outpatients or perhaps delivering small group teaching or lectures.

Q. But you had those duties?

A. Yes.

Q. And when you were on the eight-to-two system, which is the relevant one for Claire's period, does that mean that's one of the things that you were supposed to be doing in either of those two mornings when you were at the Children's Hospital?

A. It would have been students on the ward for teaching, yes, and there also would have been students coming out to the community for teaching. So yes, there would have been teaching responsibilities within that.

Q. Exactly. And when you were doing that, how would you be doing that on the ward? Is that something you would accommodate within your ward rounds?

A. You would try to be -- depending on the demands of the ward round, you would try to use teaching. You would hope the students would have written up some of the cases and be able to present them to you so that you

could discuss them and then, following the ward round, you would teach again and you may actually have had a formal teaching session later in the morning.

Q. Thank you. When you were talking about being a consultant, the period when you were on call and the period when you were in the hospital. When you were on call, can you be a little bit more expansive as to what your duties were as a consultant?

A. As a consultant on call, I was responsible for all patients who were admitted to RBHSC, to the Children's Hospital, over a 24-hour period, from 9 am on one day to 9 am on the other. I also will have been contactable about any patients who had been admitted under the other three consultants who were part of the Allen Ward team.

Q. And they were?

A. Dr Redmond, Dr Reid and Dr Hill. So usually in the evenings or overnight if there were any concerns, the junior doctors would have had the option of actually going to those consultants or they would have contacted me. I had to be contactable. The bleep system was what we used at that time, but I actually also got myself a personal mobile phone because I recognised that I was out of the hospital an awful lot and it was difficult for people to necessarily contact me at times.

We had to be contactable, we had to be able to

immediately return to the hospital, and deal with any issues that would have arisen.

Q. And who had your mobile phone number?

A. The bleeps, home numbers and mobile phone numbers were on a board in all the wards, so the emergency department, paediatric intensive care, Allen Ward, Musgrave Ward would have been the ones who had all the rotas up, so the rota of who was on each day was up for the month. Beneath that the was a list of all the contact details for the consultants who were involved in the rota.

Q. So let's be clear. You were on call on the evening of the 21st October, which is the evening when Claire was admitted, and does that mean that there would have been a rota somewhere on Allen Ward, which is the ward to which she was admitted, which would have said that you were the consultant paediatrician on call?

A. And my home number, and that would have been most likely on the board in the sister's office in the nursing station.

Q. Is that something that the junior doctors would have known?

A. Yes, that is the normal contact. Everybody knew the nurses in the ward, the doctors would be aware of where the contact numbers were. If they weren't aware, they

just had to ask, but that's normally where they were pinned up.

Q. And even when you weren't on call, for example on the 22nd, which is the Tuesday you were actually on duty, so if for any reason anybody wanted to reach you and couldn't readily find you, are they still able to go to the nurses' station and find out your contact numbers?

A. They still would have my bleep number, my mobile number. They also during the working day had the option of going to my secretary, who might have been aware of my diary duties or anything else, especially as I say when I was so much out of the hospital in the community rather than in RBHSC itself.

THE CHAIRMAN: And this had started, doctor, in August 1995 when you were appointed as consultant; is that right?

A. Yes.

THE CHAIRMAN: From August 1995 to October 1996, were you regularly contacted if the occasion arose, either at home or on your mobile or by bleeper?

A. Oh yes.

THE CHAIRMAN: So the system was already established and had worked for over a year?

A. It had worked when I was a junior doctor. It's the same system that I had worked as a junior doctor.

MS ANYADIKE-DANES: But you'd actually gone a little

further. In 1996, not everybody had a mobile. You actually did have one. So the new SHOs coming through would know that at the very least they might be able to get hold of you on a mobile and they would all know that?

A. Yes.

Q. Thank you. I want to ask you something a little about the facilities for tests and turnaround times at the Children's Hospital in this period of 1996. Just to give you the reference to Dr O'Hare's witness statement, 135/1, page 13. In answer to question 16(c), Dr O'Hare says -- if you see there:

"Queries about the tests in relation to Claire's fluid management."

And (c) is a query over Claire's urine output, urine sodium and urine osmolality. She says that urine sodium and osmolality would not have been available out of hours and in hours a result would not have been available for one to two days, as she recalls.

Is that correct?

A. No, it's not correct. The urinary sodium and osmolarity, my understanding is, runs through exactly the same machine as the blood sodium and osmolality, therefore if we take the sample, it's just a matter of the biochemist having a gap, the clinical technician

having a gap to run urine through the machine rather than the blood. So if I send a urinary sodium and osmolality, I need an answer within an hour because that's what I'm going to do, use, to judge fluids, help me with diagnoses, et cetera, and my understanding is the turnaround time would have been exactly the same as the serum, but you'd have had to phone the lab and tell them you wanted it.

Q. Is there any reason why Dr O'Hare, registrar, would have thought it should have taken that long so far as you can tell?

A. She maybe just doesn't recall what was happening at the time. It is quite a while now.

Q. What about the turnaround times in blood tests out of hours?

A. It depended. We depended on a porter system, so if we had a blood taken, the first thing you did is phone the lab to say it was coming. Usually, in biochemistry, the lab technician would have been awake and in the lab throughout the night. In bacteriology, you sometimes --they sometimes weren't necessarily in the lab and there was a delay, so you needed to phone the technician. You then needed to phone the porter. The porter had to be available to come and take the sample to the technician. The technician would then put it

through and it would depend how busy they were, how quickly you got your sample put through. They may have had several more to do as well as your own and then they would phone.

I would think if you're really needing it done and you really phone and phone and phone, you usually get it through in about an hour, maybe an hour and a half.

Q. Were you aware of that particular turnaround time causing difficulties and there being any efforts to try and see if there were ways to try and speed this system up? This is after hours I'm talking about.

A. In a general sense?

Q. Yes.

A. I think it was recognised there were lots of difficulties and it was dependent on various factors about availability of porters, et cetera. And certainly we have now changed it. We now have a chute system and it's much more rapid.

Q. I understand that.

A. But there were -- out of -- emergency blood samples and urines were always something that we always felt we needed to keep pushing. Though if you kept phoning the biochemists, they usually did prioritise for you because everyone is saying it's urgent, so is yours the one they need to do first or the one they need to do after the

rest?

Q. Let me pull up something that arose out of the Adam Strain case. Can we look at 011-014-017A? This was a statement that Dr Taylor, who you know --

A. Yes.

Q. -- had provided as part of his deposition to the coroner at the inquest. If you look at the last assertion:

"The Trust will continue to use its best endeavours to ensure that operating theatres are afforded access to full laboratory facilities to achieve timely receipt of reports on full blood picture and electrolyte values, thereby assisting rapid anaesthetic intervention when indicated."

That operation, as you may know by now, is one that started out of hours, if I can put it that way, and there was an issue as to what the turnaround time might be to get a blood sodium result back. And as a result of some of that -- well, that and other matters -- this statement was issued with the clear impression that there are going to be actions taken to try and improve that. Were you aware generally of any efforts of that nature?

A. Specifically as a result of Adam Strain, no. I was aware that the clinicians constantly agitated around quick turnaround times for laboratory results.

THE CHAIRMAN: Sorry, what did you know about Adam Strain?
A. At the time -- I don't ... I'm sorry, chairman, you know my recollections are very poor and I can ... I have had a period of ill health and my memory is very poor. I will try and help you as much as I can. My instinct tells me that I was aware that Adam had died, but it was a rare one-off condition in theatre to do with the fact that he had a high-output renal state and was not of significance to the rest of the patients.
THE CHAIRMAN: So to the best of your recollection, your understanding is that there were no lessons to be learned by paediatricians generally from the circumstances of Adam's death?
A. From what I can remember.
THE CHAIRMAN: Thank you.
MS ANYADIKE-DANES: Thank you. Just to round that off, it may be you can't remember this at all, but are you aware of how you got to hear anything at all about Adam Strain's death?
A. I can't tell you now exactly when I knew or what I knew about Adam Strain prior to a lot of the information that has been coming out through the media and through the inquiry over the last few years. So I have no recollection of knowing anything between 1996 and, say, 2000.

Q. So you don't know whether you were aware of his death at the time of Claire's admission, for example?
A. I can't recall it. No, I am sorry.
Q. You could have been?
A. I could have been.
Q. If I can ask you about the availability of EEGs. You have dealt with the bloods and the urine tests. Dr Webb in his inquiry witness statement -- I think it's reference 138/2, page 8 -- deals there with the availability of EEGs. But what I would like to ask you is: so far as you were concerned, if you required an EEG for one of your patients, how quickly is it your impression that you could have achieved one in 1996?
A. A routine EEG would, I think, have taken maybe 8 to 12 weeks. You filled in the form and you sent it round, you had to have certain criteria to want it for it to be carried out and it would be added to the list to be done. An urgent EEG couldn't be done without agreement with the neurologists. The neurologists were the ones who organised urgent EEGs.
Q. I understand that. I think you said as much in one of your witness statements. But assuming your neurologist is also of the same view as you are, in your experience, how quickly could that be organised?
A. That was dependent on the neurologist and the EEG

technician. The technician would have had a full day of routine EEGs to be carried out. Therefore, if an urgent EEG needed to be done, it would have meant something else may have been put to one side. That is a prioritisation that the neurologist would have to decide with the technician.

Q. I understand. Bumped, I think people call it.

A. Yes, possibly.

Q. So it was possible that that could happen, if the needs of the patient that you had concerns about were so pressing was it therefore --

A. -- and the neurologist agreed. It was up to the neurologist. We weren't allowed to make the decision --

Q. I understand that. I'm simply trying to understand the process. It is possible that a child whose needs were less urgent or less pressing, as confirmed by the neurologist --

A. Yes.

Q. -- could have their slot, if I can put it that way, allocated to the more urgent case?

A. My understanding is that would have been possible.

Q. Thank you. What about a CT scan?

MR FORTUNE: Before my learned friend moves on to a CT scan, it may help you to have a better understanding if Dr Steen was asked what was involved in physically

arranging the EEG and how long the EEG would actually take. Because at the moment, there is no evidence in front of you as to how long an EEG actually takes.

MS ANYADIKE-DANES: I think there is from Dr Webb, but in any event I'm happy to take the evidence from Dr Steen.

THE CHAIRMAN: Can you help us on that?

A. I think Dr Webb is probably in a better position than I am, but certainly we would have expected 45 minutes to an hour for a patient to be transferred round to EEG to have the -- for a child like Claire, you would have needed a nurse and maybe even a doctor to go with her. It would have taken maybe 45 minutes to an hour.

THE CHAIRMAN: Let's take a hypothetical situation. You have a child in a ward who, say, at 10 am is in a condition which is causing concern. You are there, you approach Dr Webb, for instance, Dr Webb agrees that this is an issue of concern. The critical role in arranging for the EEG is his role.

A. Yes.

THE CHAIRMAN: Because if he doesn't agree, in effect, the lab technician will stick to the schedule of work that the lab technician already has. If you bring in Dr Webb at, say, 10 o'clock and he agrees, do I understand you to be saying that as a result of some phone calls and the child being taken round by about 11 am or soon after

that, you should have an EEG result?

A. No, I'm saying that he would need to decide by looking at the other children booked that day where would be an available slot should he wish that urgent EEG -- who is going to be -- I think "bumped" was the word you used. From when he decided the time slot, it would take about an hour for that to go round, the technician to have done a very quick report, but he then needs to read the report as well. In paediatrics, in RBHSC, it's the neurologists who actually read the EEGs.

THE CHAIRMAN: So he might say: I can't bump the 11 o'clock or the 12 o'clock, but I might be able to bump the 1 o'clock? In that event, you're not going to get a result until two-ish.

A. Yes.

MS ANYADIKE-DANES: I thought part of what you were indicating was actually the time, the sheer mechanics of getting the child from the ward in which the child is in to where the EEG is going to take place. You might help us with this site plan. If we pull up 300-003-003.

Just to orientate everybody, you can see where Allen Ward is. Adjacent to that is the Musgrave Ward. You can see the small haematology lab for the -- there we are. And the theatres, some people have seen this before.

If we reduce it again just so we get back on -- there we are. You see where the CT scanner was located, the MRI unit. Where would the EEG take place?

A. I think EEG is still just round the corner from Allen Ward in what was Clarke Clinic. Somewhere in your papers you have a 1996 map. We're focusing mainly on Allen Ward, but I think the corner comes in. EEG was initially round the corner -- it's in the building. So initially it was just round the corner.

Q. Let me pull something up for you that might help you. 310-010-001. There we are. Does that help? There's Clarke Clinic there on the left-hand side?

A. Yes. The first room on the left as you come in off the main corridor. What is it labelled as?

Q. Expand all that. There.

A. It says, "Office". This is from 1996?

Q. Yes. But in that vicinity?

A. Yes, it was initially there and then Clarke Clinic took over that area and it was moved to ...

Q. Can you reduce that again?

A. I'm sorry, I cannot remember. It's a level below Paul ward. It was on the basement level near the labs.

Q. Okay. You can't remember whether that move was before or after Claire's admission?

A. No, but it was in the same building. It was a matter of

whether you walked 20 metres or you walked 40/50 metres.

Q. So it's not like getting her to have a CT scan, which would have been --

A. No, it's a thing where you take the bed, the nurse, maybe a doctor and you'd just go along the corridor.

Q. So that part of it wouldn't have taken very long?

A. No.

Q. It's a matter of the neurologists deciding which slot they are prepared to afford her, having measured the priorities?

A. Yes.

Q. Thank you. Then if we go back to the CT scan, we see where that is. Can you help us with how long that would take to arrange?

A. That requires transport. So you are then with the situation that you need to have an ambulance available to take you there. You definitely would need a doctor for someone like Claire to go there, and if the child needed anaesthetised, you'd certainly need a doctor. You had to get a slot, you had to have an anaesthetist available, you had to have a nurse available to go and you needed the ambulance for transport. So you needed all of those coordinated. Once you got them coordinated, transfer time from the ward through the ambulances to the CT scanner, 15 minutes, maybe, the

scan itself, and you needed the ambulance and all to come back again.

THE CHAIRMAN: Just pause. You said you would need an ambulance and a doctor for a child like Claire.

A. Yes.

THE CHAIRMAN: When you say "a child like Claire", do you mean any child of 8, 9 or 10 or do you mean a child whose condition is becoming more serious and causing concern?

A. A child who is significantly unwell. We would be bringing children in for routine CT scans, they may be reasonably well and they can go over with the nurse and a parent. If you have a child on IV fluids and observations, they may or may not need anaesthetised. Those are the children where you need to have at least a doctor there as well.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Thank you. I wonder if I can now ask you some questions about ward rounds generally.

A. Mm-hm.

Q. Obviously, we'll come to the ward round in relation to Claire in due course, but just generally, who takes the ward round so far as you were concerned in paediatrics in October 1996?

A. The ward round was usually taken by the most senior

doctor who was on the ward, and I'm sorry, that was a bit of a get out, but I'll explain maybe in greater detail. Allen Ward team were on call on Monday nights and Wednesday nights. Therefore, there would have been one of the consultants available to lead the ward round on Tuesday mornings and Thursday mornings. And those consultants would have been available to do it. On other mornings, the consultants were all timetabled to be elsewhere. So Monday, Wednesday, Friday, consultants were timetabled to be elsewhere. Therefore, the senior doctor, usually the registrar if they were there, or if not, the experienced SHO took the ward round. And the ward round would have been all Allen Ward patients that belonged to the Allen Ward team, except for the CF patients, and that would have included patients who belonged to Dr Hill or Dr Redmond, Dr Reid, and myself, who weren't in Allen Ward, but might have been in Musgrave Ward, Clarke Clinic, PICU.

Q. Let's say it is the consultant who's the most senior clinician on the ward. That consultant will be taking the ward round for all those patients, save for the cystic fibrosis patients; is that correct?

A. Yes.

Q. They'd be doing that not just for Allen Ward, but for some of the children who would be on Allen Ward if there

was enough space, but were, for that reason, on other wards, like for example Cherry Tree and maybe Musgrave Ward?

A. Yes. Cherry Tree would always have been CF, but it would be the ones who belonged to the four consultants. We would have Musgrave Ward patients in Allen Ward. Not many, but we would have had some, just as we had some. So it is the team of consultants that the junior doctors would have been working to.

Q. If that were you, for example, that would mean you were doing a ward round considering patients for, say, Dr Hill or Dr Reid on that given day?

A. Yes.

Q. In the same way as they would do the same thing for your patients whenever it was their nominated day?

A. Yes.

Q. And what do you regard as the purpose of the ward round?

A. There's several purposes. The most important purpose is that children are seen, assessed, a treatment programme is put in place and all investigations are put in place, so there's the business end of it, seeing patients and arranging things for them. There also is the opportunity to review what has been written before in the notes, to review the kardexes, check all that has been going on. You may pick up various things that you

want to bring up with the junior doctors about what might have happened. There's a teaching role and a supervision role. There's a teaching role for the undergraduates. There's a teaching role for the postgraduates, watching how they would carry out an assessment, take a history, make decisions about patients, how they write it up. So there's the business end which is basically getting the patients seen and treatment plans in place. There's the education end. And usually the parents were aware of when ward rounds were happening. So quite often you would have parents there wanting to know what was happening, what the plans were for the day, raising any issues they would have.

Q. So there's an opportunity for communication with the family?

A. Oh, most certainly, yes.

Q. Is that important so far as you are concerned?

A. Of course, it's important and --

THE CHAIRMAN: Sorry, I think we need to slow down a bit.

MS ANYADIKE-DANES: You were talking about the significance of the communication with the parents.

A. Yes. So we've got through the education component, the work component, and the communication with parents. And a lot of the parents would have been aware of the timings of the ward round. They may have been advised

by the nurses that the consultant will be on the ward. It may be, as I've said, there's four consultants we're talking about as part of our team and the nurses and juniors may be aware that so-and-so's got a clinic that morning, so they'll be in the ward in the morning or the afternoon or so-and-so is away to Downpatrick that day and won't be available.

MR FORTUNE: Can I slow Dr Steen down still? It's still at machine-gun pace.

THE CHAIRMAN: As we're interrupting you for a moment, when you say the ward rounds would usually be consultant led on Tuesday and Thursday mornings, does that mean that, saving other special issues, that all of the consultants are there?

A. No, it would be whoever had been on the day before. So Dr Redmond and I always did Monday on-calls. There was a certain amount of change, but Dr Redmond and I alternated Mondays. So the Tuesday round was usually Dr Redmond or myself.

THE CHAIRMAN: As you were in Claire's case. If you were on call on the Monday night, you would normally be doing the ward round on Tuesday morning?

A. Yes.

THE CHAIRMAN: And if it was Dr Redmond, then Dr Redmond would normally do the round on Tuesday morning?

A. Yes.

MS ANYADIKE-DANES: And is the logic of that because -- being on call, if anybody had been contacting you about the new admissions, you would have some familiarity or at least some of these new patients who had come on to the ward?

A. Yes, and our job plans gave us very little time to be on the wards, so it was also an opportunity to actually see the patients, and we tended to do a weekend on call followed by the Monday night. So actually, there was an opportunity for us to follow the patients who would have been in under us at the weekend right through. It was just very difficult when we had so little time in the ward.

Q. Can I ask you how important you thought ward rounds were? You have given us three sorts of things that were going on, obviously the medical issue, to review the patients and prepare a plan for their treatment. Then there's the educational one, both for your junior doctors and for medical students. And then there is the opportunity to communicate with the parents and maybe have some feedback from them about matters that might affect the way you treat the child or develop a diagnosis. But in general, how important did you think ward rounds were?

A. I think -- and I still think ward rounds are very important. It's the one time, all being well, you have the entire team together and you have an opportunity to actually discuss patients.

Q. Does that mean that you would try, so far as you could, to attend them?

A. Yes. Yes. The Tuesday morning was the particular one that was allocated, that was the time that I would actually be in the Children's Hospital to allow me to attend.

Q. You may know that the Royal College of Physicians and Royal College of Nurses just put out a best practice in relation to ward rounds in medicine. Of course, it relates to present day, but they are looking back to a certain extent wanting to reinstate maybe some of the significance ward rounds had. If I can pull up the first page. 311-029-01. That's so that people can see what it is. The particular page is 007.

There's an attempt to sort of categorise the ward round in that first paragraph in bold. Would you broadly agree with what's said there?

"Medical ward rounds are complex clinical activities, critical to providing high-quality, safe care for patients in a timely, relevant manner. They provide an opportunity for the multidisciplinary team to

come together to review a patient's condition and develop a coordinated plan of care while facilitating full engagement of the patient and/or carers in making shared decisions about care. Additionally, ward rounds offer great opportunities for effective communication, information sharing, and joint learning through active participation of all members of the multidisciplinary team."

It might be written in slightly more 2012 language, but does that capture the essence of what you would think was happening or should have been happening in ward rounds?

A. Yes, it does. I think the multidisciplinary team one is difficult to achieve because you're seeing many patients who may be looked after by different physiotherapists, dieticians, speech and language therapists. Certainly, our practice now is that we have multidisciplinary team meetings about specific patients at a given time when we're sure all key players can be there. It's quite difficult to have everybody together when you happen to manage to get to that patient.

Q. But if you were to substitute for the reference to "multidisciplinary teams", the nurses involved in the care, the junior doctors and perhaps the students, and then left in, of course, the reference to the carers and

the family, would the sentiments there nonetheless capture what you would have thought was the significance of them in 1996?

A. It would, yes.

Q. Thank you.

THE CHAIRMAN: Are you familiar with this document?

A. No, I'm sorry.

THE CHAIRMAN: You can see at the bottom of the page that it's issued in 2012, "Royal College of Physicians, 2012".

MR FORTUNE: Issued in October 2012.

THE CHAIRMAN: Okay. From what you have seen of it, does that appear to you to be restating something which you have always regarded as being the case?

A. From this, yes. The Royal College of Paediatrics and Child Health also issued a document, I think, in April of this year, around the standards for the management of patients, which I would have been more aware of. I'm sorry, I haven't got through -- I can't read any more documents.

THE CHAIRMAN: Don't worry.

MS ANYADIKE-DANES: Can I then just ask you, given that that's the purpose and that's the significance -- and from your point of view the importance -- of ward rounds, what sort of preparation gets done for them to

make them the most effective opportunity to address the three points that you've just identified?

A. My practice certainly was that -- and I think my colleagues did the same. We tried to arrive on the ward slightly before 9 o'clock so you could get a sense of what was happening on the ward and were there any outstanding issues. You also tried to ensure that either the registrar or the SHO who had been on overnight would come to brief you on any patients that had given concerns overnight or any patients they felt needed to be seen. You tried to make sure that the nurse in charge, who would have had a nursing handover and been briefed on all the patients in the ward, was also there, and the junior doctors who were going to be there for the day, so that we could have a brief discussion about which patients in the ward -- or indeed outside the ward that belonged to the team -- were giving particular concerns, did their care need to be prioritised above the others, or could we ensure that we had a ward round done?

If there were specific patients that we already knew we needed X-rays for or results for, we would have made sure that we had those before we started the round or, at least we would have asked one of the SHOs to try to get them before we start the round so we could actually

make a decision when we got to that patient's bed.

Q. I understand. If you're coming in at a bit before 9 o'clock, from what you said, that means that you can have, not exactly a handover, but a debriefing from whichever is the registrar who was on duty the night before.

A. Yes.

Q. In this case, it would have been Dr O'Hare or Dr Volprecht in the previous evening.

A. Yes.

Q. So it's not just that those registrars could have done a handover to their own colleagues, a handover to Dr Sands, you would have an opportunity to hear from them any concerns they had or their thoughts about new admissions, for example, or concerns about children who were already on the ward.

A. Providing they were able to come to the ward. It depends, if you have an emergency in casualty, if you have a very sick patient in ICU, they may not actually be available. But generally there was -- one of the on-call staff would have been to the medical ward which had been on call that night to briefly say this is what was going on.

Q. You mean although they were scheduled to go off duty, and therefore otherwise could have come to have that

exchange with you, but if there had been some sort of emergency that detained them, they may not be going off duty when they were scheduled to?

A. Well, my understanding is they weren't scheduled to go off duty. At those stages, I think you did 32-hour shifts.

THE CHAIRMAN: Sorry, as I understood the doctor's point, it may be to say that Dr Volprecht or Dr O'Hare were still on duty, but couldn't discuss with you because they were in the middle of something else which was urgent.

A. Yes, and then they would have had normal daytime duties, so they may belong to another ward team. So at 9 o'clock, their job would have been to go to whatever wards they were normally allocated on, 9 to 5, five days a week.

MS ANYADIKE-DANES: I'm not sure that that was exactly the case with Dr O'Hare. I think that may have been the end of Dr O'Hare's day actually. In any event, we'll come back to that. I was simply asking you the principle of it. The principle is that if they were available to you, you would be having directly your own, effectively, debrief from that doctor. If they weren't available to you, then you would look at the notes presumably.

A. And you'd be asking the nurses who would have a nursing handover.

Q. Yes. Thank you.

MS WOODS: Mr Chairman, just to assist with that issue, certainly Dr O'Hare was on duty at 9 am on the 22nd in Musgrave Ward.

A. Yes. My understanding is that the juniors were still on 32-hour shifts.

MS ANYADIKE-DANES: Thank you very much. So leaving aside whether you would have had an opportunity in this particular case to speak to Dr O'Hare, would it be your practice to look through the last notes in a child's medical notes and records?

A. You may not have had the opportunity to do that before the start of the ward round. It would have been if you had a child identified to you as one who needed seeing sooner or something needed to be done about, but the purpose of the ward round would have been to look through the notes, look through the drugs kardex, look through the observations. If the parent is there, take a further history from them, observe the junior, or if you were concerned about how the junior was carrying out, carrying out a medical assessment and then coming to a decision.

Q. Would you ask to be told anything about new admissions in particular?

A. Yes. I would be asking how many did we have in, where

were they, what outliers they were and were there any concerns.

Q. And given what was recorded in relation to Claire at that time, how would you have ordered her in your priorities in a ward round?

MR FORTUNE: [Inaudible: no microphone] specific?

MS ANYADIKE-DANES: Yes, we are.

MR FORTUNE: If so, Dr Steen ought to have the opportunity to refresh her memory if she needs to from any note made. If you're asking her a specific question --

THE CHAIRMAN: If she needs to, Mr Fortune, and if she needs to, she can ask.

MR FORTUNE: Thank you.

A. I have no -- I'm sorry, I have no recollection. But on reviewing the notes and trying to look at it as it happened rather than looking back knowing what the happening was, my understanding from the nursing notes is that she had had a settled night. She had had a few vomits, but that wouldn't have been recorded in the medical notes; that would have been at the bedside. She was active and, although she was on IV fluids, there was no particular area of concern. So just looking back with what is documented -- and the documentation's extremely poor and I can in no way defend the quality of my documentation or anyone else's -- but looking back on

what is written, I can assume from that that Claire would not have been prioritised as acutely ill at 9 am on the Tuesday morning.

MS ANYADIKE-DANES: Let's look at it, as has been suggested that we do. If we go to 090-012-014, this is the A&E note that Dr O'Hare took. You can see the doctor's signature there. There's a decision to admit her, 20.45.

MS WOODS: Sorry, if I could interrupt. What we're looking at is in fact not Dr O'Hare's note. That's the admitting SHO in A&E.

MS ANYADIKE-DANES: I beg your pardon, it is. The decision to admit is signed off by Dr O'Hare. There's the A&E note there.

So we see it's a 9 year-old girl:

"History of learning difficulties. History of epilepsy. No fits for three years. Off anti-epileptic medication. Today vomiting since this evening. No diarrhoea, cough, pyrexia. Speech very slurred, hardly speaking. On examination, drowsy, tired. Neck stiffness."

Then it goes on.

A. "No neck stiffness."

Q. I beg your pardon. Then you can see the tests being taken and a referral to a GP letter. Then, "No apparent

limb weakness". The referral to the GP's letter, would that have been available at that time in the notes?

A. It would have been in the medical notes, yes.

Q. Let's go back and have a look at that. That's 090-011-013. There we are. Then, under the "History of examination":

"Fit free for three years. Weaned off Epilim 18 months ago. No speech since coming home. Very lethargic at school today, vomited three times. Speech slurred. Speech slurred earlier. On examination: pale, pupils reacting. Does not like light. No neck stiffness. Temperature."

Then it deals with the tone. Then:

"Query further fit. Query underlying infection. I would appreciate your opinion."

So that's the GP's note. If we go back to where we were, 014. Then we can see on the primary diagnosis, "Query encephalitis".

So that would have been in the medical notes. If you had been reviewing, at that time, to help you make a decision as to where to put Claire in the order of priorities in your ward round, that would have been available.

A. That would have been available, but not necessarily reviewed at that time because you were taking

information about all the patients. So if she had been highlighted as one of concern, then the notes would have been reviewed in more detail rather than waiting until the ward round was being carried out.

Q. Yes, but what are you going to look at? Let's assume that Dr O'Hare is not there to assist you.

A. Mm-hm.

Q. What are you looking at to help you decide where to place Claire in the order of priorities?

A. I would have been listening to what the nurse in charge had said and then I would have probably looked briefly at the last note the doctors had written to help me decide.

Q. Right. Let's have a look at that then. So that's 090-022-050. This is Dr O'Hare's note. There's a quite lengthy history on that first page. Then if we go over to 051, "On examination". Then you see the tone, the reflexes. Then towards the bottom:

"Not responding to parents' voice. Does respond to deep pain."

And then if one sees over the page at 052, the queries there. The plan at that time:

"IV fluids, IV diazepam, query seizure activity. Reassess after fluids."

And then:

"Seen at midnight. Slightly more responsive. No meningism."

And then you'd have seen the less than normal sodium level ... And that particular note has a signature there of Volprecht, who was the SHO. So that would have been available to you.

A. Yes and that's what I would have looked at as my first point of call having spoken to the nurse.

Q. And how would have you assessed Claire?

A. She had obviously stabilised from admission, and this is theoretical because I can't remember what happened. Obviously, it's hypothetical.

Q. I understand that.

A. It would then -- I would have said to the nurses, "How has she been overnight, what's been happening?".

Q. But not one that you would have wanted to see, given the queries over seizure activity and that sort of thing?

A. I would have wanted to know how she was overnight to see how quickly I would have seen her compared to some of the others.

THE CHAIRMAN: Sorry, the discussion at this point isn't whether you're going to see her. As I understand it, the discussion is only with what priority are you going to see her; is that right?

A. Yes. She would have been ... She certainly was a child

who had needed to be seen within the first hour. She is certainly one you would want to see sooner rather than later compared to some of the others we know were admitted later on.

MS ANYADIKE-DANES: Thank you.

THE CHAIRMAN: Just before we break, doctor, why was she certainly a child who you'd want to see within the first hour?

A. Because a lot of the admissions we get in, it's very clear what's going on with them. They have got a wheezy chest for various reasons, they've had a fit with a high temperature because they have sore ears, but their temperature's coming down. This child, there was still a query with what was going on with here, so therefore the need to do further investigations or get further things done was always there. Therefore we needed a treatment plan for her, more so than some of the others who were already on a path of recovery.

MS ANYADIKE-DANES: Put simply, they didn't really know what was wrong with her.

A. Yes. They had working diagnoses, but they didn't have confirmation of those diagnoses.

Q. Yes.

THE CHAIRMAN: Okay. Sorry, Ms Woods?

MS WOODS: I apologise, Mr Chairman, but if I could raise

something before we leave this particular document.
A few minutes ago, on the [draft] transcript in front of us -- it's page 35 -- Dr Steen is talking about the documentation and she says:

"So just looking back with what is documented -- and the documentation's extremely poor ..."

I just wanted to clarify that Dr Steen is talking about documentation that might have been made by her rather than the documentation that was available, that would have been available to her on the ward round.

MS ANYADIKE-DANES: Dr Steen, when you said that the documentation was extremely poor, what did you mean by that?

A. Well, my documentation is extremely poor. I think there's no question about that. But I think there are other issues around the documentation in general, such as dating and timing things, saying who all was present. The blood results are there, but what time were they received? So I think some of the content is extremely good, but certainly looking at the standards that are expected of us now, it's not acceptable.

THE CHAIRMAN: Let's talk about the standards of the time. In particular, if you had spoken to Dr O'Hare -- who I know you have no recollection of speaking to -- and if you had spoken to the nurse in charge -- and I

understand you don't have any recollection of that -- you would then have turned to these notes that Ms Anyadike-Danes just took you through, in particular pages 50, 51, 52. Do you say that those notes are extremely poor -- and I'm emphasising -- by the standards of the time?

A. I think the admission note by Dr O'Hare is quite full, taking it at the time, but we don't know anything about when the blood results were done and we don't know the time that they were received and whether they actually were acted on.

MR FORTUNE: Sir, I rise at this stage because if you look at 052, if I understand Dr Volprecht's statement correctly, the hand that wrote the sodium and potassium and indeed the urea figures is different from the hand that wrote the other figures. So we have a note made by a junior doctor, who has not identified himself or herself, has not dated or timed those limited results. And no doubt Dr Steen would have a comment to make about such an entry.

THE CHAIRMAN: You have been led into it, doctor. Do you have a statement?

A. We do know because we know how the story unfolds now and we're looking back on it. Actually to know when those bloods were taken is very important. When was that

"132" and was it from the bloods at the time of admission, was it at another time?

THE CHAIRMAN: Okay. We have to break for a few minutes for the doctor. We'll resume at 11.25.

(11.10 am)

(A short break)

(11.27 am)

THE CHAIRMAN: Just to let everybody know what we're doing in terms of timetabling today: I hope that Dr Steen will be able to continue her evidence until 12.30 and we'll take an early lunch at about 12.30. We'll resume at 1.30 and today -- and only today -- we'll stop at 4. For the rest of the week, we will continue to 4.30 and, if necessary, 5 o'clock in order to get through the witnesses who we are scheduled to take between now and Friday.

MS ANYADIKE-DANES: I wonder if we could pull up again 090-022-052? You were commenting on this and you were saying in terms of your general comment about the standard of recording that a criticism of this is that nobody's entirely sure to what state that refers in terms of timing for Claire, that low sodium result.

Just so that I have correctly your criticism, if we go to the nursing notes -- and you said that you would discuss with the nurses before.

A. Yes, the nurse in charge of the ward.
Q. Yes. If we go to the nursing note for that evening, 090-040-140, you see a note for 10 o'clock on the 21st.
A. Mm-hm.
Q. That's a note taken by Staff Nurse McRandal. About four lines up before it goes into the 22nd you can see it says:

"Bloods taken. IV fluids: fifth normal saline commenced at 64 ml."

And so forth. Does that suggest to you that the bloods that were being taken for the serum sodium tests were being taken at or about 10 o'clock?
A. It does, but it's not obvious from the medical notes.
Q. I understand. I'm just trying to make sure that I have in context the nature of your criticism. So it's not if you had a search through the medical notes, you couldn't divine when the bloods myself been taken; your criticism is that if you're going to make a note like that, you should clearly record on the note the time when the bloods were taken?
A. Yes.
Q. Should it also note when you receive the report or doesn't that matter?
A. It does matter because that's then relevant about when you're going to do another one, so that should have been

timed. All entries, we should be putting times beside entries in charts.

THE CHAIRMAN: Doctor, in order so that I understand this, compared to nowadays, was it a feeling in the mid-1990s that this was not done as regularly as it is done today?

A. Certainly it's done regularly now and it's part of the guidance that we have at the moment. It was done less often then.

THE CHAIRMAN: Does that mean it should have been done better in the 1990s?

A. It should have been done better.

MS ANYADIKE-DANES: If we go back to 090-022-052, if you look at that note and you see where it says, "Observe and reassess", and then you had seen those results below it -- and this is the note that you said is one of the ones you probably would have looked at if you were taking that ward round --

A. Mm-hm.

Q. -- would that mean, as part of your reassessing, you would have wanted some up-to-date U&Es done, urine and electrolyte tests?

A. I would have wanted to know how the child was. I think the most important thing at that stage was "Reassess in AM", so what was the child like that morning, what did the nurses feel about the child that morning, and then

determine, when you saw the child, any further investigations that are required. The U&E, it's -- I don't know when you want to introduce ... A repeat U&E should have been done some time during the day.

Q. That's what I'm really asking you.

A. We've all agreed that and we've all agreed that since we went back and looked through Claire's case in 2004. The U&E should have been done during the day and it should have been part ... The reassessment -- when I came in to do a ward round, I would have expected to be told if someone was sick, if they had improved or if there were still concerns. There was supposed to be a reassessment: had that actually happened or were they expecting the day staff to reassess before the start of the ward round?

Q. Yes.

THE CHAIRMAN: If we assume for the moment that you weren't there to do the ward round on the Tuesday morning, then what you would have expected was that the registrar or an experienced senior house officer would have taken it in your absence?

A. Yes. Or my colleague.

THE CHAIRMAN: Or a colleague. And would you have expected that whichever one of those did take the lead would have arranged to see Claire within the first hour for the

same reasons as you described just before the break?
A. You're asking me to assume what other people would do, but I think it would be reasonable.
THE CHAIRMAN: Yes, because if you thought, coming in a bit before 9 o'clock on Tuesday morning, that Claire's condition was unclear and therefore that she would be given some priority on the ward round, be seen in the first hour, that same line of thinking should have been followed, you would have expected, by whoever took your place if you weren't there?
A. Yes.
MS ANYADIKE-DANES: And the sort of approach that you had to ward rounds, is that something that you would have inculcated in your junior doctors?
A. I would have hoped so. It was the way I'd been taught to do ward rounds, it was the way we did them. There was a great focus around the ward rounds, at getting the children seen and making sure they'd been seen and plans put in place for them. That has always been the focus and there has always been consultant ward rounds at weekends, et cetera, at Children's. There was a focus on getting these patients seen and assessed by, say, 11 o'clock in the morning.
Q. So the ward round was started about 9?
A. Yes.

Q. And, you say, would conclude about 11, something of that sort?
A. Probably slightly before 11. At that time, we wouldn't have done the CFs because the multidisciplinary ward round was starting at 11 o'clock on them, so that would have excluded some of the patients that we needed to see. We would have started with whoever we'd been advised was the one we needed to see earliest, or we would have just started at the beginning, making sure that we saw any that we had concerns -- someone like Claire -- within the first hour. And we would have started at the beginning of the ward and worked our way through.
Q. Well, it seems that there were ward rounds involving eight of your patients on the morning of the 22nd.
A. Yes.
Q. And there were some ward rounds that, between them, Dr Sands and Dr Stevenson took for others. I think one each -- they took a ward round of one of Dr Hill's patients and one of Dr Reid's patients. So in all ten patients.
A. I presume we -- we would not call those ward rounds. The ward round is when we see everybody. So on the ward round, those patients were seen.
Q. Sorry, I should explain what I mean.

A. It's maybe just what we perceive with ward rounds may be different.

Q. It's my failure in expression. If I just put to you what I'm saying.

As you know, we sought to access the medical notes and records of all those children who were on a given number of wards on the morning of 22 October.

A. Yes.

Q. And we have obtained those notes and records and we have identified where they record ward rounds being taken and who conducted those ward rounds. If you tally those up, you get ten.

A. That's correct.

Q. So what I'm seeking to ask you then is: are you saying that there were other children included in ward rounds who, for some reason, we won't have seen by the means that I've just described to you?

A. I can't be sure that all the patients have been captured. It's been an exhaustive process. It's been a very difficult process, a very difficult process for their parents as well. There were 17 beds in Allen Ward. We have identified 18 patients, I think. Two were in Musgrave Ward, so that gets us down to 16. Keep me right with the figures. One was in Cherry Tree, so that gets us down to 15. But the ward was full and

there's 17 beds. So I'm not sure we've caught every single child, but the majority are there I'm sure.

Q. Well, apart from the 14, we had four more added, so ultimately we have 18. You're right.

A. Yes.

Q. But of that 18, we have only been able to identify children involved in a ward round conducted by either Dr Sands or Dr Stevenson -- and for that matter Dr Stewart, who was also about -- in relation to ten patients. Eight of them were yours.

A. Yes.

Q. What I'm actually trying to ask you, now that we are getting down to trying to find out how much time was spent on a ward round is: are you saying that notwithstanding that, that they may actually have included more patients than those in some way in their ward rounds?

A. They may have. I'm not saying it's a big number, but they may have because the numbers don't quite add up yet. But the ward round was a process where the team went round each patient, saw the patient, and assessed them and decided what to do, rather than you just went here and there.

Q. Yes. Some of the patients that we've seen are patients of Dr Redmond. Your team wouldn't have carried out

a ward round for Dr Redmond.

A. We would have for her non-CF patients --

Q. Yes.

A. -- but the ones who are CF, which I think are the only ones that have been identified, were being managed through the CF multidisciplinary team ward round that morning.

Q. And we have seen the reference to who conducted those ward rounds.

A. Yes.

Q. So in the records that we have, we have only got 10 patients being involved in a ward round covered by either Dr Sands or Dr Stevenson. So what I'm trying now to find out is, given roughly how long you think a ward round would take, and given the purpose of seeing each of those patients in the ward round, how long roughly do you have with the patient?

A. The ward round for that number of patients should have been completed by 11 o'clock because some of the patients were already known and they were part of a routine process and investigations were ongoing with them, and it was a matter of seeing what was to be done. For the new patients, it depends on the extent of their symptoms, how long it'll take for a history and an assessment. But for ten patients the Allen Ward ward

round would have been completed by 10.30, 10.45.

Q. In answer to something the chairman put to you, you said that a child with Claire's presentation and given the uncertainty over what was causing her presentation -- you would have wanted a child like her to have been seen, say, within the hour.

A. Mm-hm.

Q. So that's slightly further up in the ward round, I suspect, than not. So if that's going to be the case, and given that she's a new admission, how long do you think should have been spent assessing Claire?

A. Actually assessing her or getting to see Claire?

Q. Being with her, until you moved on to the next patient.

A. Actually spending time with Claire, I think a grandparent was with her in the morning. There was an opportunity to take a history from a relative, I think, see the patient and check the vital signs and check any -- look at observations, et cetera. So 20 minutes minimum.

Q. 20 minutes minimum?

A. Yes.

Q. Well, Claire's family, or her parents, have given witness statements. If we pull up the witness statement WS253/1 at page 7. You will see under (a)(i):

"State for how long your conversation with Dr Sands

at this time lasted. I now know that the doctor who conducted the ward round was Dr Sands. I first spoke to Dr Sands on Tuesday 22 October 19969 at approximately 11 am during the ward round. That conversation lasted for about five to 10 minutes."

As I understand their evidence to be, they were with Claire all the time that that particular doctor was, if I can put it that way, examining her, being with her, spending time with her. They were there. How does that relate to what you were just saying now about the amount of time that should have been given to Claire?

A. I can't speak for how much time Dr Sands gave.

Q. I'm not asking you to do that.

A. And I can't recollect anything, but five minutes would have been a bit too brief. It depends on what his assessment was and what immediate issues needed to be addressed. And of course, recollection for all of us is difficult, as memories fade with time and we do know accuracy of memories decreases very rapidly in the first year. But five minutes sounds too brief a time to actually get a relevant history and clinical findings, especially as a CNS -- a central nervous system -- examination was carried out. It would be technically difficult to complete that in five minutes.

Q. Perhaps you can help us in this way -- and I know that

you actually weren't taking the ward round, or at least you weren't present there with Claire -- but if you were helping us, hypothetically, with the sorts of things that you might have looked at, the staff with who you would have discussed, as you believe was your practice before you started that ward round, what is it that you would have been trying to do, armed with that information, when you first came to see Claire?

A. I would have the opportunity, because a parent was there, to actually clarify the history again, and in light of what had happened overnight, reassess her central nervous system signs, look at her observations and determine if there had been a change, had we got a diagnosis, did we need a diagnosis and did we need further input from somebody else from another specialty.

Q. Maybe you can help me with this, and this goes to something you had talked about before in terms of communications with the parents. The parents didn't think that Claire actually was very much better in the morning.

A. No, and I think we failed the parents completely around communication. I failed to -- and the team failed -- to get through to the Roberts just how sick Claire was. I'm unsure of the feeling during the overnight and early morning --

Q. Pardon me, doctor, I've asked you a slightly different question although that's helpful.

MR FORTUNE: Let Dr Steen answer the question. We've had this before. The witness must --

THE CHAIRMAN: Sorry, the issue is whether she was answering the question, Mr Fortune.

MS ANYADIKE-DANES: Thank you.

THE CHAIRMAN: I will let Dr Steen finish. But the evidence will move a little more quickly if Ms Anyadike-Danes is allowed to continue with the questioning with a minimum of interruptions from the floor.

Dr Steen?

A. Ms Anyadike-Danes will have to ask me the question again, I'm sorry.

MS ANYADIKE-DANES: That is all right. What I was trying to ask you is: when you had looked at your notes and perhaps spoken to the staff, you would have got the impression that, whatever had happened over the evening, they had stabilised her and she was a bit better.

A. Yes.

Q. In fact, what the parents are saying is that so far as they're concerned, in their eyes, looking at their daughter, she wasn't better and they were still worried about her. So what I was trying to ask you is how significant is it, when you receive a piece of

information like that from the family, and how do you deal with that?

A. I think it's very significant because the family know their children and the family may not understand what's going on, but they sense this is different, this is not right, this is not what usually happens. So if a parent alerts you to something like that, it's relevant and you should look again at the patient and say, "Right, what's going on here? Have her signs changed? Are there any tests we need to be doing here? Is there any treatment we should be giving because this parent is very clearly saying this is not normally what happens with their child?".

Q. You, of course, didn't have an opportunity to examine her, but you have now seen the results or the record of Dr Sands, who did, as written up by Dr Stevenson. Faced with that, what is it that you would have wanted to be doing and what tests would you have wanted to institute at that point?

A. I would actually agree with Dr Sands that we needed a neurology input. We needed to get her assessed by someone else. She was no longer a general paediatric problem and, indeed, if she had been in a district general hospital I think they would be phoning the neurologist, just as Dr Sands went to find the

neurologist for an opinion, because her level of consciousness was not normal. She was not responding normally and Dr Sands felt that she was having non-status epilepticus -- she was fitting internally -- which was a term that her parents didn't understand, and again a failure of communication where they didn't understand the meaning of that.

So I think Dr Sands did the right approach: he assessed her, he felt she was a sick child, she needed a sub-specialty opinion, but he felt that she should have diazepam first, as it would have taken time to get a neurologist, to stop any seizures that were going on.

Q. In terms of the paediatric element of it -- that's dealing with the neurological concerns -- what would you have wanted to institute in relation to making sure that there wasn't some other matter that might be causing those symptoms? What else would you have been wanting to be doing as a paediatrician?

A. I would have been wanting to ensure the previous investigations had been sent, so make sure there are ticks to say viral titres et cetera have been sent. I would have noted that toxicology hadn't been sent, but we would have had the parents there, we would have an opportunity to say, "Could she have taken anything that would have made her condition worse?". Normally, not

always, but normally if children have accidentally taken a medication, they're improving with time, not deteriorating. I would have wanted to check that she was written up for her IV fluids and I would have also wanted to check that the routine investigations were going to be repeated, that her U&E was going to be repeated that day.

Q. And when you say "that day", when would you have wanted those results to come in?

A. We don't like putting needles into children, and I think that is always a difficulty. But I would have thought that if the neurology team were not able to see her straightaway, I'd have expected the U&E to be done in around lunchtime, but if the neurology were coming and they would probably have had a list their own investigations to be done, then the U&E could have been done with their investigations after they'd seen her. But if there was an unreasonable delay before the neurologists could see her, then you would go ahead and do a blood there and then.

THE CHAIRMAN: Before we move away from this note, the statement from the family, which is on the screen in front of you, doctor -- just to make sure we're talking about the same thing, your evidence a few minutes ago was that you would have expected, if you'd been there,

to have spent a minimum of 20 minutes with Claire and part of that was because there were family members there from whom you could get a history.

A. Yes.

THE CHAIRMAN: That question was specifically about when the family first spoke with Dr Sands. They say they first spoke to Dr Sands on the Tuesday at approximately 11 and the conversation lasted approximately five to ten minutes. But your 20 minutes isn't just speaking to the family, sure it isn't.

A. No, it's carrying out clinical examination. Technically, carrying out a CNS examination takes longer so there's the conversation with parents and the examination. Or sometimes, if you think the child is sick, you do the two at once. You're talking and examining and trying to get the information as quickly as possible because you are concerned and you want to get things moving, rather than just focusing on the history and then going on with the examination. So quite often you're doing both things together. But if you're going to elicit a reasonable, focused history and carry out an examination, which for her was -- the most critical part of her examination was the CNS examination. To do that in five to ten minutes is very quick.

MS ANYADIKE-DANES: Well it may not have been five to ten minutes; it might have been five to ten minutes spent talking to the family.

A. Yes.

THE CHAIRMAN: That's the point. We have to be very careful, I think, trying to work out back in 1996 what happened. If Dr Sands spent five to ten minutes talking with the family and then spent another, say, 10 or 15 minutes or whatever time, examining Claire, at least in terms of time, that falls within what you might have expected?

A. Yes, it does.

THE CHAIRMAN: Right. So it depends what was communicated from the family to the doctor, what questions he asked and then what examination he made and what investigations he started?

A. Yes.

MS ANYADIKE-DANES: Just to finish that off, in terms of the communication with the family, one bit is when you're actually trying to receive information from them, that's taking a history. And the other bit, I presume, is when you're communicating some information to them. Would it be as you're doing the examination, or after the examination so that they understand what's happening with their child and what is likely to happen to their

child?

A. Or both. It could be a continuous communication process where you clarify the history and when you are examining you're finding things and you would be gently saying I agree with you when I look in your eyes, they're not quite working as well as I'd like them to work, her legs seem slightly stiff compared to before, and then, when you have completed your examination, saying, "I am concerned and this is what I'm concerned about and this is what we're going to do".

Q. To be clear about that: if you did have concerns like that, sufficient concerns where you agree that you would have wanted to get in a paediatric neurological opinion, is that something that you think should be communicated to the parents?

A. Yes.

Q. And explained to them?

A. Yes, that you're going to bring in a neurologist or cardiologist or whoever to see them, and that you will -- that they may not be able to come straightaway but you will contact them and you will get back to the parents with the information of when that specialist will be able to see them.

Q. That was all an exercise, slightly in the hypothetical, which is if you had been there, what would you have done

and how would you have done it and how does that, to some extent, compare to what actually happened.

I wonder if we can start with this, which is to pull up your second witness statement, which is 143/2, and go to page 2 of it. This is something that was generated from an answer that you gave in your first witness statement, if I can put it that way.

A. Yes.

Q. If you look at 1(a). And it's because you said in your first witness statement:

"I had been aware that Claire was in the ward at 9 am on that particular day."

And you were asked to explain how and when you became aware of that. And you say in your answer:

"I have no recollection of events. I assume I was informed by medical and nursing staff when I attended the ward prior to the ward round at approximately 8.45 am."

Firstly, do you actually remember being on the ward at 8.45?

A. I have no recollection of events at all. And that is most unfortunate. At the time of the inquest, I would have had fresher memories, but as the chairman is aware, I've had health issues.

Q. I understand that, Dr Steen. The thing is, this

statement is actually dated 16 July of this year. So you are answering in the summer of this year.

A. Yes.

Q. When you provided that answer, did you actually have any recollection of being on the ward at approximately 8.45?

A. No, I note, "I assume I was informed".

Q. No, you say:

"I assume I was informed by medical ..."

So the assumption -- I had read that, but you can correct me -- being how you were informed. I didn't read the assumption to go to whether you were on the ward at 8.45.

A. I'm sorry, I can't remember. I'm not sure whether it's in the coroner's statement or something else. There was a comment made previously that I could remember being aware of Claire that morning. I don't know if it's in the coroner's statement or ...

Q. We'll try and pull it up for you.

A. Or it may have been conversing with the parents when we met with them with Dr Rooney.

Q. It's not so much whether you were aware of Claire that morning; it's the basis for you answering that you were on the ward at approximately 8.45. That's actually what I'm trying to get at. Where does that come from?

A. I have always assumed I was on the ward that morning. I

have instinctively -- I know the evidence and the documentation is not necessarily there, though there is some evidence to show that I was seeing patients and was contactable that morning. But I've always assumed that I was on the ward round. Instinctively, I have always felt I was there and was aware of what was happening. What I have never been able to understand is why the ward round hadn't got to Claire before 11 o'clock, what else was going on. So I would need to cross-reference that with earlier statements to see where I picked that up from.

THE CHAIRMAN: Could we take the doctor to her evidence to the coroner, which is --

MS ANYADIKE-DANES: 091-011-067 is, I think, what you might be referring to.

THE CHAIRMAN: Yes.

If you look at the bottom third of the page, do you see the name of "Mr McCrea"?

A. Yes.

THE CHAIRMAN: He was representing the Roberts family.

A. Yes.

THE CHAIRMAN: That says:

"I was the consultant on intake at that time. Claire fell within my remit."

It then says and this is crossed out:

"I first saw Claire at ..."

That is corrected to say:

"I was aware that Claire was in the ward at 9 am on the Tuesday morning. I cannot recall if I examined her prior to that."

A. Yes.

THE CHAIRMAN: "My recollection is that when I contacted the ward and was told that Dr Webb had seen her and had taken over her management ..."

A. The second statement is -- my recollection is that when I contacted the ward, that was in the afternoon that was after my clinic in Cupar Street, but the first statement was my recollection of what I had in 2004/2005 of being aware on the ward round. And when I was preparing my statements for this inquiry, as I had no recollection, all I could do was go back through the previous statements, medical records and depositions and try to take that information and put it in as my witness statement. Otherwise it was just going to be "I do not recall".

MS ANYADIKE-DANES: Can we stay with that because I'm going to take you to another document in relation to that? So just let it be clear this was your evidence to the coroner in answer to Mr McCrea's question, which was that --

THE CHAIRMAN: Well, you don't know the question, but this is the answer you gave.

MS ANYADIKE-DANES: Sorry, I am not going to give the question; I'm going to give the answer that you gave. You cannot recall if you examined her prior to you being on the ward.

A. At 9 am.

Q. At 9 am. Can we go to 139-132-005? I'm going to ask you why you said that. This is an e-mail that you send to Mr Walby, dated 8 February 2005. And you are, at that stage in the process, preparing a witness statement that will go to the coroner.

A. Yes.

Q. You start off by saying you think it's too long and you are not sure how much detail you need to put in. In the second sentence you say:

"Prior to her coning, although I was her admitting consultant and would have been aware of her and the fact that Andrew Sands had asked David Webb to see her, I did not actually see or examine her."

Prior to coning, that is when you became aware of it --

A. Yes.

Q. -- that would have been about 4 o'clock in the morning of the Wednesday when you became aware of that fact,

you are telling Mr Walby that, before that, you did not actually see her or examine her. So if that's what you're telling him in your cover e-mail, if I can put it that way, to your draft statement, why is it that you are suggesting to the coroner that you might have examined her?

A. Did I say I'd examined her? I said I was aware of her.

Q. Let's pull up the statement again.

A. I did not say I examined her.

Q. I beg your pardon. 091-011-067.

A. I say I could not recall if I had examined her.

Q. That is exactly what I am coming to. Why did you say you can't recall if you examined her, when actually in this e-mail you are making it quite clear that you didn't do any such thing.

A. Because I couldn't recall that I'd examined her.

Q. But you know that you didn't:

"Although I would have been aware from the fact that Andrew Sands had asked David Webb to see her, I did not actually see her or examine her."

A. Could I have that document put up, please?

THE CHAIRMAN: Yes. It's 139-132-005. If we can have them side by side.

MS ANYADIKE-DANES: You don't say to Peter Walby "actually I can't remember"; you make a statement.

A. Yes, I didn't actually see or examine her.
Q. Yes, it's not a matter of, "I can't remember if I did, maybe I did and I can't actually remember that", you are -- that's quite a definite statement when you've got your e-mail to Peter Walby. Why are you suggesting --
THE CHAIRMAN: If you also look at the next sentence. In the third line down in your e-mail after you say, "I didn't actually see or examine her", what you are really saying to Dr Walby is:

"That being the case, do I just need to put that she was admitted under my care, was seen by the registrar, Andrew Sands, and David Webb, and then go straight into the call at 4 am?"

In other words, what you are suggesting to Dr Walby is:

"I know she was admitted under my care, but I didn't see her, I didn't examine her, so in my statement to the coroner, do I just go straight into being called out at 4 am on the 23rd?"

A. Yes, because there was no written evidence. When I was preparing that, there was no written evidence or documentation in the notes that I had seen or examined her. And therefore, my concern was that when I was preparing the coroner's report, I was putting in a summary of her whole care rather than my -- what

I knew I had done, rather than what I maybe did. It was what was written down.

MS ANYADIKE-DANES: I understand that.

Between when you sent that e-mail with your draft statement and were giving evidence here in the Coroner's Court, had you received any information that might suggest to you that maybe you had examined her and you just couldn't remember doing it?

A. I have no recollection. Unless you can find documentation, I'm sorry.

Q. So why is it that you make a definite statement in your cover e-mail that you did not actually see her or examine her, but when you are giving your evidence you have something slightly softer, "I cannot recall if I examined her", which might suggest that maybe you did examine her, it's just you can't remember.

MR FORTUNE: Before Dr Steen answers: 15 months have actually elapsed between the e-mail and the time Dr Steen gives evidence.

THE CHAIRMAN: Yes. I'm sorry, Mr Fortune, that really doesn't help at all. That is not a helpful intervention. I understand Dr Steen's recent unhappy experiences with her own health have affected her memory and I entirely accept that. What we're doing is we're going back to a time when her memory was not adversely

affected by any health problems, although it may have, to a degree, been affected by the passage of time. Of course, that leads on to another issue which we are not dealing with just now about why there was a passage of time from 1996 to 2004/2005 for an inquest. But when we're on this period, at the time when the doctor's memory was not adversely affected by health problems, there is at the very least some degree of possible inconsistency between what she says to Dr Walby and then at least the impression which is given in this handwritten note at the inquest, in which the doctor appears to recall being aware that Claire was on the ward at 9 am on the Tuesday morning, but cannot recall if she examined her prior to that, and it appears therefore to leave open the possibility that she might have examined her prior to that. And I think, Ms Anyadike-Danes, that was the point you were on.

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

A. And I don't know the question I was answering at the coroner that day. I don't know why I responded in that way. I don't know what the question was.

THE CHAIRMAN: Well, what happens, as you may know, Dr Steen, in our inquest system is that you go into the inquest with a statement which has been forwarded

beforehand, which is typed up, and then you're asked some additional questions and the coroner doesn't record them as a question-and-answer session, but he encapsulates in this written note what the gist of the evidence is. So we won't ever get a question and answer here. What we'll get is a summary of your evidence, which is then signed by you at the end of the handwritten section.

MS ANYADIKE-DANES: Actually, Mr Chairman, we do have a note of that, which is to be found at 097-012-122. This is a note taken by Dr Burton, John Burton, who was present.

THE CHAIRMAN: Right.

MS ANYADIKE-DANES: If you go to 122, you'll see "Examination by Mr McCrea". And then there's a question:

"You were the consultant on take-in from 9 am Monday ..."

Then you see:

"When did you first see Claire Roberts? I can't be sure."

Then:

"I would have been aware of her presence in the ward from 9 am on Tuesday. I can't recollect examining her before 3 am."

Pretty close in terms of what was actually recorded

by the coroner. So in terms of your query, what was the question, the question was:

"When did you first see Claire Roberts?"

A. And the one that I can definitely say I saw her was at three in the morning.

Q. That's not the issue that I've asked you. What I've asked you about is the inconsistency between what you say when you are sending your private e-mail to Peter Walby and what you say when you're giving your evidence, which, as the chairman's pointed out, at least suggests that you might have examined her, you just can't actually remember doing so.

A. I don't think I examined Claire Roberts. I don't think that's an issue. Was I aware she was there?

Q. No, that's not the question. The question is: why did you suggest that you might have examined her, it's just that you can't remember doing it, when you knew absolutely that you had not examined her?

A. Because probably at the time when I was being questioned, I wasn't that sure whether I'd examined her or not.

Q. Well, this evidence is being given in March of 2005.

THE CHAIRMAN: How could you not have been sure in 2005 and 2006 about whether you saw her? Because for the purposes of the inquest, you would have had access to

the same notes and records as you had access to for the purposes of your inquiry statement. The inquiry didn't have, as far as I'm aware, better or additional medical notes and records than would have been available within the Royal at the time of the inquest.

A. Yes, and I don't know why that impression was given. As far as I'm concerned, I did not carry out a clinical examination of Claire, documented or undocumented, before 3 am. I do think I knew about her and I do think I knew what Dr Sands was doing, and we do, from the other clinical records, know that I was actually in the same ward that Claire was in. So I do think I was fully aware of Claire, looking back, but I didn't examine her, and I don't know why that is written in that way.

THE CHAIRMAN: Let's leave it at this: do you understand how, when we look at that, it gives an impression which is different from the stark statement "I did not see Claire before 3 or 4 am"?

A. Yes, I do. I think there's something in the definition of what "see" means. Does it mean you actually examined and did everything like that, or you stood and talked with someone about her?

MS ANYADIKE-DANES: Yes. Just finally -- then we'll move away from this point -- so we have the dates. The e-mail we saw going to Peter Walby was February 2005.

The statement that ultimately resulted from that exercise is dated 16 March 2005. And your evidence to the coroner was taken on 25 April 2006. If we pull up 091-011-068 ...

MR FORTUNE: I've got 4 May.

MS ANYADIKE-DANES: 4 May 2006 is when it seems to be signed.

Is that your signature?

A. Yes.

Q. Are we to understand from that that that signature indicates that you've read what you're signing to?

A. Yes.

Q. So you will have read "I cannot recall if I examined her prior to that"?

A. Yes.

Q. So when you say, "I don't really know why it's written like that", however it's written like that, you've signed that?

A. But I didn't recall examining her prior to 9 am.

Q. No.

THE CHAIRMAN: I have the point.

MS ANYADIKE-DANES: I think the chairman has the point.

A. I never have recalled examining her. I'm not sure somebody said, "Did you examine her?". I don't recall examining her.

Q. I wonder if I might be able to move on from there? You weren't at the ward round.
A. I think I was at the ward round, but I think there was something going on and it wasn't running the way it would normally have run.
Q. Sorry, what do you mean you think you were at the ward round?
A. I think I was in Children's Hospital on the Tuesday morning and we now have some writing in other charts to show that I was.
Q. We're going to come to that in a minute.
A. So I think I was there. I don't know what was going on that the ward round was only getting to Claire after 11 o'clock in the morning because she was only in room 7. And I don't know what was happening that morning. But it certainly is an unusual morning in that the ward round wasn't completed. We should have seen Musgrave Ward patients as well that morning.
Q. Let me be clear in what you mean by you think you were at the ward round. Does that mean you think you were present when Dr Sands and Dr Stevenson and/or Dr Stewart, who sometimes attended, actually went round in a ward round and saw the patients, you think you were present?
A. I think I may not have been present when they saw every

patient but I think I was at least in RBHSC and possibly -- well, I know I was in Allen Ward because I've written notes.

Q. We'll come, in a minute, as to what that shows. Let's stick to this point.

Does that mean you think, as they went round and saw at least the eight patients that were yours, and possibly also the two who were others', that you were with them?

A. I cannot say I was with them for all the time, no.

Q. At any part of it, you think --

A. I have no recollection. I just know ... I have always felt that clinical ward rounds are very important. I have always tried to ensure I was present. If I was being taken away by other issues, then I would have kept coming back and checking. And my routine would have been, before I left the hospital on a Tuesday morning, is to check with a nurse or whoever's around that all the patients had been seen and action plans had been done.

THE CHAIRMAN: Before you left? Tuesday lunchtime would that be?

A. Yes. So for me not to have been in Children's that morning would have been very unusual and if I'd known I wouldn't have been there, I'd have asked somebody else

to do the ward round. What was going on that morning, we still haven't discovered, but it was unusual in that the ward round was not complete by 11 o'clock.

MS ANYADIKE-DANES: No, what I'm trying to distinguish is between the possibility that you were in the Children's Hospital, in and about the ward, distinguish between that and somehow participating in some, to a greater or lesser degree, ward round involving the children that I've just mentioned, including Claire.

A. I cannot recollect what happened. I cannot tell you, I can just tell you that it would be normal for me to be there. There's evidence I was around. Was I there the whole time, was I there intermittently? I do not know. But something unusual was happening that morning.

Q. If you were there, would you have expected your presence to have been recorded?

A. At that time, no. At that time, the documentation was poor. I see Dr Stevenson does record Dr Sands at times and then it's Dr Stewart, et cetera. But it should have been recorded as the most senior doctor who was there and the nurses should have recorded that I had been there.

Q. If you had been there --

A. It should have been recorded.

Q. Let's go to 090-022-052. If we go down to almost the

bottom of that page, you will see 22 October 1996, "W/R [ward round] Dr Sands".

A. Yes.

Q. You're not in there.

A. I'm not.

Q. No. Given that you've already conceded that Dr Sands had concerns about Claire's neurological presentation, sufficient that led him to go and seek the opinion of a paediatric neurologist, if you'd been about would you not have expected him to have discussed that with you?

A. Yes, I would have.

Q. And if he had discussed it with you, you'd expect some kind of note because then it would be your decision rather than his about what should be done?

A. I would have expected it to be recorded.

Q. Yes. And it's not recorded?

A. No, it's not.

Q. If it's not recorded, it might mean because you weren't there and such a discussion didn't happen.

A. It might be or it might be that it just wasn't recorded.

Q. Why wouldn't be it recorded?

A. Because our documentation is poor and we know it is poor. We would have no time for that one. I know you're going to get to the other patients, but we have another example where my writing is in alongside the

ward round for Dr Sands where I've specifically written something in at the same time, yet it's not commented on that I was there.

Q. Because nobody knows that you were necessarily there, but we'll come to that particular example later on.

If we go over the page to 090-022-053, we see a few lines up from the bottom:

"Non-fitting status."

This is a note taken by Dr Stevenson. Dr Webb adds "encephalitis/encephalopathy" after he's had his discussion. Dr Sands adds that after he's had his discussion with Dr Webb. Then there's a plan written. The plan is he's going to speak to Dr Webb.

MR GREEN: I think my learned friend said Dr Webb added that. It was actually added by Dr Sands.

MS ANYADIKE-DANES: Dr Sands added it after he'd spoken to Dr Webb, "rectal diazepam". Then we see "Dr Webb". Then, "Discussed with Dr Gaston re previous history". So if there was any discussion with you, even though this is all in summary note form, they're certainly identifying who they want to talk to. So why on earth would they have not included you? You are the consultant.

A. I'd have expected Dr Sands to include me.

Q. Yes. Well, it has not. So what I'm suggesting to you

is, you're not included because you weren't there.

A. Well, Dr Sands could have contacted me in any way to include me in this. He had various ways of contacting me, but actually I think -- and I think there's some evidence now to show that I actually was in the Children's Hospital and he may well have spoken to me about it. But there is no documentation, I fully accept there's --

THE CHAIRMAN: Sorry, there are two parts to that. There's evidence from other notes that you were in the hospital that morning.

A. Yes.

THE CHAIRMAN: That's the first point and that's clear. The second point that you made was that -- did you suggest that he may well have spoken to you about it?

A. He may have.

THE CHAIRMAN: While there's evidence that you were in the hospital, there's no evidence that he did speak to you; is that correct?

A. No, and I fully accept there's little documentation.

THE CHAIRMAN: Okay. The question really is how do I interpret the documentation.

A. Yes, and it's very difficult.

MS ANYADIKE-DANES: Perhaps we might go to Dr Sands' statement, 137/1, page 6. This is the answer to

question (c)(ii), and we were trying to identify how "encephalitis/encephalopathy" had come to be added on. He says:

"The entry was made after I'd had sight of the ward round entry and immediately after my first conversation with Dr Webb, who I recall mentioning the term 'encephalopathy'. My second entry in the medical notes is the giving of sodium valproate and my third and final entry in the notes is on 11 November at 3.45."

Then this reads:

"At the request of nursing staff, I spoke to Mr and Mrs Roberts. I believe this was in Allen Ward. I was asked to do this as I believe Dr Steen was not available to do so."

I'm sorry. If you'll just give me a moment, I'm being asked to put a point. (Pause). I think this is something we may come to a little later on.

THE CHAIRMAN: Yes, because at 3.25 --

A. Well, it's November, when the parents came to the ward some time afterwards.

MS ANYADIKE-DANES: I beg your pardon.

Can we go to 137/1, page 20. It's the answer to (c):

"State what you mean by 'unavailable'."

This was an answer to a previous question where

Dr Sands had believed that you were unavailable.

THE CHAIRMAN: This is Dr Sands again.

MS ANYADIKE-DANES: This is still Dr Sands' statement:

"Say what you mean by 'unavailable' and how and when you first became aware that the consultant was unavailable [that is you were unavailable]. I don't recall where Dr Steen was on 22 October 1996. I believe she was not in the Children's Hospital but was contactable by telephone."

That was his recollection. And then he goes on at (f):

"My recollection is that Dr Steen was contacted at least once by telephone by myself in relation to Claire. I believe this was on the afternoon of 22 October 1996. I believe I advised of Claire's condition and Dr Webb's involvement. However, I cannot recall specific detail. I am unable to recall the time or whether additional contacts with Dr Steen were made by myself or other members of the ward team."

But this line of questioning was prompted by your suggestion that you might actually have been either on the ward round, popping in and out in some way. So then if we leave the generality of the ward round aside and come to Claire, are you suggesting that you might have been actually present at any time when the ward round

had reached Claire or was actually -- the doctors were dealing with Claire?

A. I can only work it out from looking at other documentation because I have no recollection, but I certainly would appear to have made comment about a child who was in the same room as Claire, and we will come to that. But one of the children was being looked after by the same team of nurses as Claire was, which would suggest that I actually had been in room 7 at some stage on the morning of 22 October.

Q. And if you'd been there when the ward round reached Claire, if I can put it that way, would you not yourself have wanted to ask some questions, given how, when you were answering the chairman earlier, how serious you considered her condition might have been? You wouldn't have been a passive bystander, you're her consultant.

A. Yes.

Q. You would have asked some questions, would you not?

A. Yes.

Q. You would have spoken to the family, wouldn't you?

A. Yes.

Q. And if you had, do you not think the family would have remembered that?

A. Yes.

Q. But they haven't remembered it.

A. No.
Q. No, they've remembered Dr Sands.
A. Yes. But I haven't said I examined Claire.
Q. I didn't say "examined".
A. No, my sense is that I was in and around Children's, in and around Allen Ward, but the exact times I was in various places, I do not know. And I do not know what was going on that morning that the ward round was running so late.
THE CHAIRMAN: Having seen these other records, is it now your working supposition that on the morning of 22 October, when you were scheduled to be in the Children's Hospital, you were in the Children's Hospital, but the unknown issue is what else was going on which appears to have delayed the ward round later than you would have expected and appears to have resulted in you not seeing Claire, who would have been one of the higher priority patients to see that morning?
A. That is what I can only work out from looking at the documentation.
THE CHAIRMAN: Right.
MS ANYADIKE-DANES: I wonder, given that you have referred to it a number of times and I know that our time with you is limited, but perhaps --
THE CHAIRMAN: Don't worry about that just yet.

MS ANYADIKE-DANES: We'll try and look at some of that documentation. Bear with me a moment. (Pause).

It's patient S7, so one of your patients. Reference 150-007-003.

THE CHAIRMAN: This is not going on the screen.

MS ANYADIKE-DANES: I beg your pardon. This is for the purposes of people who have the hard copies.

THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: Do you have the hard copy there with you?

A. Yes.

Q. If you turn to the page immediately before that, you'll see the admission sheet for this patient, 002.

Do you see that for this patient, the date of admission is 22 October, coming in at 13.33, at least being sent off to the ward, which is Allen Ward, as you can see from the ward there.

A. Yes.

Q. Then if we look at 003, you can see that there is a note taken by Dr Stevenson and there's a time there of 5 pm. He refers to it being a recent admission and then you see, two lines up from the bottom redaction:

"Seen by Dr Steen. Admit for further assessment and management."

And then if we go over a few pages to the nursing

notes at 007-007, you can see at 2 pm:

"Mum phoned Dr Steen this morning concerning reflux. Brought down to Allen Ward at 1.30 for admission."

Is that one of the documents that you say places you in and about the ward at the time of the ward round?

A. It places me in RBHSC that morning.

Q. Why do you say it places you in RBHSC that morning?

A. Because the child had to be seen before she was admitted, so she was seen in RBHSC.

Q. Is it not open to another interpretation, which is that as this was a patient of yours, the mother obviously was able to contact you by phone?

A. Mm-hm.

Q. Presumably she had your number. And you simply told her, "If that's what you're telling me about the child, then take her on down to the ward"?

A. No, because it actually says that the SHOs -- 003 says I saw the child:

"Seen by Dr Steen and admit."

So mum contacted me, I saw the child and the child was admitted.

THE CHAIRMAN: Are you saying this, doctor, because this document has jogged your memory or is this your interpretation of the document?

A. No, it's my interpretation. I have no memory, sorry.

THE CHAIRMAN: That's fine, don't worry about that. I just want to get it clear. Let's start on 007. That indicates that this child's mother -- you'll understand that we're going to be very careful about what we say so as not to make anybody identifiable. When I read this, it seems to me that if a child's mother rang you, it might be because this is a child who had been in and out of hospital before and you might have given the family your number to contact you.

A. They wouldn't have had my personal numbers. But this mother could have phoned Allen Ward or could have phoned my secretary.

THE CHAIRMAN: Right.

A. This child was in and out of hospital a lot and mum knew how to contact our services if she needed them.

THE CHAIRMAN: It then says:

"Brought down to Allen Ward at 1.30 for admission."

So does that mean the admission was arranged over the phone or is the child brought down at 1.30, is examined, and then admitted?

A. No, my interpretation is that I'd seen the child before it was brought to the ward. The admissions office was at the front of the old hospital at Falls Road entrance, beside the emergency department, so you had to go there for your paperwork and to be admitted before you went to

the ward. If she arrived on the ward at 13.30, I wouldn't have seen her because I wouldn't have been there. I would have been in Cupar Street, I wouldn't have been in the ward at 13.30, so for me to have seen her, I needed to have seen her prior to 13.30.

THE CHAIRMAN: Accepting the imperfection of records, should there not be a record of you having seen the child?

A. I would have thought there would have either been an Emergency Department record or there may have been something in her notes, but I don't know if her notes were accessible at the time I saw her.

THE CHAIRMAN: And this interpretation is based on the entry on 003, which has a record towards the end of that note, saying that the child was seen by you?

A. Mm-hm.

THE CHAIRMAN: Right.

MS ANYADIKE-DANES: It could be susceptible to a number of different interpretations. It doesn't mean that you saw her and, as a result of you seeing her, you made the decision to admit her and she was brought down therefore to the ward at 1.30-ish. It needn't mean that at all, need it? It might mean that you had told the mother that in those circumstances she should bring the child for admission to the ward and that's what's happened?

A. But then I wouldn't have seen her.

MR GREEN: If we go to 002 and look on the admission flimsy in the row "admission type", the code number "4" is entered in that box. That is a booked admission.

MS ANYADIKE-DANES: If it's a booked admission, doesn't that mean that she just comes in?

A. No, I don't know why it's been coded like that because if she was a planned admission, mum would not need to have phoned me. If she was a planned admission, the mother would have been told several days in advance to bring her to the ward. The content of her presentation is acute; it's not something that we were bringing her in for investigations or management.

Q. Could it not have been written like that because she told them, "I have spoken to Dr Steen and she says she is to be admitted"?

A. But I --

Q. Sorry, bear with me. Could that not have been treated or interpreted as a booked admission?

A. It may have been, but it still says that I saw her.

Q. It doesn't actually yet say when you saw her --

A. No.

Q. -- but you are seeking to suggest that because the child was brought to the ward at 1.30, or whenever it was, that that means you necessarily had seen the child before then? All I'm saying is since you can't actually

remember, what you're trying to do is to see what is a reasonable deduction.

A. And knowing that I couldn't technically have seen her after 1.30 because I wouldn't have been in the hospital.

Q. Yes. I don't necessarily mean about this day, about which you can't remember, but if there were urgent cases or urgent matters, did you ever come back from Cupar Street to see patients?

A. Yes, I would have phoned towards the end of my clinic. So 5ish, 5.30, I would have telephoned the ward to see what was happening with patients to find out if things had improved or if things were being managed appropriately, and if there were any concerns, then I would have come back into the hospital on the way through.

Q. So you could have seen her then?

A. I could have -- well, the note's made at 5 o'clock. I wouldn't have got back from Cupar Street by 5 o'clock. I would still have been tidying up at the clinic.

THE CHAIRMAN: That raises another question. If that was your habit, to ring the ward when you finished the Cupar Street clinic, would you not have expected to be told that things were not going at all well with Claire to alert you to come back to see Claire?

A. Sorry, I don't remember where ... Maybe it was at the

inquest again. I did remember phoning the ward and speaking about Claire and being advised at that time that Dr Webb had seen her. I can't remember my exact words of what I said, but I think it's in the inquest. Whatever I was told when I phoned the ward after my clinic reassured me enough to go home and if I hadn't gone home, if I had gone back in and see Claire, it might have made a difference, I don't know. But whatever was said to me ...

THE CHAIRMAN: The record you're referring to is 091-011-067. It's the last four lines on that page and it says:

"My recollection is that when I contacted the ward, I was told Dr Webb had seen her and had taken over her management."

A. Yes.

THE CHAIRMAN: So are we to understand that, as you developed this, you're saying that what that means is you contacted the ward from Cupar Street and you were told at about 5ish that Dr Webb had seen Claire and he had taken over her management so that Claire was no longer your patient?

A. I'm not saying that Claire was no longer my patient, but that Dr Webb was doing her management and that everything was moving forward and I was not required

back in the hospital.

THE CHAIRMAN: Well, if Dr Webb has taken over her management, to what extent does she remain your patient?

A. Until it's formally taken over and there's a formal transfer, and Dr Webb and I discuss it, I remain the named consultant.

THE CHAIRMAN: What is required to constitute a formal transfer?

A. Dr Webb and I would have had to have a conversation and it would be noted that the child had been formally transferred completely to neurology rather than remain under paediatrics with neurology input.

THE CHAIRMAN: Right.

MS ANYADIKE-DANES: But you actually hadn't had a conversation with Dr Webb.

A. No, Dr Webb did not contact me and I have no recollection of contacting him.

Q. And you didn't contact him.

A. I have no recollection of contacting him.

Q. So you can't say you did contact him.

A. No.

Q. No. And he certainly doesn't recall you contacting him.

A. No, I don't recall him contacting me --

THE CHAIRMAN: I think that's the doctor's basis for saying that there had not been a formal transfer to Dr Webb.

A. Yes.

MS ANYADIKE-DANES: Exactly.

So how I was going to develop that is not so much the formal transfer, but you say you phoned the ward, somebody told you that Dr Webb had taken over her management effectively.

A. Yes.

Q. So you haven't spoken to Dr Webb.

A. No.

Q. So you don't know exactly what that management means. What else did you know about Claire at that point when you phoned the ward?

A. I have no recollection. I don't know what was said in that conversation. It was most likely the nurse in charge of Claire that I spoke to. That would be the normal process. And unfortunately, we don't have her evidence. But whatever was said to me when I telephoned, I felt reassured enough not to come back to the hospital.

Q. But this is your patient. You haven't spoken to the consultant who apparently is going to now manage her care in whatever way that is. You have not, I presume, seen any of her notes and records following the ward round, when various tests and examinations were carried out. And she's still your patient and she is

sufficiently serious that Dr Webb has been brought in, and you don't think that, even if he has taken over her management, I ought to at least go and talk to her parents?

A. I don't know what information was given to me in that telephone call. All I can say is I was reassured not to come back in.

Q. What information --

A. I deeply regret that I didn't come back in, but I was reassured by whatever was in that conversation.

Q. What information should you have been seeking?

A. I would have been seeking that her condition was stable, that Dr Webb was managing the neurological things, that there was a plan in place for managing her overnight, and there were no other issues.

THE CHAIRMAN: Doctor, do you believe on the evidence that we have seen that you could possibly have been told that Claire's condition was stable at about 5 o'clock on Tuesday afternoon?

A. Looking back at the evidence that's received?

THE CHAIRMAN: On the notes and records which we have, which were presumably reflected in any conversation which you had from Cupar Street at about 5 o'clock on the Tuesday afternoon, could it be said that Claire's condition was stable?

A. I think -- and others have commented on the observation charts that afternoon -- that her condition was serious, but that her observations have not deteriorated further from about 3 pm. So in no way would I say that Claire's condition was not serious, but there hadn't been further deterioration in the last couple of hours.

MS ANYADIKE-DANES: Can we pull up 310-001-001? This is a timeline, and the only reason I pull it up is because it brings in one place a number of things that were happening with Claire. If you've not seen this before, along the bottom is the dates and times. Let's go straight to this period from 1400 hours to 1700 hours. That's a period of time you're in Cupar Street; okay?

A. Yes.

Q. Let's look at what's happening to Claire as would have been recorded. If you'd asked or you had been given accurate information, she would have received 5 milligrams of rectal diazepam, she would have received phenytoin, she would have received midazolam. She would have been seen by Dr Webb. If you don't go literally to the limit of 5 o'clock, she'd have been seen by him twice. If you took it literally to 5 o'clock, she'd have been seen by him three times.

You can see what is happening with the Glasgow Coma Scale. She's got a midazolam infusion going on, and the

upshot of it is that nobody actually knows what is happening to Claire or why it's happening to her. If that information had been given to you, is that not something where you'd think, "This is my patient, I haven't actually seen or talked to her parents, I should get down there", even if the neurological aspects of her care are being guided or managed satisfactorily by Dr Webb? "She's my patient, I ought to be there. This is not a happy state of affairs."

A. I agree with you and I regret not coming back in. I can only say that whatever I was told on that telephone call reassured me enough not to go back in.

Q. Let's do it another way: in the light of that information, what could you have been told on the phone that could have allowed you to think, "I don't need to come in to see either Claire or speak to her parents"?

A. I would have been told that her condition was being managed by Dr Webb around the neurological status, that he had a plan in place and that, at the moment, there were no concerns and that her condition was being managed.

THE CHAIRMAN: Sorry, doctor, I think there's really two issues. One is that your answers to me a few moments ago, which have been really said in different terms to Ms Anyadike-Danes, are that at 5 o'clock her condition

was stable in the sense that it hadn't got worse from 3 o'clock --

A. Yes.

THE CHAIRMAN: -- but it was serious.

A. It was.

THE CHAIRMAN: Right. Mr and Mrs Roberts didn't know it was serious. Mr and Mrs Roberts never knew that Claire's condition was serious. I understand you're doing the best you can to put together what happened on Tuesday the 22nd. But if I take your evidence as it is, it suggests that you were told by phone that her condition was serious, but it was sufficiently stable that you didn't need to come back in and Dr Webb was managing it and it was under Dr Webb's control, despite the fact that -- in other words, you were getting more information down the phone in Cupar Street than the Roberts family in the hospital were getting.

A. Yes. And --

THE CHAIRMAN: That's appalling, isn't it?

A. It is appalling, it's absolutely appalling, and there's no defence for it. By this stage -- there was a question earlier on, I think. You said to me, "How ill was Claire?", or something. Sorry, I'm getting very tired.

THE CHAIRMAN: We'll finish for today in the next minute or

two.

A. But by 12 o'clock or 1 o'clock, with the hourly observations, Dr Webb's seen this child three times, starting all that medication, staff should have all been aware that Claire was ill, and the fact that I phoned and Dr Sands remembers phoning me in the afternoon -- I don't remember that, but I -- or I did previously remember phoning back. This child was really ill and how we never got through to those parents, to the Roberts, that their daughter was so ill is just appalling because I know Mrs Roberts wouldn't have gone home. I know she wouldn't. They were very committed to their daughter and I think it's absolutely appalling that for nurses, doctors, everybody involved in this child's care, we never managed to get through to the parents how ill their child was. They went home thinking she would go to sleep and waken up the next morning and that's awful.

THE CHAIRMAN: Thank you. We'll break until 1.45 and Dr Stevenson will be available from 1.45. Thank you.

Dr Steen, can we see you tomorrow morning at 10 o'clock, please? Thank you.

(12.45 pm)

(The Short Adjournment)

(1.49 pm)

THE CHAIRMAN: Just before Dr Stevenson is called, could I say that in another further effort to anonymise file 150, we're going to replace a couple of pages at the end of today's business. So if anybody who has a copy could wait, this will just take a few moments after 4 o'clock to take out two pages and replace them.

MS ANYADIKE-DANES: I wonder if I could call Dr Stevenson, please.

DR THOMAS ROGER STEVENSON (called)

Questions from MS ANYADIKE-DANES

MS ANYADIKE-DANES: Dr Stevenson, do you have your CV there?

A. I do.

Q. Thank you. I believe you've made two witness statements, both for the inquiry.

A. Yes, that's right.

Q. For the reference, they are 139/1, which is made on 6 January this year, and 139/2, made on 20 June this year.

I ask everybody if they are standing by, if I can put it that way, their previous evidence, subject to whatever they might say to the chairman in this hearing, but sometimes there are matters to correct --

A. That's right.

Q. -- or clarify.

A. Yes.

Q. And I understand that you might have a matter that you would like to clarify in relation to your first witness statement, which I think is at 139/1, page 15, if we could call that up. I think it's in relation to (i). That's a question that deals with how you considered matters then and you've answered:

"I recall that Dr Sands went to seek further opinion in the light of the possible diagnoses."

I think you maybe want to clarify that.

A. Yes, I would like to correct that and say that I am unable to recall.

Q. You don't recall it?

A. No, I don't.

Q. Am I to understand that what you had put there is what you think might have happened?

A. Yes, based on the notes -- and then the recollection of my memory is based on my notes.

Q. So that would seem reasonable and logical to you, but you don't actually remember that happening; would that be it?

A. Yes, that would be it.

Q. Thank you very much indeed.

So if we can go now to your CV. That's at 311-002-001. If we look down at your past appointments and we go to the fourth down, the third SHO appointment

down:

"SHO, paediatrics, Children's Hospital, August 1996 to February 1997."

So that covers the period of Claire's admission.

A. That's right.

Q. And in fact, that means that you'd been an SHO in paediatrics for not quite three months before she was admitted?

A. Yes, that's right.

Q. Is that your first encounter with paediatrics at a specialist level?

A. Yes.

Q. Before that, you'd been at the Ulster, but then you'd been at the Mater Hospital and then at the Royal Victoria, where your previous rotation had been in geriatric medicine.

A. That's right.

Q. When you came to paediatrics at the Children's Hospital, were you aware of any discussion about the death of Adam Strain?

A. No.

Q. Not at all?

A. None. Not that I recall.

Q. Does that mean there could have been some discussion, you just don't actually remember it at this stage?

A. I just don't remember.
Q. I wonder if I can ask you about the role of SHOs. You've helped us a little bit in your statement with what you thought your role was. If we pull up 139/1, page 2, in answer to question 2, you say, on the role of the SHOs:
"We were expected to take part in daily ward rounds, write up the notes from that ward round, undertake any blood tests, write up card kardexes."
And so on. Can we just be clear that it was the role of the SHO and not the registrar or the nurse to undertake blood tests that were directed, primarily?
A. Primarily it would be the job of the SHO.
Q. I presume the registrar could do it if there was some pressing reason.
A. Yes.
Q. It was something that fell within your role?
A. Yes, it was more our role than a registrar's role.
Q. So if there was going to be an issue as to whether there should have been repeat blood tests, let's say for the sake of argument, in the morning, that would be something that you would actually carry out?
A. Yes, it would be more an SHO role, yes.
Q. Who decides whether there will be one, if I can put it that way, as opposed to who carries it out?

A. It would generally have been done at the time of the ward round, so it would be discussions amongst the medical team, you know, what follow-up bloods or repeat bloods needed to be done.
Q. So you would have an input about that, but by and large, the directing of what's going to happen is whoever is leading the ward round; would that be fair?
A. That would be fair.
Q. Unless of course somebody from the previous shift had indicated, "In the morning, do repeat blood tests"; that could happen?
A. Yes.
Q. And if that happened, how would that get organised? Would you start that process before the ward round?
A. It depends if you were directly spoken to by whoever was coming off duty. Then you would organise that, but generally it would have been done probably after the ward round because the ward round could change the management --
Q. And there could be other tests --
A. And there could be other tests.
Q. -- so there's no point in leaping off and doing one if there are other things you were going to do as well?
A. That would be true, yes.
Q. But in terms of having something like that drawn to your

attention directly, is that because there'd be an SHO handover typically?

A. Not always. It just depends on the busyness of the previous SHO, where they were then going on to.

Q. I think Dr O'Hare, who's a registrar, was going on to Musgrave Ward. Musgrave Ward isn't terribly far away from Allen Ward. She was going on to Musgrave Ward, which is not terribly far away from Allen Ward.

A. Yes.

Q. So if you'd wanted to satisfy yourself about anything you were unsure of if you looked at the notes, it is not terribly far to go.

A. No.

Q. Would it happen like that or not?

A. It's more likely not to happen because they were going on to their own ward and start their own ward work, so it didn't always happen like that.

Q. So that was unless it was something quite pressing and you were really unsure?

A. And the previous doctor was concerned enough that they wanted to pass that information on to the incoming staff.

Q. Yes. Then you say later on in that question:

"We were generally to assist in the day-to-day running of the ward and liaise with the nursing staff

in the care of the patient present and deal with any problems that arose."

Can I ask you about that, that role with liaising with the nursing staff; what did that entail?

A. It would be more of an informal discussion in regard to if the nurses, you know, had an issue that they needed a doctor to decide on, write up medication or if there was a change in the condition, they would have come to you to say, "Patient A was unwell, please can you see them?", or, "Can you write up paracetamol?". So it was a verbal communication rather than a ...

Q. Yes. Does that mean, for example, if certain things have been prescribed and directed for the nurses to do, that you might be keeping in contact with them to see how that was going, whether that had happened, what the effect of it was?

A. It was a two-way process. So likewise, you would have gone to them and said, "Has this been done?", and then that would have been part of your management plan.

Q. Just so that we understand how the day might go. Leaving aside the ward round, which creates a particular focus for people to discuss things and so forth, after that has happened and everybody goes on their way to carry out the plan, if I can put it that way, are you then the point of contact typically for the nurses?

A. Well, we would be ward based, so we would be writing up notes or filling in forms for blood requests.
Q. So you're the most accessible?
A. So we would be on the ward, yes. The majority of the time during your working hours.
Q. And if there was a patient about whom there had been some concerns, it's you -- not you personally but the SHO -- who is in a particularly good position to keep a weather eye and see what's going on?
A. Yes, because you would be the first point of access to the nursing staff.
Q. And if you had your own concerns, and you had sort of seen that in the context of what the nurses were telling you, then you could take that further up the hierarchy, if you felt you needed to?
A. Yes.
Q. And if the SHOs were principally wardbound, if I can put it that way, where are the registrars typically?
A. Well, they would have been -- part of their duties I recall would have been on the ward, but then they would have had other duties in their own training, possibly looking at outpatient clinics, whenever they ran, and then they would have had educational commitments as well if that was part of their remit.
Q. So the most constant factor in terms of clinician are

the SHOs?

A. Yes.

Q. Thank you. I want to now take you to a comment that you made and I wonder if you might help us with what you mean by it. In this first statement of yours, 139/1, page 3, in answer to question 3. This is a question in relation to (c):

"What contact did you have with Claire and her family during that period?"

Because you'll have, given the period that you were on duty, said effectively that you were mainly ward based. And then you say:

"I had little contact with Claire and her family over the rest of my shift other than administering medication as per the instruction given by Dr Webb over the afternoon of the 22nd."

You're present during the ward round.

A. Yes.

Q. You're making the note and then going away to do the things you're directed to do. You are present at some -- it's not entirely clear how many -- of those examinations by Dr Webb. But you say that you had little contact with Claire and her family. Why is that?

A. That would be direct contact in the sense of speaking directly to Claire's parents or her family.

Q. Why wouldn't you?
A. Because that was led in context of the ward round, the discussions, as I recall, were possibly with Dr Sands.
Q. Yes, but when the ward round had happened and the registrar has gone off to do what registrars do and you're essentially based there in the ward, you're carrying out the things that have to be carried out -- not just for Claire, but for the other patients in terms of their treatment plans and so forth -- and you're the first contact point for the nurses really. You are closest to the patient and the family. So why wouldn't you be having contact with certainly the family if there were concerns about the condition of the patient, which it seems there were about Claire?
A. But I don't recall that there was any concerns expressed to me by other members of the medical -- or the other staff. So the contact with Claire would be in the context of me giving the treatment that was organised at the ward round.
Q. But leaving aside concerns being expressed to you by other staff, are you saying you could have been present on the ward, you could have been aware of at least Dr Webb's involvement -- because you write up some of his suggestions as to treatment plan -- and somehow not appreciated that Claire was actually quite ill?

A. That could be true, yes.
Q. You might not have appreciated that?
A. I might not have appreciated how ill Claire was.
Q. Would you have appreciated that she was, in fact, ill?
A. Now when I've had an opportunity to go through the records, it is clear that Claire was more unwell than maybe I realised on that day.
Q. Forget about more unwell than you realised. When Dr Sands is having concerns about her neurological presentation, which is why he wants to get Dr Webb's view, that all arises during the ward round --
A. Yes.
Q. -- at which you're present. So what I'm asking you is: did you not appreciate that Claire was actually a sick child?
A. At my level of experience, I don't think I was aware of how sick Claire was.
Q. Well, did you, during the rest of that day, before you went off duty, if I can put it that way, ever look at the notes that were being made of the hourly observations or anything of that sort?
A. I don't recall looking at the records.
Q. Well, would you not typically do that to appraise yourself of the condition of a child on the ward?
A. Yes, if that was indicated and there was a change in the

condition and part of the observations of the ward, but I was ... I recall taking the lead from more senior colleagues who were coming in to give opinions.

THE CHAIRMAN: Sorry, surely as the day went on it became clear that she was very unwell?

A. I don't recall if I was aware that that was the case, Mr Chairman.

THE CHAIRMAN: You see, doctor, were you here this morning?

A. I was.

THE CHAIRMAN: Dr Steen was drawing the distinction between being seriously ill and being stable. As I understood her evidence this morning, she was saying that at about 5 o'clock, Claire's condition was serious, but it was stable in that it appeared to be no worse than it was at 3 o'clock. If that's the message that Dr Steen was getting over the phone at the Cupar Street clinic that Claire was serious, are you remembering that that is something which hadn't reached you, that she was serious?

A. I'm trying to recall with the best of my memory, Mr Chairman, and I don't recall how serious Claire was throughout that afternoon. On looking retrospectively in light of the evidence that was given to me, that's obviously not the case.

MS ANYADIKE-DANES: Well, let's go a little bit further on

into your witness statement. 139/1, page 32. In answer to 53:

"Describe your perception of the seriousness or otherwise of Claire's condition during your care of her and give the reasons for your view. My perception of Claire's condition was that this was a child who had very complex medical problems, who was not very well with no clear diagnoses and who was not responding to the treatment suggested by more experienced clinicians than myself at the time."

You thought she wasn't very well. Not only did you think she wasn't very well, you thought that nobody really knew what was going on.

A. That's obviously a perception that I have given, yes.

Q. Yes. So you are there, the parents are there, is that not an opportunity to talk to the parents, who, one presumes, will be worried about the condition of their child and what's happening?

A. It certainly would have been the case.

Q. Well, why didn't you do it?

A. I'm afraid I don't know.

Q. You prescribed, calculated and prescribed much of the anticonvulsant medication; isn't that right?

A. That's right.

Q. When you did that, did you look at the notes before you

prescribed?

A. Yes, the notes were written up by Dr Webb in regard to the anticonvulsants.

Q. After from that, did you look at her notes generally?

A. I'm afraid I don't understand.

Q. Well, Dr Webb is not the only person who wrote in Claire's medical notes and records.

A. Yes.

Q. Right. So did you look at her notes apart from looking at what Dr Webb had written in?

A. Yes, because I had written the notes on the ward round and there is a note from Dr Sands.

Q. So you looked at that?

A. Yes.

Q. So you knew that if there are issues to do with status epilepticus, for example; that's a serious thing, is it not?

A. Yes, it is.

Q. And if you were looking at your prescriber -- did you have access to the prescriber?

A. The British National Formulary?

Q. No, the paediatric prescriber, Children's Hospital issued.

A. I can't recall.

Q. Right. Let me just pull it up to help you.

311-023-001. There we are. Did you have access to that?

A. I may have, I don't recall.

Q. Let's go over the page. 002. That's the third edition, July 1994. Let's see what it says about itself. It provides general guidance, and if you look at 006, the second paragraph:

"This booklet outlines the first-line drug therapy currently used in the Royal Belfast Hospital for Sick Children."

And then it gives all its acknowledgments. Over the page at 007, it gives general guidelines as to how drugs should be prescribed and so forth. And then just for the sake of example, 008, "The management of seizures", "Classification of seizures".

Then 009:

"Seizures may indicate underlying disease or dysfunction of the brain."

Then it tells you that every anticonvulsant has some unwanted effects:

"Diagnosis depends almost entirely on history. Energetically seek a cause of seizures."

A. Sorry, that's not what I'm seeing on the screen.

THE CHAIRMAN: What page are you at, Ms Anyadike-Danes?

MS ANYADIKE-DANES: If you look at item 2. Then at 4:

"Every anticonvulsant has some unwanted effects."

And then under "General guidelines":

"1. Diagnosis depends almost entirely on history. Energetically seek a cause of seizures."

And so on.

And it goes through, 010, status epilepticus, for example. There you are. It gives you the drugs, how to calculate them and so forth. And it goes through a whole range. I've just taken you to the anticonvulsant section, but it goes on to deal with the gastrointestinal, cardiovascular and so on and so forth, right up to IV fluids.

So were you aware of that when you were in the Children's Hospital?

A. It is likely it was part of the ward equipment on the drugs trolley, yes.

Q. Yes. So you'd have looked at that?

A. I could have looked at that.

Q. And if you looked at it, you'd have appreciated that anybody for whom there was any suggestion that they were in status epilepticus or they had any neurological problem, that is a serious matter?

A. It is.

Q. And what I was asking you about is: why, since you're the doctor who's most accessible to the parents, do you

not take the opportunity to see just what the parents understand about their child's condition and how can I help them. Nobody else actually knows what's going on, but at least I might be able to help them. Did that occur?

A. I don't recall, you know, speaking to the parents to highlight the issues that you've mentioned, other than my more senior colleague I would have maybe deferred to.

Q. But you're there. Would it have been appropriate?

A. I could have given an explanation to the family, certainly, but I maybe wouldn't have the experience to explain exactly what is wrong with Claire and what needed to be done.

Q. No, but you are the person who is actually making the calculations and going to administer the treatment therapy that Dr Webb has suggested, so you're in a particularly good position to explain to them what's going to be happening in the next few hours.

A. Yes, I could have explained that.

THE CHAIRMAN: Just be careful because that's based on the assumption that when the doctor is giving the medicine, he actually understands what's wrong. I'm not sure, doctor, from what you said earlier that you did understand at least the extent of what was wrong.

A. I think that would be a fair comment, Mr Chairman.

THE CHAIRMAN: Does this mean that you were in the position that you were calculating and administering medication to a child when you were not really alert to how ill the child was?

A. I was being led in managing Claire's situation by more senior colleagues.

THE CHAIRMAN: Yes.

A. And that might also mean that I didn't have the level of understanding or experience to discuss that with Claire's family.

MS ANYADIKE-DANES: I suppose how I approached it was: you were aware that you were in the course of calculating and administering anticonvulsant medication.

A. Yes.

Q. And to be doing that at all, that means a child is sick?

A. Yes.

Q. Yes. So even though you wouldn't be, as you I think would say, in fairness to you, sufficiently experienced to know exactly what was causing that, you knew that that's the therapy that you were about to embark on with her.

A. That would be true.

Q. All I'm saying is, while you had the opportunity, do you not think it would have been appropriate to have seen just what did Claire's family understand was going on?

A. It certainly could have been done in a better way to explain exactly to the family what was happening.
Q. Thank you. And in retrospect, not bringing to 1996 2012's standards, but back in 1996 do you not think it would have been appropriate to have done that?
A. It would have been.
Q. And that if they had queries or concerns and things that you couldn't address, that is something that you might have referred to a more senior colleague.
A. I could have done, yes.
Q. Yes. I would like to move now to the handover. You touched a little bit on that before and said there wasn't always a handover between SHOs. If I might ask you to comment on a statement that Dr Stewart has made about handover. He was an SHO as well, wasn't he?
A. He was.
Q. Let's pull up his witness statement, 141/2, page 2, and it's the answer to question 1(a). This is seeking what the normal procedure is for handover. So it's presupposing that one is going to happen, if I can put it that way, and saying, if there is, what's the normal procedure. And he says that normally the retiring senior house officer gave a verbal report to their colleague coming on duty. Then he says what it covers:
"All relevant information we would need to continue

the patients' care."

This would be the night, but we're talking about the handover that might have happened in the morning. Then he gives some examples of what a report might include:

"Details of the patients on their way for admission who still needed to be clerked in; information about current ward patients whose condition was causing particular concern; important tests to check before the morning wards."

So that might be a blood test, for example.

A. It could be.

Q. "A list of outstanding tests that medical staff had yet to complete."

Those could be blood tests as well:

"And a list of outstanding urgent test results that I would need to personally call the lab about through the night."

Would you agree with that?

A. Yes.

Q. So you are familiar with a handover like that from one SHO to another?

A. Yes. It sounds typical of what would normally happen.

Q. Yes. Did one happen between SHOs on the morning of 22 October, which is the Tuesday?

A. I don't recall if one did happen.

Q. If it had, would you have noted it?
A. I don't know if I would have had, you know -- I would have mentally recorded it and may have brought it then to the ward round, I don't know if I'd actually written it down as a formal transfer in the patient's notes.
Q. Let me put it slightly differently because that was a bit of an open question. If there had been some thought that it would be useful to have U&Es done again in the morning for example, so the sodium result was slightly low, is that something that you'd have noted just to make sure you brought that to the attention of whomsoever is taking the ward round?
A. Again, mentally maybe I would have recalled it to bring it to the ward round. I don't know if I'd actually have written it down.
THE CHAIRMAN: Isn't that the problem, really? If there's a handover of a number of patients, you need to write things down because you can be told two things about patient 1 and three things about patient 2, and unless something is written down, there's a risk that even doing the best you can, points are going to be missed?
A. That's very true, Mr Chairman. It could happen like that.
MS ANYADIKE-DANES: I'm very conscious we're in 2012, but in 1996 was that good practice to make a note of something

like that for the very reason the chairman has mentioned?

A. I think it would have been very good practice to have documented it.

Q. If we now pass on to the ward round itself. If you'd been listening to the evidence this morning from Dr Steen, you would have heard her say what she does typically if she's taking a ward round. She gets there a little bit early, she speaks to the members of staff, and certainly the nurses. If there is some sort of outgoing registrar from the night time shift, she would speak to that person. And then she would look at the most recent note, which in this case I think would have been the note of Dr O'Hare with some parts perhaps added by Dr Volprecht. So she would have looked at that and then perhaps read into it a little bit more when it perhaps got to the bedside of the relevant patient. That's what she would have carried out. There would be some discussion trying to sort out on that basis, superficial though it might be, the order of priorities, and you heard her view as to where she thought Claire may have lay in that.

You are now coming on as the SHO. What do you do before a ward round?

A. Again, in 1996 it would be a similar fashion. You would

want to know if there were any new patients, you would have tried to get the notes all together in the note trolley, any results that were outstanding from the previous day, anything that was significant for follow-up for those patients. And really just get ready for the consultant to come to start ...

Q. Sort of brief yourself?

A. Yes.

Q. So although the consultant might just look quickly at the most recent entry, is your role to look at it a little bit more than that because you might want to prompt the consultant as to things maybe we should discuss or perhaps you want to look at that?

A. To the best of my memory, that was not necessarily likely to happen. You were there to physically get things practically organised so you had all the notes ready. And then the review was again done at the time of the ward round at the side of the bed.

Q. It does serve, as Dr Steen said, an educative purpose as well. So the consultant could have turned to you and said, "What about X and what about Y?". And I suppose you don't actually want to be in the position of having to say, "Well, I've only read one page of those notes".

A. Well, you would have -- any new patient ... It's certainly possible that you could have got yourself up

to speed, but it would have been a short time frame to do that from the time that you came on to when the ward round started.

Q. Would you be trying to do that?

A. Yes. Just to get a handle of a number of patients and who to see and who's new and who's already been ongoing [sic] treatment. That would have been normal.

THE CHAIRMAN: You start at 9; is that right? Or you did at that time.

A. Yes.

THE CHAIRMAN: You'd start your shift at 9?

A. The shift officially, I think, started at 9. Invariably, you were in before 9, getting yourself organised for the day's work.

THE CHAIRMAN: Would you expect the ward round to start reasonably promptly on a normal day at 9 o'clock?

A. Most times not always dead on 9 o'clock, but certainly within 10, 15 minutes, by the time everybody got themselves together from wherever they were coming from.

MS ANYADIKE-DANES: Could I ask who everybody is, typically? Who is typically following in a ward round, if I can put it that way?

A. There would be your consultant, your registrar, your SHOs, and then nursing staff.

Q. And any students, presumably?

A. Yes, any medical students, yes.
Q. And once a ward round starts, what's your role?
A. We're a scribe, in a fashion, where the most senior person takes the lead and then we're following the clinical discussions with the family, the child and then the medical assessment and the examination findings of that clinician, if they're doing an examination, and then formulating a management plan as per the discussions or the guidance by your senior colleague.
Q. And as a scribe, I presume you're not taking down verbatim everything that's being said, but what sort of training do you have as to how to compile the most helpful note, if I can put it that way?
A. You generally have a format where you have a presenting complaint and then history of presenting complaint, drug history, past medical history, family history. And then your examination findings.
Q. What about times? Are they relevant to include?
A. Well, certainly the timings from a point of view of a child's illness or the timings of when the ward round starts --
Q. -- ward round, really.
A. Good practice would say that you should put your times and dates down.
Q. There isn't a time.

A. No.
Q. No. Were you taught to include the times or have just worked out that that might be helpful?
A. We were taught that that would be good practice. As the notes indicate, I didn't do that. I dated it possibly with the assumption that the ward rounds were around the same time at 9 o'clock, but as discussed this morning, times could be 10 o'clock, 11 o'clock, but I didn't do that.
Q. Yes. If you timed it, that would be a time for when you were actually with that particular patient, wouldn't it?
A. Yes.
Q. So that might be relevant to know when that patient was because you can't see them all simultaneously at 9 o'clock?
A. That's right.
Q. Can you think of any reason why you wouldn't have put the time?
A. No.
Q. Do you have any knowledge of where Claire fell, if I can put it that way, in the numbers of patient, who were seen on that ward round?
A. I've no memory I'm afraid of where Claire was in regard to the ward round or the ... In the line of order, for want of a better description.

Q. Okay. Let me put it this way. Do you have any sense of whether she's one of the first you saw or towards the end?
A. I'm unable to remember that.
Q. I see. You have talked about the people who were present and your role as a scribe. You mentioned nurses. Are we talking about senior nurses or just any nurse that happens to be there?
A. No, it would generally be the senior nurse on that particular day. And then there would be usually another nurse who was maybe tasked to work that particular section of the ward is what I recall.
Q. So that nurse is going to do the nursing things that are in the plan, but the senior nurse is accompanying?
A. Yes.
Q. Do you know who the senior nurse was on that day?
A. I can't recall other than what I've read on the information.
Q. Were you aware of whether there actually was a senior nurse?
A. Oh yes, every ward --
Q. No, no, I don't mean whether there was a senior nurse in the hospital that day, but whether there was a senior nurse who was part of that ward round?
A. I can't remember exactly who was there and what level

they were, the nurses.

THE CHAIRMAN: Do you remember the ward round?

A. I can't recall specifically this particular ward round.

THE CHAIRMAN: Right.

MS ANYADIKE-DANES: In addition to it being good practice and you were taught to do it, to put the time of the ward round, was it also good practice to sign your note, any note, that you made?

A. Yes.

Q. Always?

A. Yes.

Q. I know that you'd been on that rotation for just three months, but have you any sense of what determined the order in which patients were seen?

A. For Allen Ward, no, I can't remember whether we started in A and worked around B or whether we --

Q. Or saw new admissions first?

A. I can't remember what order that was done in.

Q. Just while I'm asking you about what was the sort of practice, Dr Steen has said that it was common knowledge how she could be reached. When she was on call, she had a home number, a bleeper, she had a mobile number, and even when she wasn't on call, those numbers, probably the mobile number might be the more useful or the bleeper, were there at the nurses' station. Did you

know that?
A. I don't recall that there was a noticeboard with those details on it.
Q. Were you aware of knowing, if you needed to, how to contact Dr Steen?
A. I would, at my level of experience, have gone to the next senior, more experienced clinician, who could have -- another SHO or the registrar.
Q. But if somebody like that is not available and you are worried, would you have known how to contact Dr Steen?
A. I probably would have had to go through switch and find out.
Q. Does that mean you wouldn't have known how to contact her directly?
A. Yes, I would have known to contact the switchboard to find out her numbers, which I would assume they would hold if she was on call.
Q. Did you know what Dr Steen, or any other consultant for that matter, expected of the junior paediatric team in terms of at what stage they needed to be referring to somebody more senior, how to keep in contact with more senior people? Were you at any stage told that sort of information?
A. It very much depends on the clinical situation of --
Q. Let's deal with Dr Steen.

A. I don't recall specifically being told by Dr Steen: this is when I need to be contacted and in what circumstances I need to be contacted. I'm not certain if that answers your --

Q. No, no, it is an answer. Was it your impression that out of hours or during hours, that if you felt it was important that you could freely contact a consultant?

A. I don't think I ever had an issue where I didn't feel as though I couldn't contact a consultant.

Q. I understand. Well, then let's go back to the ward round. I can't remember if you told the chairman that you had some recollection of the ward round.

A. No.

Q. You have no recollection whatsoever?

A. I have recollection of ward rounds, but not specifically of that ward round.

Q. Do you mean you have a recollection of ward rounds on that Tuesday?

A. No.

Q. None at all?

A. No, it's a generic --

Q. I understand. Did you have any sense that Dr Steen was present at any of those ward rounds?

A. I don't have any memory that Dr Steen was there.

Q. If she had been present, would you have recorded it?

A. Yes, because on my records I would usually write who the most senior doctor is, you know, present on the ward round. So if Dr Steen was there, it would be "Ward round: Dr Steen", would be the title, like I have "Ward round: Dr Sands".

Q. And if she had been present and discussing any elements in relation to the child, are you likely to have included any of that discussion in your note as a scribe?

A. Yes.

Q. If you look back -- and let's pull it up -- at 090-022-052. Can we put alongside that 053? That's your ward round note. It starts at the bottom of the left-hand page:

"Ward round: Dr Sands. Admitted. Viral illness."

And then you've got some notes there.

Over the top of the page:

"Attends Dr Gaston."

It goes down to the examination, "CNS". If one looks above "plan", is that "diagnosis", is that what that means?

A. Impression.

Q. "Impression: non-fitting status."

And then a bit is added on later on, which we have heard evidence about. Then there's the plan:

"Rectal diazepam, Dr Webb. Discussed with Dr Gaston re patient's history."

A. Yes.

Q. "Past medical history".

I know you can't remember this, but is there anything to indicate to you there at all that Dr Steen was present at any stage during that?

A. No.

Q. You carried out, with Dr Sands, and I think one on your own, a number of other ward rounds that day; is that correct?

A. Yes.

Q. Let me see if I can help you with that. There were ward rounds, which we have seen, and I presume you've seen a file called "150"?

A. Yes.

Q. That file relates to other patients of Dr Steen, Dr Redmond, Dr Reid and Dr Hill, who were all either on Allen Ward. One, I think, on Cherry Tree Ward, two on Musgrave, I think, but in the main, most part, on Allen Ward.

A. Mm-hm.

Q. And as we went through that, one can see that there are eight of Dr Steen's patients for which Dr Sands either takes a ward round himself. In fact, there's one that

you take. You take the ward round for S2.

A. Mm-hm.

Q. So S1, S3, S4, S5, S6, S8, S9 are all patients that Dr Sands is being recorded as having taken the ward round. And you for S2. Then you actually carry out or write up the note for a number of those, S3, S4, S5 and S9. We can go to them if necessary, but that's what the records seem to show. And Dr Stewart writes up the note for others: S1, S2, S6, S8 and H1. I think you also do the note for MRI1.

So in all of that note taking of ward rounds, I haven't been able to see -- and I stand to be corrected -- any reference to Dr Steen actually being present, however fleetingly, at any of those ward rounds, so it's not just a matter of Claire. If she had been present at any of those others, you would have noted that?

A. It would be my practice to put down the senior person on the ward round, so if it was Dr Steen I would have put down Dr Steen.

Q. Dr Steen has said she can't remember either, but she also can't understand how it came to be that she wasn't at the ward round. Is that, so far as you can recall, a unique thing?

A. At my level, the consultants' routine wouldn't have been

something that I would have been involved in or aware of. I would have just dealt with it whenever they came on to the ward.

Q. I'm talking about ward rounds because very often it's the SHO, as you say the scribe, who's writing that. So you're in a very good position because you or Dr Stewart or somebody else in your position is actually going to write that up.

A. Yes.

Q. So are you conscious of the fact that this might not have been an isolated occasion --

A. I am not entirely certain --

Q. -- when she didn't attend a ward round?

A. It wouldn't have been recorded if she didn't attend.

Q. I know that. What I'm trying to find out is --

THE CHAIRMAN: Sorry, it's effectively recorded by the fact that you refer to the senior doctor and it's not Dr Steen. So in effect, that is recording that Dr Steen is not leading the ward round or at least that part of the ward round.

A. Yes.

THE CHAIRMAN: And I think what you're being asked is: it appears from the records which carry your signature that Dr Steen was not there leading the ward round for any of the patients that you were involved with on 22 October,

and what you're being asked is, in your admittedly limited experience as a paediatric SHO, was that something which you can say was unique or were there times when the consultants weren't there for all or part of the rounds for various reasons, or can you just not remember?

A. I just can't remember.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: Thank you.

Dr Stewart was present on that ward round as well, wasn't he?

A. I believe so.

Q. Yes. How did you sort out who had what responsibilities? You're both SHOs. Who's going to do what?

A. It was just "you do this and I'll do that", and you split it evenly, so everybody wasn't, you know, loaded with a workload and the other person sat and went off and had a coffee. You tended to work with each other. So if you saw patient A, you were the scribe for patient A. Then patient B, the other SHO was getting ready for patient B for Dr Sands or the senior clinician to come to the next patient and they would have taken the lead in that patient.

Q. Does that mean if you've been the scribe and it's your

note, typically you'd be the person carrying out whatever was being directed to be carried out in that note?

A. Generally, yes, because you would have split your workload. But if it was a patient that you had taken the lead on, you followed up on it.

Q. I wonder if you could help us about things that might have been discussed during that ward round. In Dr Sands' witness statement, I think it's 137/2, page 8, in answer to question 5(b):

"I believe that the possibility of infection in the brain, or encephalitis, was discussed in the ward round. I think it likely that this was also discussed with Claire's parents."

Let's deal with the Claire's parents point first. You said you had very little contact with Claire's parents. But they were present there when the ward round got to Claire's bedside; isn't that right?

A. I believe so.

Q. Yes. And there's a reference here to what Dr Sands believes was being discussed with them. If something was being discussed with the parents, is that something you should include in your note as well?

A. It would have been good practice to put it down, that it's been discussed and the discussions with any

patient's family ...
Q. Yes. Well, it's not there.
A. No.
Q. Does that mean that it might have happened and you just didn't record it in the same way as you didn't put the time, or you don't think it did happen, which is why it is not recorded?
A. It's more likely that I didn't record it, but I can't be certain on that point.
Q. But is that not important, what the discussion is between the doctors and the parents?
A. Yes.
Q. According to Dr Sands, he says there was a discussion about that condition with the parents. The parents in their evidence, which you will have heard me put to Dr Steen, also were of the view that they imparted some information, namely that our child is not looking actually any better and we are concerned as to her presentation. That's a bit of feedback. Is that something that should have been recorded --
A. It should have been recorded, yes.
Q. -- and should have been factored into the discussion --
A. Yes.
Q. -- which is part of trying to work out what your differential diagnoses are?

A. It would be, yes.
Q. And if the possibility of infection, encephalitis -- in our glossary, we have it as:
"Inflammation or infection of the brain, usually caused by a viral or bacterial infection."
Would you accept that that's a reasonable definition of it?
A. Yes.
Q. Well, if that's being discussed, then what was discussed as to how that would be dealt with?
A. Well, it's not documented. I didn't document that discussion.
Q. Well, what gets documented is:
"Will give rectal diazepam, contact Dr Webb, and we'll also have a discussion with Dr Gaston."
But the rectal diazepam and the contact with Dr Webb is all going in the neurological direction, if I can put it that way.
A. Yes.
Q. So what's the plan for how to deal with possible infection, which actually might be causing some of those neurological conditions?
A. I don't recall and I didn't document what the plan was.
Q. Could it be that that just actually got omitted because people got themselves very concerned about the

neurological aspects and went off to see what guidance they could get from a paediatric neurologist, and actually left the whole paediatric side, which is the possibility of an infection?

A. That may well have been the case, I just don't recall.

Q. And if there was that sort of concern, that there was something else going on, is that not the sort of thing which you might have wanted to take some guidance from the consultant paediatrician about? So we've got the consultant neurologist, he's going to help us with the neurological presentation, but there's this whole other aspect that could be there. Is that not something that you'd want to seek some guidance from the consultant paediatrician about?

A. Yes, it could be.

Q. So if Dr Steen was about, is that the sort of thing you might have wanted to get her guidance on?

A. It could have been.

Q. So that you had a balanced plan?

A. Yes.

Q. Is there any reason why you didn't do that?

MR FORTUNE: When my learned friend uses the term "you", are you actually meaning Dr Stevenson or Dr Sands or the two of them?

MS ANYADIKE-DANES: At the moment, I'm meaning the

discussion that's taking place at the ward round, which is involving at least three doctors and one nurse, apparently.

So is there any reason why that discussion didn't lead to, "We ought to get Dr Steen here to get some guidance on this whole infection aspect of her potential condition"?

A. I don't know why that didn't happen.

Q. Would that seem appropriate to you?

A. Yes, now. Absolutely.

Q. Would it have seemed appropriate to you at the time if anybody had mentioned it?

A. Yes.

Q. Was there any sense that you couldn't get hold of her for some reason?

A. I never got that sense, that I recall.

THE CHAIRMAN: Well, can you recall? Let's just be very careful. Was there any sense that you couldn't get hold of her? If you don't remember that ward round, then how could you remember that there was a sense of not being able to get hold of Dr Steen?

A. Well, I don't -- I suppose I don't remember.

MS ANYADIKE-DANES: But I presume if you had got hold of her and you'd had any guidance on that, that's something that best practice would have required you to include in

your note.

A. It would.

THE CHAIRMAN: Because the note would then have been added to, "Dr Steen says A, B, C and there's a plan for the infection".

A. Yes. I would have discussed with Dr Steen and -- as you have said, Mr Chairman.

MS ANYADIKE-DANES: Thank you.

Did you know what non-fitting status was at the time?

A. I can't recall exactly what my memory would have been, looking back at 1996.

Q. Did you know what "encephalitis/encephalopathy" was?

A. My memory or my understanding would have been some form of inflammation of the brain.

Q. This is a matter that is puzzling Dr Sands apparently. He's not sure. He's got three things going on, he actually goes in and adds the latter two after he's spoken to Dr Webb, and it's causing him sufficient concern that he's going to go and seek the views of a consultant paediatric neurologist. Did you ever go and look up and say, "What are these things? I'm going to be the point of contact for the nurses, I'm going to be calculating or prescribing whatever has to be done here in terms of therapy". Did you ever go and look up

what these things were?

A. I don't recall whether I -- on that day, I don't recall if I did look it up because I was doing the other things that were put down on the plan.

Q. Please don't get me wrong. I'm sure that you had an awful lot to do, as all the doctors did on that day. I'm just trying to pick up something that the chairman was asking you about. You're not very sure about the seriousness of her condition, although I assume you must have thought it was reasonably serious, otherwise nobody is going off to find a consultant opinion.

A. Yes.

Q. There is sort of a differential diagnosis, which gets added to, so clearly the registrar isn't terribly sure, otherwise he would have had those diagnoses there in the first place. And yet you're going to be the point of contact, you're closest to the parents and so forth. But it is not clear from what you're saying, and maybe it's simply that you don't remember, that you actually understood the pathway of what that meant about what was going on with Claire, if in fact she did have those things; would that be fair?

A. I think that would be fair, yes.

Q. So you'd got quite a sick child, nobody truly knew what had happened and you didn't properly understand the

differential diagnoses.

A. That could be true, yes.

Q. Well, then, to see what help you had at your disposal, you'd mentioned that you thought that paediatric prescriber might have been on the ward somewhere as a sort of ready reckoner, would it not be, for you? What about actual paediatric textbooks? Was Forfar & Arneil there?

A. I don't remember if they were on the ward.

Q. Nelson?

A. No. I don't recall that either.

Q. Well, if those textbooks may or may not have been available to you, you have at least your registrar. Did you think to ask the registrar, "What does all this mean?", so at least from an educational point of view you could follow what was going on, if not be terribly helpful to Claire's parents?

A. I don't recall whether I asked Dr Sands that day to educate me in my lack of understanding.

Q. But why wouldn't you?

A. I just don't recall considering or discussing that.

Q. Does that mean that that is not an isolated occurrence, that sometimes children did come in with things and you didn't properly understand what their presenting condition was or what the differential diagnoses were

and you didn't look them up to see what it was or ask the registrar or the consultant? Was that a practice?

A. No, at times you would have asked questions and asked, "Can you explain why this child is presenting this way and how you treat this in this condition?". At my level of experience, I certainly would have asked.

Q. In fairness to you, you're saying you don't recall whether you did that or not?

A. No, not on that day.

Q. I understand. I do know that this is difficult as you don't remember this day very well, so it's hard for you to comment on things that --

THE CHAIRMAN: Can we just pause?

Do you remember anything about 22 October?

A. Very little, Mr Chairman.

THE CHAIRMAN: Could you tell me what you do remember as opposed to what you are surmising or working out or putting together from the various statements and notes and records that you've read?

A. And that's all I'm trying to base my memories on. I don't actually have any clear or exact memories of that day other than what I'm trying to formulate through what I've read through the inquiry documents.

THE CHAIRMAN: For instance, do you remember Mr and Mrs Roberts?

A. No.
THE CHAIRMAN: I just want to get this clear, Dr Stevenson, to be fair to you because I know it is a long time ago, and, after Claire died, I don't think you were part of the inquest, were you?
A. No.
THE CHAIRMAN: And you weren't involved with her after 22 October?
A. No.
THE CHAIRMAN: You weren't part of the inquest in 2006. So you simply don't have any recollection at all of Claire or that day, 22 October 1996?
A. No.
THE CHAIRMAN: Okay. So when you're giving your evidence here, you're reconstructing events as best you can from the experience which you had at that time as a paediatric SHO and from the documents which have been put before you?
A. Yes.
THE CHAIRMAN: Okay.
MS ANYADIKE-DANES: Thank you, Mr Chairman.
I appreciate that you were only been three months into this rotation. That's about halfway through, isn't it?
A. It is.

Q. Had a child died since you'd been in the Children's Hospital that you were aware of?
A. At that time in those six months?
Q. Yes.
A. I don't recall.
Q. Well, if a child had died, is that something that you think you would have been aware of?
A. It would have certainly been discussed amongst the other doctors.
Q. Were you aware that Claire had died?
A. The following day when I came to the ward, yes.
Q. Yes.
A. As far as I remember, you know --
THE CHAIRMAN: Is that an assumption that you must have known the following day or is it a recollection that you did know the following day?
A. It's a ... I just can't recall, Mr Chairman, to be honest, whether it's an assumption or a recollection. I just ... You know, based on, you know, the evidence that I saw for the first time.
MS ANYADIKE-DANES: If you just can't recall, that means the fact that a child that you'd been on the ward with all through your daytime shift had died the next day is not something that helped fix those events in your mind?
A. Well, that's ... It certainly would have fixed, you

know -- when a child that you were treating on the ward and then you come in the next day to say a child had died, yes, certainly that does burn a --

Q. I think that's the question I was putting to you.

A. Well, the answer is yes, but the details, you know, at this stage, I'm afraid, are difficult to bring back, you know, exactly in the way that's been asked.

Q. But at the time, you'd have discussed that, wouldn't you, with the other clinicians, at least at your level, amongst your SHOs and maybe with Dr Sands, would you not?

A. Yes, certainly when we come on to the ward round. I can only assume that it was discussed.

Q. Dr Sands has provided a statement for us, which I think will have been released, although it happens in the governance section, which is 137/3 at pages 9 and page 10. If we could put those alongside each other. Thank you.

You can see what we are trying to see is what was available, the very questions that I was asking you, if you see that in relation to question 33:

"In respect of Forfar & Arneil, please state ... And in terms of (b), whether this was in the Children's Hospital in October 1996. I don't recall specifically, but I believe one or more copies would have been

available in the Children's Hospital in 1996."

And then he goes on over the page at the top at (d):

"I believe Nelson's Textbook of Paediatrics may have been used and perhaps more frequently."

That's Dr Sands' recollection, but you have no recollection that those textbooks were available for your use?

A. No.

Q. Would you have considered it unusual that there were no paediatric textbooks on the ward available for the use of either students or the SHOs?

A. I don't know whether the books were present on the ward and should have been as part of the ward equipment.

Q. Well, where did you go to look up, if you weren't sure about something, apart from the British National Formulary, literally a prescription issue, where did you go for guidance to look up things?

A. To the best of my memory, there was another smaller handbook.

Q. The prescriber?

A. No, it would be Oxford Handbook of ... I can't even recall. But from a houseman's point of view, there would have been a smaller book that you'd have carried around in your bag that you could refer to, but it wouldn't have been a paediatric textbook, it would have

been a general textbook.

Q. Okay. But you did have the British National Formulary available to you?

A. Yes.

Q. Thank you. If we move on to fluid management. Solution No. 18 seems to have been prescribed over the day; do you accept that?

A. Yes.

Q. And in your first witness statement, 139/1, page 4, in the answer to question 5(a), you said that your role, or one of your roles -- you had a number I'm sure -- one of them was:

"... to ensure that the prescribed intravenous fluids were written up over the period of time required as per the morning ward round. The administration and monitoring was undertaken by the nursing staff."

So you would write that up, the prescription effectively?

A. Yes.

Q. And then that would be actually carried out by the nurses; is that the effect of that?

A. I believe so, yes.

Q. How did you know what to write up?

A. I ... I believe there was a -- I followed on from the previous entry.

Q. Sorry?
A. I believe that what -- the write-up was usually discussed at the ward round.
Q. Is there any discussion about that, about what fluids were to be given in your note?
A. There's no notes, no.
Q. So there's no note telling you what you should be prescribing by way of intravenous fluid?
A. No.
Q. So you were saying you would do what in those circumstances?
A. When the fluids ran out, then you would have ... What I've done is continue on with the previous fluid regime.
Q. Did you not think it was appropriate that you would maybe take stock, reassess and see if that was actually suitable in the circumstances?
A. Yes, that would have been good practice, but I didn't do it.
Q. It might have been important.
A. Yes.
THE CHAIRMAN: Doctor, how can you have any idea what fluid regime to continue? How do you know that the fluid regime which applied before is the right regime to continue?
A. I didn't at the time, I just continued on what someone

else had started.

MS ANYADIKE-DANES: Well, did you not think that's potentially quite dangerous?

A. Yes.

Q. In fact, one of the things that you did know and did write down is that the previous evening she had had a slightly low serum sodium result.

A. Yes.

Q. And she had been prescribed IV fluids, Solution No. 18, and you're going to carry on with that throughout the day? But there's no U&Es, so at the time you're carrying on with that low-sodium fluid, you have no knowledge of what is the current state of her serum sodium.

A. That's true.

Q. So actually, what you could have been prescribing for the nurses to administer is something that was actually potentially harmful?

A. Yes.

THE CHAIRMAN: Would you not speak to Dr Sands and say, "Is that what we should be continuing?", or did you know that 132 was slightly low?

A. Well, certainly because I've indicated in the clinical notes ...

MS ANYADIKE-DANES: Yes, we can pull that up. 090-022-052.

I'm not quite sure who made this, but it's just above Dr Volprecht's signature. You can see the sodium, "132, [arrow down]". That means --

A. I think in the next page --

Q. If we go to the next page --

THE CHAIRMAN: 132 is on the fourth line.

MS ANYADIKE-DANES: Yes.

THE CHAIRMAN: And you recognise that as being slightly low?

A. Yes.

THE CHAIRMAN: Would that make you say to Dr Sands, "Look, do we need to change this or are we okay just to continue what was done before or do we need to check it?", or do you just continue what was happening before?

A. I don't recall, Mr Chairman, if I'd asked any of those questions of Dr Sands.

MS ANYADIKE-DANES: So you just continued on?

A. Just continued on, yes.

Q. With something that was potentially harmful?

A. Yes.

Q. Were you aware of the dangers of too much low-sodium fluid being prescribed?

A. No.

Q. Had you ever heard of something called hyponatraemia?

A. No.

Q. Never heard --

A. Sorry, hyponatraemia, yes.
Q. You had? And did you know what that means?
A. From a perspective of symptoms or --
Q. What does hyponatraemia mean?
A. It's a low sodium level.
Q. Right. So if you knew that's what it meant and it means low sodium level, and you're giving more low sodium.
A. Yes.
Q. I want to ask you something about the electrolyte testing now. As I understand it from having been through Adam Strain's case, which I accept you weren't part of, and this case, sometimes reports from the lab are telephoned through and a doctor will simply note what that is and it's the most up-to-date record, and the lab result will follow. Sometimes the lab result gets lost, but at least you've got that. And then very often, when the lab result comes, that gets attached in a slightly different section in the medical notes and records; that's correct, isn't it?
A. Yes.
Q. If I just put to you something that Dr Stewart said -- I'm only putting these things to you so that we can see what level of agreement there is amongst you because both of you were there as SHOs at the same time, just to see whether's there's any real difference or not about

these things. 141/1, page 4, question 7. What he says is:

"It is normal practice for the doctors on call to review the hard copies of lab results when they arrive in the ward. These generally came in from the morning ward mail and, as a rule, these results have already been acted upon, but these hard copies are reviewed to ensure nothing untoward is missed."

Which means that there would have been or should have been a hard copy lab result for that serum sodium result of 132; is that correct?

A. Yes.

Q. Would you agree with what Dr Stewart says there, that that was normal practice and that's what you did?

A. Yes.

Q. And when he says "the doctors on call", would you expect to look at the hard copy lab results when they came into the ward? Would you personally expect to look at those?

A. Yes, because they usually came in a bundle of all the bloods that were taken that day and then you'd have gone through them.

Q. That reference to them coming in in the morning ward mail, just to help us, does that mean they tended to come in before the ward round got started?

A. I don't recall exactly when they would have come,

whether it was before or during. I just don't recall or remember.

Q. When they did come in and you saw them, that would give you an opportunity just to check whatever you had yourself included as a note in the medical notes and records; would that be right?

A. Yes, you could have confirmed what you've written.

Q. Well, because in fact you don't have perhaps everything that might be on the lab result in your -- if we pull up your note at 090-022-053. If we look at where the chairman had taken you to, the U&Es. You see the sodium result, the full blood count, the white cell count up at 16.

If we just put alongside of that the lab result, let's have a look at that, 090-031-099. So there we can see, there's the serum sodium, 132. We see there the white cell count. Sorry, if we take that down for a minute. 090-032-108. That shows 16.52. Isn't that right, that's the white cell count?

A. Yes.

Q. And you've got 16.4.

A. It looks like a 4, yes.

Q. Yes. So when you actually get the lab result, that gives you an opportunity -- maybe you misheard on the phone or wherever it is you got the information, and you

can then just correct the note?

A. Yes.

Q. Yes. Did you do that?

A. No.

Q. No. Okay. If we have a look then at --

THE CHAIRMAN: Just give me one second.

MR FORTUNE: Can I assist my learned friend? On page 108, the squiggle in the middle of the page is the same as on 099. And that squiggle is Dr Stewart's.

MS ANYADIKE-DANES: I don't believe it is.

THE CHAIRMAN: Maybe you can discuss that. Thank you. We'll take a few minutes and we'll be back at 3.15.

(3.09 pm)

(A short break)

(3.15 pm)

MS ANYADIKE-DANES: What I was exploring with you there is the differences between -- just a minor difference but a difference nonetheless -- between your note of the white cell count -- your note had it at 16.4 -- and then the lab result, which came back, which had it at 16.52. If we look at Dr Volprecht's note -- sorry, it's not Dr Volprecht's note, we don't know whose note it is. Oh actually, I think the particular thing we're looking at might indeed be Dr Volprecht's note. If we pull that up, 090-022-052. It's not entirely clear who wrote

that. It seems that the right-hand side of the figures, which include the white cell count, that is written by Dr Volprecht, as I understand it. And she has got the white cell count as 16.5, which, not putting in the extra decimal point, is pretty much the lab result.

Is there any reason why your note, admittedly not hugely different, is different, why yours says 16.4?

A. Transcribing errors.

Q. Transcribing from what?

A. From the 16.5 and I put 16.4. That's ...

Q. So if that's what you're doing then, you are fully aware of the fact that when you write your note and put in these values, that you are doing that not from any new sample that's come in that morning, but actually from something that Dr Volprecht or somebody else has written the previous evening?

A. That could have been the case, yes.

Q. What do you mean, "could be the case"?

THE CHAIRMAN: Is that not the only case it could have been?

A. Well, yes.

MS ANYADIKE-DANES: So that is the case.

A. Yes.

Q. So we're actually clear about that: in between whoever wrote the serum sodium result and Dr Volprecht's recording of the white cell count, in between that and

when you write your note, there is no new blood sample that's been taken, tested, analysed and reported on?

A. Yes.

Q. So the two are supposed to be one and the same?

A. Yes.

Q. Right. If that's the case, did it not occur to you that it might be useful actually to time that notation that you put of the U&Es, lest anybody understand, when they go back and look at that and think that what they're actually looking at is a record of something that was done that morning?

A. Yes.

Q. It did occur to you?

A. No, but it would have been good practice to put down the times.

Q. More than good practice, it would be actually quite important.

A. Yes.

Q. Much might have changed. In fact, we won't now know. Much might have changed between when those bloods were taken in the previous evening and 9 or 11, whenever it is, that you're writing that up in relation to the ward round for Claire --

A. Yes.

Q. -- which could be quite significant?

A. It could be.
Q. And in fact, Dr Webb will say that that's exactly what happened. He read that and was under the assumption, without having gone too far back in the file, just at face value when he saw that, he thought he was looking at results for that morning and that actually affected the way he regarded certain things because he thought, that morning 132 serum sodium was a little bit low, but not maybe too far away from the normal bracket. Whereas in fact, it could have been anything at that stage. Nobody actually knew.
A. Yes.
Q. So you're very fairly, if I may say so, recognising a number of, if I can put it that way, deficiencies with that note --
A. Yes.
Q. -- that were not helpful for somebody coming after you who was trying to understand where Claire was and what might be a useful step to be taking with her further treatment plan.
A. Yes.
Q. So before we go much further on in what happened during the day, did anybody at any point after that have a look at that note and say something to the effect of, "Really, Dr Stevenson, that was actually below par and

in some respects what was omitted or what was included was significant and that's not the standard that I, as a consultant or as a registrar, expect"? Did anyone have that kind of discussion with you?

A. Not that I recall, no.

Q. Well, now that you've fairly recognised the deficiencies of that note, would you have expected that somebody would have at some point?

A. Yes.

Q. You're in training --

A. Yes.

Q. -- strictly speaking.

A. Yes. It would have been good -- and a learning process for myself.

Q. In fact, from your point of view, would it not have been helpful if somebody at some point had sat you down and had a discussion with you about some of the things that you might have done better?

A. Absolutely.

Q. Is that what you'd have expected as part of your training?

A. It would have been good if it had happened.

Q. No, but as you're being trained, going through into your second three months of your rotation, would you not have expected that that was precisely the kind of feedback

that you would have got to help you improve?
A. Yes.
THE CHAIRMAN: Just be careful. Not just in relation to Claire, but in relation to any other patient, did you ever get that sort of feedback?
A. At times, yes.
THE CHAIRMAN: You did, right. From who? During your time as a paediatric SHO?
A. Throughout all of your experiences, from your more senior colleagues. If they felt that there was something that was wrong or that you needed to be informed about, it could have come from anybody in your training posts.
THE CHAIRMAN: Either a consultant or the registrar?
A. Yes, because they would have had maybe more experience and known the deficiencies and what would have been better practice for me as a doctor at that stage.
THE CHAIRMAN: Do I understand it rightly that nobody spoke to you about the 22 October and what you had done or not done in Claire's case?
A. No, not that I recall.
MS ANYADIKE-DANES: If they had spoken to you in those terms, is it something you think you're likely to have recalled?
A. Absolutely.

Q. Yes. Just if we stay with the serum sodium levels, you haven't ascribed a time to that. It's difficult because, in a sense, you don't have an independent recollection of this, but can you help at all with whether you thought that people believed blood results related to anything that had happened that morning or not? Those in the ward round.

THE CHAIRMAN: That's too speculative.

MS ANYADIKE-DANES: I think it might be too speculative. I apologise.

MR COUNSELL: With respect, I wonder if that is a matter that might be pursued because the one issue that Dr Stevenson hasn't been asked about is his understanding as to when these tests are done. And that may assist, sir, if you hear that evidence.

MS ANYADIKE-DANES: I'm grateful for that.

If you've had tests done the previous evening and you've had a result which is slightly below the normal tariff, if I can put it that way, what's your understanding of when repeat tests are done, typically?

A. They're done after the ward round.

Q. After the ward round?

A. Yes. Rather than before.

Q. So if that's the case, just so that I understand you, even though you don't actually recall that ward round,

if that's the practice and anybody seeing your note wouldn't have -- who was on that ward round -- had any feeling that that related to something that you had somehow done that morning, but would have appreciated that that must be relating to something for the previous day?

A. Yes.

Q. Because the time for doing repeat tests wouldn't have happened yet?

A. That's right.

Q. I think you gave in your evidence that you wouldn't have done it anyway because you had waited to see what other tests, whoever was taking the ward round, might have required?

A. That's right.

Q. So whatever Dr Webb's concerns may have been, so far as you're concerned, Dr Sands and whoever else was on that ward round would have appreciated that those results did not relate to anything that morning?

A. That's right.

Q. In other words, that you didn't actually know definitely what Claire's serum sodium levels were that morning?

A. No.

Q. Thank you. In fact, to be fair, I think that's already been stated in a witness statement. If we put up 139/2,

page 3, the answer to question 4(c):

"It was likely that he was aware --"

I think there's a transposition. I think it should be "unlikely" or "likely that he was unaware". One or the other of those.

THE CHAIRMAN: No:

"It was likely that he was aware that these results were from the sample taken on admission as it was unlikely that any further samples would have been taken to the ward round that morning."

MS ANYADIKE-DANES: Yes. If you read it carefully, the statement is really confirming what you had just told us.

A. Yes.

THE CHAIRMAN: And just replace the word "of" in the first line with "that".

MS ANYADIKE-DANES: If we go to something Dr Sands says in his witness statement, at witness statement 137/1, page 8, and he says:

"Although no mention is made in the notes of repeating the serum electrolytes, I believe this would have been part of the ward round discussion and planned to be carried out."

So he seems to be clear that that isn't something that would have happened before the ward round.

A. Yes.
Q. Is that something that would have been generally known?
A. Yes, because they wouldn't have had time for the -- to do a blood test before the ward round and then get the results back.
Q. So that would have been fine for anybody who was part of the ward round. But for anybody coming afterwards, say for example perhaps Dr Webb seeing the notes at 2 o'clock, he wouldn't be able to tell whether he was looking at something that was from the night before or a result that had happened as ordered during the morning ward round?
THE CHAIRMAN: No. If a consultant in the Royal is familiar with the Royal system, which is that arrangements are made during the ward round for tests to be repeated, then that consultant would know that if a result is in the note of the morning ward round, it is not a later test that day.
MS ANYADIKE-DANES: Yes, quite right, Mr Chairman, sorry.
THE CHAIRMAN: Sorry, I'm saying that as if I'm the consultant. This is just to develop the point. Dr Sands is, in terms, agreeing with you about -- if a note of a test result is in the ward round notes, then it cannot be a result of something which was done after the ward round.

A. Yes.

THE CHAIRMAN: Am I right in understanding that anybody who was working in the Children's Hospital at that time, particularly at consultant and registrar level, would also be familiar with that system?

A. Yes.

MS ANYADIKE-DANES: So Dr Webb would have realised that that must be the previous evening's result because you've incorporated it in your note at the ward round?

A. Yes.

THE CHAIRMAN: He would have a way of knowing or believing that that was the fact. Whether he did believe it or not is another matter.

MS ANYADIKE-DANES: Yes.

Could you help us with this: if you had been asked to arrange blood tests as a result of the discussion during the ward round, so let's say the ward round is -- I think Claire's family believe that she was being seen at roughly 11 o'clock, so let's say everything is completed by about 11.30 or so, or that's when you're free to do this and another matters. Then at what time would you expect to be getting a result?

A. If it was based on a -- as part of a routine request?

Q. Yes.

A. You might have got it that afternoon, towards the end.

Q. Roughly?
A. Oh, maybe half 4, 5 o'clock.
Q. So not by 2?
A. No.
Q. And if you had wanted to get it urgently and you were asked to do that, then how quickly do you think you might have achieved that?
A. You would have had to contact -- from what I recall, you would have had to contact the lab to say, "We're sending urgent bloods, can you do this as an urgent process rather than as a routine matter?".
Q. And I know it is trying to cast your mind back many years, but if you had done that, do you have any sense of how quickly you might have got a result?
A. The results might have come back within an hour, hour and a half, possibly phoned through by the lab if you'd requested it.
Q. And then you'd have made a further note and included that?
A. Yes.
Q. So what would have appeared on the face of the notes is your earlier note incorporated into the ward round and then another note with these fresh results?
A. Yes.
Q. Thank you.

THE CHAIRMAN: If you're going on to electrolytes, do you want to stay with that note that's on the screen?

MS ANYADIKE-DANES: No, I don't want to stay with that.

Could we put up 137/1, page 37? This is in answer to 17(a)(i). And it's to do with not requesting further serum sodium and full blood count tests. This is Dr Sands' statement. He says:

"Although not specified in the ward round notes, further electrolytes are likely to have been requested. This would often have been documented by an SHO on a separate piece of paper or book as 'work to do'."

Do you have any knowledge of having a book like that where you included work to do?

A. I don't recall specifically a book, but I'm aware of what it would have held ...

Q. If that was requested, why would you put it on a separate piece of paper and not have included it in your note?

A. It would be my usual practice to put it in the notes.

Q. It would be your usual practice to put it in the note?

A. Yes, that it was a request.

Q. Putting it on a separate piece of paper is simply perhaps inviting that separate piece of paper to get lost.

A. Exactly.

Q. Do you agree with the comment that Dr Sands makes there, that it was likely that that had been requested?
A. I don't recall if it was likely that it was discussed or requested.
Q. Well, if he's right, then either you didn't carry them out or you did carry them out and somehow the results have not been recorded.
A. But I believe it would still be my practice, if I was requested to do a blood test, that I would document it in the notes.
THE CHAIRMAN: Under the plan section?
A. Yes.
THE CHAIRMAN: Because that is part of --
A. That's part of my plan, you know. As an SHO, it'd be one of the jobs --
MS ANYADIKE-DANES: Those are the things that you have to do.
A. Yes.
Q. So someone would ask, "Have you done the things?", and you would need to know what the list is that you have to do?
A. And I would have written it down, "U&E, FPP", actually in the body of the notes.
Q. So whilst you can't actually remember, is your take on the way that you've written up your note that such

a thing was not asked of you?
A. Yes.
Q. I'm just going to ask you now about Dr Webb's attendance at 2 o'clock. I'm trying to move through the day roughly chronologically and picking up the bits where you have some interaction if I can put it that way.
A. Yes.
Q. And I think you say in your first witness statement, 139/1, page 16, that you were on the ward, but you were unable to recall if you were present when Dr Webb examined Claire for the first time.
A. Yes.
Q. When you say you were on the ward, does that mean that you knew he was coming, you knew he was about, you simply weren't physically there when the examination was taking place?
A. Yes. I was on the ward at the ward desk, but actually seeing Claire physically at the bedside, I don't recall that I was there.
THE CHAIRMAN: Sorry, just a moment. When you answered this question, were you saying, "I was on the ward because, to the best of my recollection, I was on the ward all day"?
A. Yes, because I had no other -- that was where I'm based. I wouldn't have gone anywhere else.

THE CHAIRMAN: So this is part of your best reconstruction of events?

A. Yes.

THE CHAIRMAN: Because you were on duty that day, on Allen Ward, if anything happened at 2 o'clock or any other time, you were on the ward?

A. Yes.

THE CHAIRMAN: Right.

MS ANYADIKE-DANES: That doesn't mean that you actually remember being on the ward?

A. No.

Q. Right. Are you aware of who else was there when Dr Webb was examining Claire?

A. No.

Q. No? Do you have any knowledge of where Dr Sands was at that time?

A. No.

Q. Did you know that Dr Webb was going to come to examine her in the afternoon?

A. I can't remember, you know, if I was told that Dr Webb would be coming, no.

Q. Let's ask about practice. If the registrar -- or you, if it had fallen to you to do it -- had actually needed to have another consultant provide a specialist opinion about a patient, then what would be the practice about

how that happened --

A. The practical practice would be --

Q. -- in 1996?

A. -- would be to find out where the relevant consultant -- in this case, Dr Webb -- was in the confines of his daily duties.

Q. So you have located Dr Webb, Dr Webb is the person you want. Not you personally, but Dr Webb has been located and asked if he will do this, and let's assume that Dr Webb said, yes, he will provide the opinion. So what happens when he turns up?

A. He will have spoken to the relevant nursing staff to get the notes and then to find out where Claire was and he would have been directed towards Claire's bed.

Q. Would it be typical for that to happen all without the presence of another paediatric clinician?

A. Yes, it could happen.

Q. It could?

A. Yes.

Q. Would that be typical?

A. It's not unusual. Each consultant has their own practices. Some would want to go on their own and others would want to have you tailing along --

THE CHAIRMAN: It would be helpful if you or Dr Sands, who had been on the ward round a few hours earlier, had been

able to be with him when he saw Claire.

A. Yes.

THE CHAIRMAN: He's being brought in for a specialist opinion on a patient with which you had at least some degree of familiarity from the ward round.

A. Yes.

THE CHAIRMAN: So rather than send him over with some notes pretty and much on his own, it might have been helpful for somebody to be with him, depending on their availability.

A. Yes, that's right. But it might be -- and I can't speak for Dr Webb, but it might be his own practice that he wants to go with a fresh pair of eyes and he's gone to look at Claire.

MS ANYADIKE-DANES: That might be the difference between you bringing him up to speed, if I can put it that way, and him conducting an examination.

A. Yes.

Q. So it may be that you bring him up to speed or you know how the concern has arisen and it may be then that he conducts his own neurological examination by himself; is that possible?

A. That's a possibility.

Q. Would you agree with the chairman that it would have been helpful on the bringing-up-to-speed part of it for

a member of the paediatric team to explain how that concern had arisen and what her presentation had been to date?

A. Yes.

Q. That would have been helpful?

A. It could have been helpful.

THE CHAIRMAN: For instance, if it was Dr Sands who did contact him a few hours earlier -- Dr Webb has other patients who he's responsible for. He then comes along to Allen Ward and he might want to be updated at the very least about how has she been over the last two or three ways since I was first asked to become involved.

A. That's right.

MS ANYADIKE-DANES: Similarly, whenever Dr Webb has formed a view as to what his opinion is, would it not be helpful if there was a member of the paediatric team there so that he could explain that to them?

A. Yes.

Q. Because they, after all, are going to end up carrying out his suggestions?

A. That's right.

Q. In fact, it was you --

A. It was --

Q. -- in large part.

A. It was.

Q. So would it not have been helpful for you to have been there and have Dr Webb explain to you the significant elements of Claire's presentation, the views he had formed, what he wanted to do, and why he wanted to do that?
A. It would have been helpful.
Q. And then if there were further queries later on from the parents, then you or Dr Sands could address those. If you needed to bring -- you would have a better idea or Dr Sands would have a better idea if they needed to bring Dr Webb in again because you would understand what he's looking for, what's significant and be able to see what had happened.
A. That's true.
Q. All of that would have been helpful?
A. It could have been.
Q. But are you thinking that didn't happen?
A. I don't think it did happen.
Q. Can you recall if Dr Sands actually asked you anything about what had happened when Dr Webb came?
A. I've no memories of Dr Sands speaking to me about what Dr Webb ...
Q. With the exception of the medication that you calculated and prescribed and, to some extent, administered, are you aware of actually discussing Claire with anybody?

A. No. I don't recall.
Q. You don't recall? If you had discussed her, is it something you think you would have remembered or you just don't know?
A. I just don't know.
Q. Were you not interested professionally, even at that level, to find out what was happening and what it all meant?
A. Yes, but I was, I suppose, concentrating on what I had to do rather than looking at the bigger picture. I was asked to do certain things and the bigger picture -- maybe I was distracted in the practicalities of what was asked of me.
Q. One of the things you did do is you wrote up the phenytoin.
A. Yes.
Q. Now, if one looks at the medical notes and records, 090-022-054, one sees there's a note from Dr Webb. He signs that and this is his suggestion. If one looks there:

"Starting IV phenytoin, 18MG per kilo stat. Followed by 2.5 milligrams per kilo, 12 hourly. Will need levels 6 hours after loading dose. (ii) CT tomorrow if she doesn't wake up."

And he's characterised those as suggestions. What

did that mean to you when you saw that in the note?
A. That was a plan for me to undertake.
Q. So it's not a suggestion, it's something that you're supposed to do?
A. Yes.
Q. Did you take the view that, given he's asked to provide an opinion, he's providing his opinion and somebody else, perhaps Dr Steen as the consultant paediatrician, will determine what to do about that opinion?
MR COUNSELL: With respect, he can't possibly answer that question since Dr Stevenson has said on countless occasions that he can't recall.
MS ANYADIKE-DANES: If you bring in a specialist consultant and the consultant writes up a note, suggesting things to be done, in your experience -- and it may end up as exactly the same answer, you just can't remember -- is that something then that the team who have brought the expert in to provide an opinion then decide how they factor that in to the course of treatment for their patient, in this case it would be Dr Steen's patient?
A. I can't remember. I just can't remember.
Q. You can't remember how that works?
A. No.
Q. And does that mean that you can't also remember what discussion, if any, this suggestion of Dr Webb's

prompted?

A. No, I can't remember.

Q. Then how did you know that you were to start calculating and writing up a prescription for phenytoin? Who told you to do that?

A. Well, it's based on: a consultant has come in and made recommendations or suggestions, which I took to mean that I was to undertake these, you know, this management plan.

Q. Do I understand, though, that you don't recall being present when any of this was happening?

A. Other than in the surroundings of the ward.

Q. So then if you're not going to be present because you have to do other things, maybe at that time, then when the consultant leaves, is it that you get the notes, see what's written up and start to do it?

A. Yes.

Q. And that means you read those notes then, otherwise you don't know what to do?

A. Yes.

Q. When you saw that you had to write up a prescription for the stat dose of IV phenytoin, did you look that up in the BNF, the British National Formulary?

A. I don't remember looking it up.

Q. Well, would it be your practice to do that?

A. Certainly if I felt I was uncertain of the dosage, to confirm or check it out, I would have looked up the BNF.
Q. Well, let's have a look at your calculation a little bit further down that page if we go back. So you have 24 kilos, so that's Claire's weight. 18 milligrams, and the loading dose you calculate as 18 times 24, and you get 632.
A. That's wrong.
Q. Yes, we know that. How did you get that?
A. I can't remember how I got it wrong.
Q. When did you first appreciate that you had got it wrong?
A. When I got the request for the statement questions in December of last year.
Q. So even though you write a note in relation to midazolam the next day, you never look back at your notes; no?
A. No.
Q. So you didn't check?
A. Because I had made the ... No, it's the wrong assumption that that was the right dose.
Q. Well, did you have any sense of whether that's a large amount or not a large amount?
A. I've no memory whether I felt it was large or not.
MR FORTUNE: Sir, there was a slip of the tongue by my learned friend. Dr Stevenson did not write the note for midazolam the next day. It's the same afternoon.

MS ANYADIKE-DANES: The same afternoon, sorry, I beg your pardon. But at a different session if I can put it that way.

THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: Then that's your calculation, which you admit is incorrect. Let's look at the prescription, which is 090-026-075. There you see, it's the second block, the "once only", because it's going to be the stat dose, 22/10, phenytoin, 635. Is that correct?

A. Yes.

Q. "Time of administration, 2.45. IV". And you sign it with your signature and also your initials as having actually administered it?

A. Yes.

Q. So it's not 632, it's 635 now? That's a typographical error as well, is it?

A. I believe so.

Q. Okay. So when you're doing this, you don't think -- well, can I ask you this: how often before then had you actually written up a prescription for phenytoin?

A. Never.

Q. Never?

A. Well, I don't recall ever beforehand writing it up.

Q. No. So did it not occur to you that maybe it would be wise just to look at the British National Formulary,

just to see what they said, or wise to look at the paediatric prescriber?

A. Yes.

Q. That would have been wise?

A. Absolutely.

Q. We actually have some extracts of that, if we go to 311-028-010, which is the formulary. I think it's 15 milligrams per kilo, which is the loading dose. I'm trying to see where that is.

THE CHAIRMAN: It's at the bottom of the entry, is it, just before where the X is now? "Dose by mouth initially"?

MS ANYADIKE-DANES: No, that's by intravenous injection.

THE CHAIRMAN: Just go above that.

MS ANYADIKE-DANES: I think actually we have to go over the page. That's the dose by mouth, but there's "by intravenous injection" if one goes over the page to 011. (Pause).

I beg your pardon, it's at 014, sorry. Right down at the bottom:

"Dose by slow intravenous injection or infusion. Status epilepticus 15 mg per kilo at a rate not exceeding 50 mg per minute as a loading dose."

Firstly, you accept that it says that?

A. Yes.

Q. So you were starting with your calculation at 18 because

that's what Dr Webb had put in?

A. Yes.

Q. But let's go to the paediatric prescriber and then I'll ask you a question about that, which is --

MR SEPHTON: Sorry, before my learned friend moves on, I certainly haven't seen this document before, nor any of the other documents in 311. I just wonder if she could tell us which version of the BNF this is.

MS ANYADIKE-DANES: Yes, I can, it's right here. It's the one for September 1996, which is the one that would have governed the admission.

Then if we go to the paediatric prescriber, which is a publication that I took you to before, or a guide, at 311-023-010. I think you can see under the phenytoin:

"15 milligrams per kilo (maximum 1g) slow IV push."

And then it gives the rate. Do you see that?

A. Yes.

Q. So in both the British National Formulary, which you say you had access to, and the paediatric prescriber, which was there to assist you, although you didn't particularly resort to it, both have 15 as a starting point. So if that's the case and you had gone there, is that not the sort of thing that you would have raised a query about, "If I'm right here doing 18, is it really supposed to be 18, or is it 15"?

A. I would have needed to double-check if it was meant to be the 18 as written down or whether there's enough of a discrepancy there for me to query.
Q. Yes. And of course, the reason why you have to double-check is, apart from the fact that you want to get the prescription right, if one looks at the very front of the BNF, 311-028-003, just under that little box, "prescription", it says:
"The Department of Health has advised that legal responsibility for prescribing lies with the doctor who signs the prescription."
A. Yes.
Q. You would know that?
A. Yes.
Q. So apart from all the normal reasons of wanting to get it right because you're trying to assist in the care of a child, this is your responsibility if it's wrong?
A. Yes.
Q. Did you check whether it should have been 15, or 18 was right in the circumstances?
A. I don't remember if I did check it.
Q. If you had, would you have made a note to that effect?
A. It would have raised enough of a query for me to go and find -- and ask for advice to confirm.
Q. And if you had received that confirmation, would you

have made some sort of note?

A. Yes, because I would have -- you know, my usual practice would have been to document that, you know, discuss with the relevant clinician to continue on at the dose as suggested.

THE CHAIRMAN: In other words, if you'd spoken, say, to Dr Webb and said, "I've got what you've suggested. That's a bit more than either of these other sources suggest. Are you sure I should be going in that direction because you'd be giving 432 instead of 360?", you would want some reassurance from Dr Webb?

A. Yes.

THE CHAIRMAN: And since you're the person who is liable or responsible for the actual administration of the drug, then you would want some reassurance from a consultant, who frankly knows more than you did about this, that it is appropriate to go down that route for whatever reasons he suggests?

A. Yes, and I would have just written it down in the chart to say that this has been discussed.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: What about the slow push? Is there any guidance in your prescription as to how this is to be administered?

A. Generally, any intravenous injection -- well, in regard

to these types of medications, from my understanding of my training, this would be done slowly rather than on a rapid type of an injection.

Q. Well, you administered it. Do you know how you administered it?

A. I don't recall how I administered it.

Q. No? Well, the reference to "slow push" is included there presumably for assistance because one would assume that there are other ways of administering it?

A. Yes. You could have put it as quickly as you could get it physically injected whereas in this case you did -- the slow push essentially means that you have to do it slowly so you would do it at a slower rate than more rapid injections.

Q. Well, how did you know to do that?

A. Because those type of medications, they're not something that you would have routinely given, so you're more hesitant, so you tend to be a bit more slower giving your injections.

Q. Well, there's hesitant because you're not so familiar with the drug that you're administering and there's slow because, however familiar you are, that is the appropriate way to administer that drug.

A. Yes.

Q. Now, what the BNF is saying and what the prescriber is

saying is, however familiar you were with that drug, that drug is to be administered by slow push.

A. Yes.

Q. And what I'm saying is, were you aware that that is the way in which that drug had to be administered?

A. At that time?

Q. Yes.

A. I don't specifically recall, but I think I would have been.

Q. And how would you have been aware? Who would have told you?

A. Through my knowledge and training.

Q. You'd never actually prescribed this before?

A. No, but in part of your training, you would have been given instructions about medications and how medications are -- if you're treating status, you know, with medications, it would have been done as a slow process, but I've never physically actually ever given anybody that medication.

Q. But you think you would have known that at the time?

A. Yes, I believe so.

Q. And you think that's how you administered it?

A. I think so.

Q. So is that something that you don't think needs to be incorporated into the prescription?

A. In what ...
Q. The mode of delivery.
A. Um, no. Normally, the way you would have written it up would have just been as an IV dosage in the kardex rather than any other mode.
MS ANYADIKE-DANES: Thank you.
Mr Chairman, I'm about to go on to some other drugs.
THE CHAIRMAN: Okay. We'll finish now for today and tomorrow we will not be stopping at 4 o'clock. As I said to you at the start of this afternoon's session, could I ask you all to wait for just a couple of minutes to replace two pages in file 150, and we'll resume with Dr Steen tomorrow morning at 10 o'clock.
Dr Stevenson, if you'd be good enough to come back tomorrow for us. Thank you very much.
(4.03 pm)
(The hearing adjourned until 10.00 am the following day)

I N D E X