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2 (10.00 am)
3 (Delay in proceedings)
4 (10.10 am)
5 THE CHAIRMAN: Doctor, yes, please. Thank you. Have a
6 seat.
7 DR HEATHER STEEN (called)
8 Questions from MS ANYADIKE-DANES
9 MS ANYADIKE-DANES: Good morning, Dr Steen.
10 Dr Steen, before I take you through to some of the
11 issues, more or less in their chronological order, there
12 was a point that arose last week when Claire's parents
13 were giving their evidence that I would like to ask you
14 about.
15 Dr Walby gave -- you and, I believe, Dr Webb and
16 possibly Dr Sands also saw a copy of the original
17 hospital notes to allow to you draft your statement for
18 the coroner; isn't that right? Or at least you had
19 access to them.
20 A. Yes.
21 Q. Were you here when Mr and Mrs Roberts gave their
22 evidence?
23 A. No. I am sorry. I wasn't able to attend.
24 Q. That's all right. I think we can pick it up in the
25 transcript for 13th December, and if we start with

1 she didn't think she would have to check details and she
2 would accept what was in the autopsy request form. So
3 that's the starting point for the issue that Mr Roberts
4 is making in relation to bias. His point is that all
5 that information, with its errors and with its slant, is
6 actually pointing the pathologist towards a viral
7 encephalitis or a viral element of some description.
8 A. I heard Dr Scott-Jupp gave evidence on this and I
9 know -- I haven't heard the pathologist experts, but my
10 understanding when I filled in that autopsy request
11 form, and indeed up until I heard part of Dr Herron's
12 evidence, was that that was a brief summary. The reason
13 for the records going over was that those records would
14 be looked at and that information would be used to
15 assess them. I had thought at the beginning of
16 Dr Herron's evidence he had suggested the summary
17 allowed them to timetable the -- which post-mortems were
18 carried out when on the day. I was very surprised to
19 hear that they didn't go back through the records.
20 I believe Dr Mirakhur suggested that the final report
21 not be issued prior to the neurosciences
22 multidisciplinary meeting when there was that clinical
23 input to allow the whole thing to be summed up, but
24 I certainly did not introduce any bias that I was aware
25 of into the autopsy report. As far as I was concerned,

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2 MR FORTUNE: You want to go back to page 121, which is the
3 issue of bias in the request for the autopsy.
4 MS ANYADIKE-DANES: Yes, certainly. So then if you look at
5 line -- oh, sorry. I was going to go to line 20. In
6 any event at line 16 is where Mr Roberts identifies what
7 he refers to as another critical area of concern and he
8 says:
9 "And that was a bias attached to that request form
10 [that is the autopsy request form] to the pathologist,
11 which pointed the pathologist in a certain way."
12 Were you here to hear Dr Herron's evidence?
13 A. Some of it, yes.
14 Q. So you may have appreciated from that that his evidence
15 was that he is actually quite busy or at least the
16 department is quite busy and they rely quite heavily on
17 the information on the autopsy request form. If they
18 had an opportunity to, of course, they would like to
19 look at the medical notes and records, but that wasn't
20 always possible, and certainly if they got an autopsy
21 request form which had detail on it which all seemed to
22 connect and make a certain sense to them, then possibly
23 that -- I wouldn't say disinclined, but it meant they
24 felt it less necessary to check up the details in the
25 medical notes and records. Dr Mirakhur's evidence was

1 I was giving information with medical records for
2 reference to a pathologist, who would examine the brain,
3 describe what they had seen and then see if it fitted in
4 with the clinical scenario and, if it didn't, raise
5 those issues with the clinicians.
6 Q. Yes. We will actually come back to the detail of that
7 in a little while. I wasn't taking you there. I was
8 actually setting the scene for the context of
9 Mr Roberts' concern?
10 A. Yes.
11 Q. So he starts with that concern that there is a bias.
12 Then you see he goes on to say -- in fact, the chairman
13 raises it with him:
14 "Then the next point you wanted to make from the
15 medical records was this entry about
16 'encephalitis/encephalopathy' and I think unless you
17 have anything more to add, we have gone through that."
18 And then he asks if there are any more specific
19 issues.
20 I think if I can now go to page 127, because that is
21 a specific issue, if I can put it that way, and if we
22 start with line 20, he says:
23 "I think it's pretty obvious, if a doctor looks at
24 a medical note and she's about to face criticism, that
25 she will want to go through the medical notes,

1 scrutinise the medical notes and perhaps see what their
2 content it."

3 Perhaps we can bring up 128 as well:

4 "I feel that if Dr Steen was reading through the
5 medical notes, she would realise that there had to be --
6 well, if she looks at her definition, she is confident
7 that she has brain infection within the post mortem
8 report, but the medical notes do not find encephalitis.
9 I feel by that Dr Steen need to close the circle within
10 the medical notes."

11 Then the chairman is putting it quite clearly:

12 "Question: If I understand rightly, in effect what
13 you're querying is whether when Dr Steen saw the notes
14 and the issues had been raised on the back of the
15 documentary. She then saw that there wasn't a reference
16 to encephalitis, so she got Dr Sands to write it in.
17 Bluntly, is that what you're saying?"

18 "Answer: That's my belief."

19 Then if we continue on, you can see the chairman's
20 comment there:

21 "I'm trying to expose exactly what is being
22 suggested."

23 And Mr Roberts talks about:

24 "... they conspired to fabricate notes in order to
25 try to see off the queries which you raised some years

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1 contemporaneous with whenever that discussion that
2 Dr Sands said he had with Dr Webb, but is much later
3 after the UTV programme and it's a product of some sort
4 of communication between you and he. I think that's the
5 essence of it. Can you comment on that?

6 A. When I knew I would be involved in this inquiry,
7 I understood there would be a review of all the clinical
8 notes and all the issues and our decisions would be
9 questioned and we would have experts to inform us. I
10 was quite shocked to find that honesty and integrity was
11 going to be questioned in this way and I think other
12 witnesses have too. I was brought up to tell the truth
13 and, if you don't tell the truth, you were in more
14 trouble than if you didn't. That's a value I brought to
15 my children. That's a value I brought to my work. I
16 have never been involved in a cover-up. I have not
17 asked anyone to alter the notes. I would not involve
18 anyone in this.

19 I understand there's concerns. A child has died,
20 which is tragic. A child has died because of medical
21 mismanagement, which is tragic. To compound the whole
22 issue, the medical mismanagement wasn't noted for eight
23 years and the parents had to come back to find it, and
24 I understand that that is just very difficult for the
25 parents, but I never asked anyone to cover-up the notes.

7

1 later."

2 Mr Roberts says:

3 "Exactly, yes. I think Dr Steen, looking at the
4 notes, would realise that there had to be a trigger for
5 the status epilepticus -- or as she had put down
6 'non-fitting status' -- there had to be a reason for
7 that and that is why I believe the 'encephalitis' was
8 added into the medical note in and around the ward
9 time."

10 Then if we just see where we go further on 129, if
11 we bring that up. There we are:

12 "It is one thing for me to decide that there's been
13 errors and omissions. You'll understand that it's
14 a much greater jump for me to say that notes were
15 fabricated after the event. In order just to be fair to
16 everybody, isn't it right that from the time Claire came
17 in, there was a bit of an issue and a bit of a question
18 about encephalitis because it's in and then it's stroked
19 out? So from the start encephalitis had occurred to the
20 admitting doctor and then to Dr O'Hare."

21 He agrees with that. I'm not sure that the point
22 gets any further developed than he has already expressed
23 it there, which is that in order make things fit, if
24 I can use that expression, then there is an addition to
25 the medical notes and records that's certainly not

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1 I'm unsure why it is felt adding those two words in
2 would have made any difference. My understanding is
3 that's the note Dr Sands made before Dr Webb came, but
4 Dr Webb's notes talk about encephalopathy. He started
5 acyclovir in the afternoon. So encephalopathy and
6 encephalitis were there in Dr Webb's notes. So why
7 would asking someone to go back eight years later to add
8 those two words in make a difference?

9 Q. Well, can I ask you this question, which I think in
10 a way you've touched on some of it: can you understand
11 how, in Claire's parents' -- and indeed her family's --
12 position, there might be a loss of trust and confidence
13 between them and the clinicians?

14 A. I can understand, and I understand their grief and their
15 difficulty coming to terms with everything, and I can
16 understand that they are troubled by the way processes
17 have taken place. I can only say that myself and anyone
18 else who I have been aware of involved in this case have
19 tried to be open and honest all the way through. We have
20 tried to be sensitive. We have tried to give info.
21 Sometimes the information we have given may not have
22 been correct, but we felt at the time it was correct. I
23 have left the door open for the parent to come back any
24 time if they had questions, and I am not aware that
25 anyone tried to cover anything up.

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1 We tried to give information we had at the time in
2 a way that the parents could understand and leave the
3 door open for them to come back if they had other
4 questions.

5 Q. Can you understand how that perhaps feeling of the loss
6 of trust and confidence is exacerbated maybe or allowed
7 to develop by, when they do have the opportunity to talk
8 to Claire's clinicians, both in 1996 and in 1997, what
9 they hear now does not entirely accord with what they
10 were told then? Can you understand that situation?

11 A. I can --

12 Q. And for that matter -- sorry -- just to finish that
13 off -- and for that matter what they were told in 2004,
14 so it is not just now.

15 A. Our documentation of what they were told in '96 and '97
16 is poor and I think it was Mr Roberts who talked about
17 the mists coming down. So I understand that there's
18 a difference in the information coming forward. That
19 doesn't mean that the information being given at the
20 time was not the information that the clinicians thought
21 was correct at the time and being given to the parents
22 in a correct way.

23 I apologise if they feel they have been misinformed.
24 From my perspective, I have no recollection, but I have
25 no reason to think that I misinformed them deliberately.

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1 and I think in your evidence during the clinical phase
2 of this you did acknowledge that there were some things
3 that could have been done better.

4 A. Yes.

5 Q. I think you expressly stated the blood test should have
6 been carried out earlier.

7 A. Definitely.

8 Q. I think you have also said that maybe they -- or if you
9 haven't said it, I think it has been implied from what
10 you said -- there could have been better communication,
11 coordination of communication. The records could have
12 been better kept so that people understood what had
13 happened before them and there was a more accurate
14 account in order to base views and communicate to the
15 families and forth -- the family and so on.

16 As you look at that time now, can you develop that,
17 because you have just mentioned the fact that you are
18 taught to be reflective. It is one of the things you
19 try and do and --

20 A. Uh-huh.

21 Q. -- in fact, in 2004, you were clinical lead. Would you
22 be leading people on how to hopefully approach
23 a situation exactly like this?

24 A. Yes.

25 Q. But in any event, the reflective manner is something you

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1 It is not how I practise medicine. It is not how
2 I practise my own life and my own family life. I have
3 tried to provide information to this family from what I
4 have been given and if I've misinformed them, I am
5 sorry.

6 I understand now when they look back it looks as if
7 someone has done something wrong, trying cover it up,
8 but at the time I am quite sure that neither myself nor
9 anyone else tried to cover anything up. This is
10 a tragedy. I hope I am a reflective practitioner. We
11 have all been taught to be reflective. I think the
12 chairman suggested that we are naturally defensive if
13 something arises that's an error. You know, you have
14 a natural defence mechanism. That's quite right, but we
15 have been trained that you actually say "oh" -- rather
16 than being, "Let's not pretend it happened", it is "oh,
17 right, could this be a possibility, do we need to look
18 at it again? What can we learn from it?" That's how I
19 have practised medicine.

20 So if I found a problem and I knew it was a problem,
21 whether I was criticised or not, my approach always has
22 been: Okay, can we look into this in more detail, what
23 is to be done, what do we need do for the future?

24 Q. Well, if you leave aside the fact that anybody
25 intentionally tried to mislead, if we leave that aside,

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1 would want to encourage, I presume. So if you do that
2 and you apply that now, can you help with the areas
3 where you think, frankly, there was a falling short?

4 A. I think you've mentioned communication and I'll deal
5 with that first.

6 Q. Yes.

7 A. Because communication is on various levels, I think,
8 when you look back. There is communication between
9 nurses and doctors, between doctors and doctors, between
10 doctors and nurses. So there's the professional
11 communication, which was not as good as it should be.

12 Q. Well, if I pause you there, as you are looking back,
13 what do you mean by that?

14 A. I mean that there's no -- on the Tuesday morning, on the
15 post-take ward round.

16 Q. Yes.

17 A. I have no recollection of where I was. We know I was
18 contactable. Why I wasn't on the ward I don't know, but
19 I think it should have been clearly documented when
20 I was with patients because I did see one or two
21 patients on the ward, what happened with them. So I
22 think there's the issue of documentation of which
23 doctors see patients when and then what plans are made
24 for them. I think there was no clear documentation of
25 communication between myself and the registrar and the

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1 registrar and myself. We believe --
2 Q. There isn't any, is there?
3 A. No, we believe conversations take place, but nothing is
4 documented. Therefore when you go back, you cannot say
5 what happened because nothing is documented. So we need
6 better documentation. There needs to be clear
7 communication. I have would have liked to have very
8 clearly been able to say that Dr Sands had phoned me at
9 a certain time, that this is what I had said and this is
10 what was in place, that I had phoned the ward. So
11 There's the issue around that sort of documentation and
12 that communication. I would have liked clear evidence
13 that I kept the juniors up-to-date and the juniors kept
14 me up to date. I am not sure how clear those lines of
15 communication were. I would have liked to have seen
16 a clear plan between Dr Webb and myself at teatime and,
17 indeed, I think I have previously said it was with deep
18 regret that I didn't return at teatime and I would have
19 liked to have seen clearer documentation in the notes
20 from both nursing and medical staff of what exactly had
21 been said to which parent, and then what the parent had
22 actually understood by that.
23 Q. These things you would have liked to have seen, I take
24 it you are dealing with them from the perspective of
25 what is reasonable to have expected in 1996.

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1 A. I think it should have happened contemporaneously.
2 I think there should been a degree of reflection there
3 and then. Again when we were feeding back to the
4 parents -- and again I believe Dr McKaigue remembers the
5 case being presented at a mortality meeting. I can't
6 remember, but again that was a time when there could
7 have been reflection and that reflection should have
8 resulted in discussion with junior doctors and nursing
9 staff about how to improve things.
10 Q. Well, would you agree there's absolutely no evidence of
11 that actually happening?
12 A. No, there is no evidence.
13 Q. Which is possibly its own recording issue.
14 A. Yes.
15 Q. If there isn't any evidence, and maybe because it didn't
16 happen, at least not in the way that you are suggesting
17 would have been appropriate, what is the reason for
18 that?
19 A. Sorry?
20 Q. What could be the reason for that, for why it just
21 wouldn't have happened?
22 A. Why what wouldn't have happened?
23 Q. The kind of reflection you are talking about, which
24 should have happened, which would have led to lessons
25 being learned for the junior staff and translating

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1 A. I can't remember.
2 Q. I understand.
3
4 A. I can't put myself back to 1996, but they are reasonable
5 standards of care.
6 Q. Yes, and before you go on to talk about other elements
7 where there might have been deficiencies or where things
8 may have been done better, if we just stick with those
9 that you have explained now, firstly, whose
10 responsibility it was to make sure those things were
11 done, and if they weren't done -- and it wouldn't take
12 you very much reflection on looking at the notes to see
13 that things weren't quite up to the standard perhaps
14 that you would like -- what happens then? Whose
15 responsibility is it to appreciate that from the notes
16 and do something about it, if only for the learning of
17 the junior doctors involved?
18 A. Well, ultimately it was my responsibility as the
19 consultant in charge of Claire's care, and it would
20 have been also part of Dr Webb's reflection as the
21 neurologist who was involved in supporting the neurology
22 side of Claire's care.
23 Q. And when do you think that should have happened, that
24 reflection?
25

14

1 itself presumably into some better action or something.
2 A. I am not sure why it wouldn't have happened because the
3 process was there. We have no evidence the process was
4 followed in so much as there is no documentation there.
5 Q. Yes.
6 A. But I don't know -- I mean, I don't know what was
7 discussed at the mortality meeting, whether there was
8 discussion about improved note taking, about
9 communication issues. I don't know. So I don't know if
10 the process failed or not, but I do know there's no
11 documentation to support the process did, you know,
12 happen.
13 THE CHAIRMAN: Doctor, I have to make it clear that the
14 process did fail.
15 A. Yes.
16 THE CHAIRMAN: Okay. I think you said a moment ago:
17 "[You] don't know if the process failed or not, but
18 I do know there is no documentation to support the
19 process."
20 Without going nearly as far as Mr and Mrs Roberts
21 did last week, the process did fail in 1996/1997.
22 A. Around improving communication between staff?
23 THE CHAIRMAN: Yes, because there is no evidence whatever
24 that after Claire's death any of the doctors or nurses
25 sat down and thought, "How did this go wrong?", "How

16

1 could this all have been going wrong in front of us and
2 none of us spotted it?' Mr and Mrs Roberts went home on
3 Tuesday night sometime after 9 o'clock, expecting to
4 come back and see Claire the next day and got the most
5 awful shock they will ever have by being called in at 3
6 or 4 in the morning. It did go wrong.

7 I don't want to go over all the ground you have gone
8 over before. I know you want to respond in the
9 strongest terms to the suggestion made last week that
10 there was a fabrication at some point perhaps in 2004
11 and 2005. I have got your response to that. In fact,
12 you say:

13 "I am sorry. However much I can understand Mr and
14 Mrs Roberts' concerns, that simply did not happen."

15 Isn't that --

16 A. That's correct.

17 THE CHAIRMAN: Well, I have got that, so let's move on.

18 MS ANYADIKE-DANES: Thank you.

19 So then in terms of anything else that you would
20 recognise now as being a deficiency or lack of
21 appropriate care, if we put to one side the
22 record-keeping, although you would include in the
23 record-keeping, would you not, the way that the
24 medication was recorded?

25 A. Well, we were dealing with communication.

17

1 around 5 or 6 if he had thought she was in real danger.
2 I also suspect that Dr Sands would not have left if he
3 had thought that and I also suspect that if you had been
4 informed that there was a girl who was very, very
5 seriously ill, that you would have returned. So
6 I believe you would have returned --

7 A. Uh-huh.

8 THE CHAIRMAN: -- if you had received that message.

9 A. Yes.

10 THE CHAIRMAN: But one of the points which Mr Roberts made,
11 which I have to say does appeal to me, is whether when
12 Dr Sands gave evidence about Claire being the sickest
13 child in the ward, whether that is not something of
14 a retrospective interpretation of how sick Claire was
15 and whether how sick she was was missed, even by about 5
16 or 6 on the Tuesday evening.

17 Do you see how that can fit into the picture?
18 Because if she was as sick as Dr Sands has described,
19 then the three people who were involved in her care --
20 namely yourself, Dr Sands and Dr Webb -- all left.

21 A. Yes.

22 THE CHAIRMAN: You weren't beyond being contacted, but would
23 you really all have left if there was a view that she
24 was very seriously ill?

25 A. I think -- I have no recollection. So it's a matter of

19

1 Q. Ah, communication. Sorry. Yes.

2 A. The first thing we were dealing with was the
3 communication between professionals --

4 Q. Yes.

5 A. -- but also communication with the parents.

6 Q. Let's go to that then.

7 A. Okay. Communication with the parents is two ways, the
8 information given and the information understood.

9 Q. Yes.

10 A. I have no doubt that people throughout the years have
11 given information, but perhaps not in an appropriate way
12 for the parents to understand, and they certainly didn't
13 understand what was happening that Tuesday night,
14 because they wouldn't have gone home.

15 Q. Yes.

16 THE CHAIRMAN: That then led into the other problem, which
17 is: did the doctors understand what was happening on
18 Tuesday night? Because when Dr Webb went home, he
19 thought Claire was going to recover. I accept that
20 because I know from Dr Webb coming backwards and
21 forwards a number of times on Tuesday afternoon that he
22 was committing himself to Claire's care.

23 A. Uh-huh.

24 THE CHAIRMAN: Right. So I don't think for a second that
25 Dr Webb would have gone home on Tuesday at some time

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1 looking back and I agree with you, when you look back
2 through her records on that Tuesday afternoon, she comes
3 across, looking back, as a very, very sick child, even
4 at 5 o'clock, and she certainly was sick enough that
5 I phoned back. So whatever information I had about her,
6 it made -- it was enough to make me phone at the end of
7 my clinic rather than just go home without making any
8 contact with the ward.

9 THE CHAIRMAN: Let me just pick you up on that.

10 I understood -- please correct me if this is wrong --
11 that your phone call at about 5 o'clock on the Tuesday
12 afternoon -- it is either you ringing from Cupar Street
13 or the ward rings you at Cupar Street -- and this is
14 a way of confirming, in either direction, that you don't
15 need to come back or whether you do need come back.
16 Isn't that right?

17 A. But it would not be done every time.

18 THE CHAIRMAN: Right.

19 A. It's done when I'm -- there's someone ill or there's
20 something that has been worrying me that I think isn't
21 tidied up.

22 THE CHAIRMAN: But if you got the impression in that phone
23 call that Claire was not well, but not so unwell
24 that you needed to return --

25 A. Yes.

20

1 THE CHAIRMAN: -- that is a sign that the seriousness of her
2 condition was missed.
3 A. Yes, it could be taken as that.
4 THE CHAIRMAN: And if the seriousness of her condition was
5 missed between the doctors and nurses, it must follow
6 that the parents weren't told how seriously ill she was.
7 A. Yes, and I think the parents' actions show they were not
8 fully informed of how sick she was. The parents
9 didn't -- there is no way they would have gone home.
10 THE CHAIRMAN: Exactly. In fact, Mrs Roberts said last week
11 they wouldn't even have gone for lunch if they
12 understood she was so ill that she was so seriously
13 unwell that another doctor was going to be brought in.
14 A. Yes.
15 THE CHAIRMAN: They would have stayed to see that. Given
16 what we know about how constantly the Roberts family
17 were at Claire's bedside, that makes sense, doesn't it?
18 A. Yes.
19 THE CHAIRMAN: Okay.
20 MS ANYADIKE-DANES: Dr Steen, the issue is you are trying,
21 so far as I can tell, to make some concessions as to
22 what you think was poor or inadequate or sub-standard
23 care --
24 A. Uh-huh.
25 Q. -- that she received. That's what I understand you are

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1 Q. What I am putting to you is it is not just a matter of
2 recording -- I am sure Dr Sands said something of the
3 sort, that if he had been invited to attend that
4 meeting, he would have remembered it because he had been
5 involved in that child's care. There is not a single
6 piece of paper that emanates from the kind of review you
7 are suggesting should have happened to identify: these
8 are the learning points, this is what we need do, we
9 need take the junior doctors over this point -- or
10 whatever is your conclusion as a result of that --
11 because this has been missed. So it is not just
12 a matter of recording in and of itself. Nobody actually
13 remembers having a meeting where it became clear to all
14 that their care of Claire had been deficient and may
15 have been partially responsible for her death.
16 I presume that if you'd given something of that
17 sort, you would remember that. I don't know how many
18 children have died in your care. I presume Dr Sands,
19 when he gave his evidence, he would remember that, but
20 nobody remembers that kind of exchange.
21 A. Well, I have no recollection -- I appreciate what you're
22 saying -- of what happened at the time.
23 Q. I appreciate that.
24 A. I would think specifically at the mortality meeting that
25 is the conversation that should have been held, and we

23

1 doing. So you had started off talking about the
2 record-keeping. Then you went to the record-keeping in
3 relation to the parents. I think you have conceded that
4 the record-keeping is very poor in relation to that.
5 A. Yes.
6 Q. But when you link that with how serious Claire was, her
7 illness and that therefore that was not properly
8 communicated and recorded as having been communicated to
9 the parents, the point -- and I am sure you have taken
10 it -- that the chairman was making is that all
11 presupposes that everybody has understood she was that
12 ill, as you seem to be able to glean from her medical
13 notes and records.
14 If they had not appreciated that she was as ill as
15 that, then that is an issue all on its own, and that's
16 precisely the sort of thing that presumably you would
17 want to have discussed at a mortality meeting or
18 something of that sort because there would definitely be
19 learning that should come out of that have if
20 a consultant paediatric neurologist has not appreciated
21 that, if your junior paediatric team have not
22 appreciated that and, therefore, clearly the nurses
23 didn't appreciate that. That's a big point and it needs
24 to be addressed.
25 A. It is.

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1 should have been in a position to minute it, and then we
2 would have been clearer about whether the conversation
3 was there or not and if the learning was identified or
4 not.
5 Q. Well, if you are presenting it as Claire's consultant
6 paediatrician, would it not fall to you to be drawing
7 together these threads of learning that you will be
8 wanting to make sure that the junior members have
9 embraced?
10 A. I think there's two strands to that. Firstly, normally
11 when we're presenting at the mortality meeting, we are
12 presenting facts initially because if you try to draw
13 the strands together yourself, you are missing the
14 learning that might be achieved.
15 Q. Yes.
16 A. I can't remember this case, but I am just saying any
17 other cases I have done --
18 Q. Yes.
19 A. -- my process it would be normally present the facts
20 first --
21 Q. Yes.
22 A. -- because otherwise you bias the history.
23 Q. Yes.
24 A. So present the facts. Then have a discussion and
25 determine if there's learning. If you present the case

24

1 purely as what you perceive are the learning things out
2 of it, you may miss other things. So I think the
3 presentation of the case, a bit like this inquiry, has
4 to be factual first, a discussion and then learning.
5 Q. You are not being prescriptive as to how you present it.
6 A. Yes.
7 Q. I am saying: you have clearly identified learned friends
8 learning; whether anybody else brought any other points,
9 you have some clear points that you would want junior
10 doctors and, for that matter, anybody else to take out
11 of it.
12 A. Yes.
13 Q. What I am putting to is given that you were the
14 consultant paediatrician, did it not fall to you to make
15 sure those were taken forward?
16 A. Yes.
17 Q. Thank you: then I asked you about the medication, the
18 recording of the medication. The deficiencies, would
19 you accept, fall into two areas of difficulty: one, that
20 there seems to be some dispute over the way the dosages
21 were communicated and that she seems, therefore, to have
22 received an overdose: an overdose of phenytoin, because
23 there was of a simple arithmetical miscalculation; and
24 an overdose -- a considerable one -- of midazolam,
25 because there seems to have been miscommunication or

25

1 that you were not very familiar with these drugs. They
2 are typically administered by a neurologist, rather than
3 a paediatrician.
4 A. Certainly in 1996.
5 THE CHAIRMAN: That's what you would have liked to discuss
6 with Dr Webb?
7 A. Yes.
8 THE CHAIRMAN: I mean, it's an unfortunately simple point:
9 no such discussion ever took place.
10 A. No. The drug errors were not noticed.
11 THE CHAIRMAN: Neither in 1996/7, when you were both in the
12 hospital, or in 2004/5, by which time he had left the
13 hospital.
14 A. Yes.
15 MS ANYADIKE-DANES: I am grateful to you that you are sort
16 of trying to identify some of these points that you
17 recognise now, but if we go to the point that the
18 Chairman has just raised: the two of you had to sign off
19 on a brainstem test form.
20 A. Yes.
21 Q. And one of those had to do with the presence of, loosely
22 speaking, the presence of any sedating drugs because
23 that would be relevant to the presentation.
24 A. Yes.
25 Q. If you were going to do that, did that not mean you had

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1 mishearing over what the appropriate dose was.
2 Then there are other deficiencies as to when things
3 are signed off, whether they are given at that
4 particular time, whether that's properly recorded.
5 Those fall in the area of -- let's call them the
6 medication issues. Is that not something that troubles
7 you?
8 A. Yes, and medication issues still occur and they trouble
9 us a lot.
10 Q. Yes.
11 A. And there's a lot of work that has been done on it. The
12 two drugs you have mentioned are not drugs I would have
13 used or prescribed. I do, however, think when I was
14 going through the notes that there was an opportunity
15 for me to identify them. They weren't identified and
16 they weren't identified for the coroner and I think part
17 of the reason they weren't identified is that the kardex
18 wasn't put alongside the notes, the sign off.
19 So the 120 of midazolam was on a kardex whereas the
20 12 was in the notes.
21 Q. I understand that. But you don't need that in relation
22 to phenytoin. The phenytoin calculation is right there
23 and it is an arithmetical error.
24 A. I didn't check that.
25 THE CHAIRMAN: You told me when you gave evidence before

26

1 to look at the drugs to see actually what was prescribed
2 and when it was prescribed because that is likely to
3 have had some kind of impact on her current state?
4 A. We -- I have no doubt we considered her anticonvulsants
5 when we were signing that form off. There was a serum
6 phenytoin level of 19.2 at least two hours before the
7 brainstem results, midazolam had been discontinued,
8 therefore, were those drug dosages at that point in time
9 sufficient to have her unresponsive, not able to
10 breathe? So I think my approach -- and it is only
11 working back and trying to reconstruct.
12 Q. I understand.
13
14 A. My approach was: were there drug levels in her blood at
15 6.00 am sufficient to cause her condition? And because
16 I had the phenytoin level, I did not go back -- and I am
17 not sure if Dr Webb went back -- to look at what had
18 been given because we have a serum phenytoin level.
19 Q. Yes. I am not getting into the substance of that point.
20 I am asking about the process because this is governance
21 now.
22 A. Yes.
23 Q. Would not the process mean that you really ought to have
24 looked at what was in her system because actually you
25 only had one level of anticonvulsant medication result,

28

1 which is phenytoin --
2 A. Yes.
3 Q. -- which is at the higher end of the therapeutic range?
4 A. Yes.
5 Q. And, as you will know, one or two, I think, of the
6 experts for the inquiry have been concerned that you
7 would proceed with the phenytoin level at that end of
8 the range, but be that as it may --
9 A. Uh-huh.
10 Q. -- in order to form a view, you have to look at the
11 drugs, because you only know one result.
12 A. But midazolam would be out of the system; you couldn't
13 measure serum midazolam.
14 Q. How do you know whether it was out of the system?
15 A. Because it has a very short half-life.
16 Q. You knew that sufficiently about midazolam in 1996?
17 A. Yes. That's why it was by infusion --
18 Q. And you discussed that?
19
20 A. I can't say we discussed it or not, because I have no
21 recollection.
22 Q. Does that mean you went back to look -- to see when the
23 midazolam was prescribed to know the midazolam would be
24 out of her system?
25 A. I can't recollect what I did or didn't do. I can only

29

1 Q. Is that therefore not a point that somehow something
2 which could have been quite significant in terms of the
3 effect it had on her presentation, when the doctors were
4 trying to work out what are the implications of her
5 presentation for her condition and her differential
6 diagnoses, something that was potentially significant
7 about that, there was an error about it or there are
8 errors about it, because she shouldn't have received
9 that level of medication?
10 A. I am sorry. You have lost me with that question.
11 Q. The point I am trying to get to is: because you missed
12 that sort of thing, which is very important, and the
13 junior doctor involved is not helped to see the
14 potential significance of what is seemingly just
15 an arithmetical or a transcription error --
16 A. Because we missed the drug transcribing, there was no
17 feedback to the junior doctors about drug errors.
18 Q. Exactly.
19 A. That was an important learning point that was missed.
20 Q. That was an important learning point?
21 A. Yes.
22 THE CHAIRMAN: There was one other point that emerged since
23 you gave evidence because Dr Herron gave evidence after
24 you in this inquiry. Dr Herron says that on its own the
25 over-administration drugs should have lead to a referral

31

1 reconstruct from the notes. I have noted the midazolam
2 was discontinued. And I would not undertake brainstem
3 tests without being very sure about each area.
4 There were two real areas when one looks back at
5 Claire's. One was around the drugs and one was around
6 the sodium level. Her blood gasses fell within the
7 range that we required and I wouldn't have approached
8 that form without discussing those with Dr Webb and the
9 two of us being happy to move forward.
10 Q. Yes. Okay. If you are looking -- and this is the final
11 point on it -- from a governance point of view, it means
12 in a very important area which I have just identified to
13 you has, for some reason, not led to you looking at the
14 actual dosage, checking when it actually -- what level
15 was last given and therefore being able to satisfy
16 yourself on that basis that everything is in order to
17 proceed. I am not talking about the substance of it --
18 A. No.
19 Q. -- just the process because that means, although that
20 would have been the process, the two of you have missed
21 those errors.
22 A. We missed the drug errors, yes.
23 Q. You missed them then. You missed them when you did the
24 review in 2004.
25 A. Yes.

30

1 to the coroner. It wasn't a point that he picked up,
2 and I am assuming it wasn't a point that you or Dr Webb
3 picked up, but Dr Herron has said, on its own, the fact
4 that Claire got too much midazolam and too much
5 phenytoin should have lead to her death being referred
6 to the coroner because nobody could be satisfied in
7 those circumstances the cause of her death was known and
8 that there was a natural death.
9 A. Well, that's right, because there was a medical
10 mismanagement on the way through to that event --
11 THE CHAIRMAN: Yes.
12 A. -- and that is another indication for referral to
13 coroner.
14 MS ANYADIKE-DANES: That is another deficiency. In fact,
15 one that went unnoticed despite reviews for some
16 considerable time.
17 A. Yes.
18 Q. And then even leaving aside the learning that you take
19 from 1996/1997 about that, should there not have been
20 some learning about the fact you can have, to all
21 intents and purposes, a case note review to explain to
22 the parents what happened and that that's still missed?
23 A. Yes, and I think there is an issue about just how
24 critically we can manage to go through these notes
25 within our governance arrangements to identify all the

32

1 problems, and I am not sure that there still isn't
2 problems when we have cases about being able to do the
3 detailed review that this inquiry has done because there
4 were reviews carried out. There were reviews carried
5 out by experts and yet things have been missed. I don't
6 know how we put a process in place where all the details
7 are picked up.

8 THE CHAIRMAN: Let me explore that with you, because that's
9 important going forward.

10 A. It is.

11 THE CHAIRMAN: It is important beyond Claire's case. It is
12 impossible you can have an inquiry like this, which goes
13 on for too long, but it shouldn't take an inquiry like
14 this to pick up significant issues like drug overdoses.
15 Right? So when you say you are not -- you are still not
16 sure about how you can go forward, even within your
17 updated governance arrangements, what is your concern?

18 A. The most detailed in-house review we probably do is root
19 cause analysis where a serious or adverse incident has
20 been done and you actually have people who are able to
21 go through the notes in detail. I think to be able to
22 go through some of the charts and go through everything
23 in detail is very, very difficult. The drug errors
24 should be picked up now because we finally have
25 pharmacists on the wards who review all the drug

33

1 medications, which have been carried out and ensure that
2 the drug medications, if there's been an error, are
3 identified through. We have a much better review of
4 ongoing concerns during patient care. We have much
5 better adverse incident reporting, but when you look at
6 how this case is gone through in detail and the little
7 bits that have been picked up, I don't know how we would
8 pick those up. I mean, if they were missed at the
9 coroner's ...

10 THE CHAIRMAN: : Yes.

11 A. We can put in as tight --

12 THE CHAIRMAN: Can we agree it shouldn't emerge because
13 Mr Roberts is sitting on his computer late one night
14 looking at the records and then he finds this point that
15 everybody has missed?

16 A. No, it shouldn't.

17 THE CHAIRMAN: Yes.

18 MS ANYADIKE-DANES: I am taking it a little bit out of turn,
19 but since we are dealing with this particular area,
20 maybe you can help it with this: I have understood the
21 point you made to the chairman that not every review of
22 every child's case notes can take the form this inquiry
23 has taken, but I think you have just conceded you don't
24 need that to identify some of the points you have just
25 been conceding.

34

1 A. Yes.

2 Q. But if one looks at the letter that Mr Roberts wrote
3 dated 8th December 2004, and if we pull that up,
4 089-003-006. Let's have the next page too, 007,
5 alongside it.

6 This is Mr Roberts. He is looking at things, trying
7 to puzzle out what had happened to his daughter, does
8 not have obviously the benefit you do in terms of trying
9 identify these things. He doesn't know exactly what it
10 is, but he gets himself to paragraph 4, which relates to
11 the anticonvulsants and he is raising questions about
12 the number of anticonvulsants and antibiotic drugs
13 through Tuesday:

14 "Did this mixture of medication compound and worsen
15 Claire's symptoms given that her sodium levels were
16 falling?"

17 He doesn't know:

18 "Should the medication have been stopped?"

19 And so on. Then at paragraph 5 he says:

20 "What impact would the combination of both strong
21 medication used along with an incorrect fluid type have
22 on Claire?"

23 Maybe he is not there able to exactly say: I think
24 she got twice at much phenytoin and three times, or
25 whatever it is, as much midazolam, but he is pointing

35

1 you to, he is directing you to the anticonvulsant: tell
2 me what you think the implications of that are. How
3 could that not have required you, in 2004, to go back
4 and think, "Let's look very carefully at exactly what
5 was prescribed and what was administered and when that
6 happened?"

7 MR QUINN: Before that comes in, could I remind the inquiry
8 that, at this time, Mr Roberts didn't have Claire's
9 notes, Mr Chairman.

10 A. I am aware they didn't have Claire's notes. They could
11 have had them at any time they wished them.

12 MS ANYADIKE-DANES: Is that not pointing you to --

13 THE CHAIRMAN: I think the point of the intervention was, if
14 this was an issue, it was not really a complaint Mr and
15 Mrs Roberts had not been given a copy of the notes at
16 that point. The intervention was: if Mr and Mrs Roberts
17 are picking up this issue as a concern to which they are
18 seeking an answer, how can it not be picked up when they
19 receive a reply or for the purposes of giving them
20 a reply?

21 A. I am not sure -- I can't remember how this is responded
22 to. I can no longer hold facts in my mind.

23 THE CHAIRMAN: Okay.

24 A. But did this mixture of medication compound and worsen
25 Claire's symptoms, given that her sodium levels were

36

1 falling? To me, now, today, I read that as
2 a combination of: did the medication affect the serum
3 sodium level directly?
4 MS ANYADIKE-DANES: Sorry, Dr Steen, that's not the question
5 I am putting to you. He doesn't have the benefit of her
6 medical notes and records. So he doesn't actually know
7 there was an overdose; he just wants to know what is the
8 effect. And what he knows is quite a bit in terms of
9 different amounts of anticonvulsant were administered to
10 his daughter. What I am asking you is: when he raises
11 queries like that, does it at the very least not require
12 you and whomsoever are going through the case notes to
13 actually look at what was prescribed, what was
14 administered and when that happened?
15 A. Yes, and presumably I went back through the notes and
16 did not do the calculation round the phenytoin, did not
17 know the midazolam one, but had serum phenytoin levels
18 to reassure me that the phenytoin levels in her blood,
19 although initially high at 9.00pm, was down to the
20 therapeutic levels at 4 am.
21 Q. I appreciate at 4 am, but he is actually asking during
22 the course of her treatment. So is what you are driven
23 to say that even though something like that has been
24 identified -- not in the precise terms as I am putting
25 to you now, but an area has been identified -- even with

37

1 one on Barbour Ward and Paul Ward. They are there
2 certainly most mornings, although they may be called
3 back to main pharmacy in the afternoon. Their job is to
4 go through each drug kardex, each discharge slip,
5 identify any problems, make suggestions about drugs we
6 could use in a slightly different way to help overcome
7 problems. Then there is a senior pharmacist who has
8 an overview of PICU.
9 THE CHAIRMAN: Thank you.
10 MS ANYADIKE-DANES: Thank you.
11 Well, that seems to have addressed the recording and
12 so forth issues around the discussions or the
13 communications and the medication. Are there other
14 areas that you think were deficient now when you apply
15 your retrospective or reflective hat?
16 A. So we have covered the fact the documentation was
17 inadequate?
18 Q. Yes.
19 A. It did not help with communication.
20 Q. Yes.
21 A. And there were significant problems with communication
22 between professionals and between parents.
23 Q. Yes.
24 A. And when we reviewed the notes, important issues were
25 missed --

39

1 that, still the clinicians going through her medical
2 notes and records are not able to see at the very least
3 that the phenytoin resulted from an arithmetical
4 miscalculation?
5 A. We obviously didn't. I mean, we didn't, and nobody
6 recognised it up until this inquiry. We didn't check
7 Dr Stevenson's sums.
8 Q. So then that will have some bearing on presumably the
9 learning that surrounds case note reviews. They
10 obviously have to be a little more thorough.
11 A. Yes, and around drug errors now we at least have
12 pharmacists on the ward for the last couple of years,
13 who would be identifying those in detail and be feeding
14 back on those. That's just one step to try to reduce
15 dug errors.
16 THE CHAIRMAN: The issue before was that there were not
17 pharmacists who were working in the
18 Children's Hospital --
19 A. That's right.
20 THE CHAIRMAN: -- they were working in the main hospital, if
21 that's not the wrong term. How many do you now have in
22 Children's?
23 A. Don't quote me, but we have at least one fully on for
24 the oncology unit and that works purely for oncology.
25 We have two junior pharmacists, one on Allen Ward and

38

1 Q. Yes.
2 A. -- despite reviewing them several times, which could
3 have learning points.
4 Q. Yes. Anything else?
5 A. You are going to have to help direct me. I am sorry. I
6 am very, very tired. I am very tired.
7 Q. Oh, well, I am sorry. I wonder is there any issue
8 around the cover?
9 MR FORTUNE: Can I help? If you direct Dr Steen's attention
10 to the discussions with parents and in particular the
11 issue of the post-mortem and the autopsy, you may find
12 that fruitful.
13 MS ANYADIKE-DANES: Does that help direct you?
14 A. I am never quite sure if Mr Fortune helps.
15 MR FORTUNE: Dr Steen, I am your counsel!
16 MS ANYADIKE-DANES: We will move on.
17 A. Okay. I think one of the areas we need -- we are
18 discussing about is communication with the parents and
19 correct information because the parents were dependent
20 on me as her clinical lead --
21 Q. Yes.
22 A. -- with Dr Webb beside me to provide the correct
23 information for them to make their judgments at a time
24 when they were very, very emotionally upset.
25 Q. Yes.

40

1 A. They couldn't think. They were dependent on the
2 information myself, Dr Webb and other professionals gave
3 them to make judgments around the end of life of their
4 daughter and around what needed to be done at the end of
5 life, and I was her consultant. Dr Webb was with me,
6 but it was important that we gave information to them in
7 a way that would help them with that.
8 Q. Well, if we come then to the post-mortem element of it.
9 A. Uh-huh.
10 Q. If you had formed the view this was a coroner's case,
11 which you know many of the clinicians who have given
12 evidence thought it was, and that's what should have
13 happened, but leaving that aside, that's not something
14 that you're really going to take the consent of Claire's
15 parents about. If it is a coroner's case, you have
16 a statutory obligation and that's the end of that.
17 A. Yes.
18 Q. So let's go to the limited post-mortem, which is
19 something that can be done. I wonder if that's where
20 you are going, that they were dependent on you to
21 provide them with information about that.
22 A. Yes.
23 Q. Is it not correct, though, that you -- well, you can
24 help me. I didn't get the impression from your
25 evidence -- and certainly from their evidence -- that

41

1 post-mortem. I would normally discuss all those issues
2 with the parents.
3 I realise the parents do not recollect all this
4 being discussed. I genuinely believe that myself -- and
5 Dr Webb was with me -- that Claire's illness was related
6 to her brain, that it was a neurological illness and
7 that any additional information would be gleaned from
8 a brain-only post-mortem. I fully accept that on
9 reflection it should have been a coroner's post-mortem,
10 and that way there may be further information -- I don't
11 know if there would have been further information, but
12 there may have been further information for the parents.
13 THE CHAIRMAN: I think I have to say to you, doctor, my
14 primary concern in this issue is not whether it was
15 a full or brain-only autopsy; my primary concern is that
16 it should be referred to the coroner.
17 A. Yes, and on reflection it should have been for several
18 reasons.
19 THE CHAIRMAN: And I think one of them is that she had
20 arrived in hospital on Monday evening. She is
21 effectively dead in the early hours of Wednesday
22 morning, subject to this testing that follows. That is
23 not the expected outcome of Claire's treatment, and my
24 concern is that in order to decide to not refer Claire's
25 case to the coroner, you would have to have a degree

43

1 you were saying, "Well, on the one hand, you could have
2 a full post-mortem or you could have a limited one.
3 These are the pros and cons of both. You know, if I
4 were you, I would think we could perfectly achieve our
5 objective by having a limited one". That's not how
6 I thought the evidence went. I thought the evidence was
7 that a limited post-mortem would suffice and you were
8 seeking their consent for that.
9 A. I think I said -- and I am not sure whether I said it,
10 but I thought I said that we would have -- that my
11 practice --
12 Q. Uh-huh.
13 A. -- when I am discussing it with parents is to discuss
14 all the options and then suggest which one would be the
15 best option forward. I realise that I have no
16 recollection of this, but any other cases that I do
17 remember, it was very much, "This is our problem. We
18 think we know this is your daughter's cause of death and
19 we either have enough information to go ahead and sign
20 a death certificate or we can sign a death certificate
21 and we'd like additional information or for other
22 reasons we want a hospital post-mortem or we need
23 a coroner's post-mortem". So there are several: there's
24 death certificate; death certificate, limited
25 post-mortem; full hospital post-mortem; or coroner's

42

1 confidence about what the cause of death was, and
2 I don't understand, from what happened, how that degree
3 of confidence was held.
4 A. I think Dr Webb had a strong degree of confidence in the
5 epilepsy triggering the SIADH. There was a viral
6 illness. I am not sure, but looking back in my mind,
7 I think, was: did the viral illness also cause the
8 encephalitis? But that's only reconstruction.
9 THE CHAIRMAN: Thank you.
10 MS ANYADIKE-DANES: We don't need to express that further,
11 because the chairman, I think, has expressed his view.
12 THE CHAIRMAN: I should say for the record that that view is
13 subject to submissions from everyone, but I think
14 there's a fairly strong direction in the evidence of the
15 various experts and I think various people within the
16 hospital accept that it should have been a coroner's
17 post-mortem for a variety of reasons.
18 A. Yes.
19 THE CHAIRMAN: But the one which seems to me to have been
20 most likely to be evident, even in the early hours of
21 23rd October 1996, was whether anyone was able to say
22 with confidence that Claire died from natural causes --
23 A. Yes.
24 Q. -- without an issue arising from the management of her
25 care.

44

1 A. Yes.
2 MS ANYADIKE-DANES: When you -- sorry.
3 MR FORTUNE: [Inaudible: no microphone] Dr Steen accepts, on
4 reflection, it should been a coroner's case and you have
5 just heard her say that.
6 A. There were several points you have raised.
7 MS ANYADIKE-DANES: When you are doing your review of the
8 medical notes and records in 2004 for the purpose of
9 reaching a view for Dr McBride and also going into the
10 meeting with Claire's parents, do you consider again --
11 you have everything before you then, including the
12 autopsy report and a little bit of the benefit of
13 hindsight. Do you consider then that she should have
14 been reported to the coroner or is that something you
15 have realised now, having heard the inquiry?
16 A. No. It was very obvious in 2004. We missed the drug
17 errors, but Professor Young picked up the fluid
18 mismanagement. He talks about three slices of a pie and
19 which proportion is attributable to which, but it was
20 very obvious the minute he did his fluid review that
21 there were concerns.
22 Q. We will come to that in a minute. I am actually
23 interested in your own thought process. So before you
24 have had the benefit of Professor Young's view, you are
25 asked to look through the medical notes and records and

45

1 Transfer to PICU would have happened.
2 THE CHAIRMAN: So these -- sorry. Just to get it clear,
3 these are not hyponatraemia-related developments; these
4 are sort of parallel developments in encephalopathy are
5 they? They might end up at the same point, but --
6 A. Yes, because the hyponatraemia was part of the problem,
7 but there was the rest of the problem. You still needed
8 to manage all her symptoms and try to investigate it
9 more fully and work things out in a better way.
10 When we were reviewing the notes -- I believe when
11 we reviewed the notes in 2004, we were trying to
12 remember what was happening in 1996, because that's what
13 you review to, not what you know at the time, but
14 I think when I had time to sit down and go through the
15 notes, that I did recognise, yes, it wasn't just the
16 fluids. There were issues around the fluids, but there
17 were other issues as well.
18 MS ANYADIKE-DANES: Yes. Can you help me with this, though,
19 because even before you get to 2004, your other time to
20 review matters is when you get the autopsy report back.
21 A. Yes.
22 Q. I mean, you had given the parents a view of things as
23 you saw them when -- just before you got the CT scan
24 back and then when you did. So you have talked the
25 parents through and given them the information as you

47

1 you are doing that.
2 A. Yes.
3 Q. When you do that, do you have a view then, "This is
4 something that probably should have gone to the
5 coroner"?
6 A. Yes, because, by 2004, thinking around fluid management
7 has significantly changed and the case was being
8 reviewed with a different knowledge base.
9 Q. Yes.
10 A. And with that knowledge base, it became quite obvious
11 that there were concerns around the medical management.
12 Not all the concerns were recognised.
13 Q. Yes.
14 THE CHAIRMAN: Apart from the guidelines on hyponatraemia,
15 which had been published in 2002, was there any other
16 significant area of learning or was it the
17 Northern Ireland guidelines?
18 A. The whole management of encephalopathy had significantly
19 changed. So a child who came in with neurological
20 symptoms, the fluid would have been restricted straight
21 away. There would have been -- no matter the sodium
22 being 132, the sodium would have been much more closely
23 monitored. The fluids would have been managed
24 differently. A CT scan would have been done. An EEG,
25 if it was during the working day, would have been done.

46

1 believed it was at that time.
2 A. Yes.
3 Q. But that's partial because you have told them you really
4 want a brain autopsy done so you can get information on
5 what you think is the viral cause.
6 A. Yes.
7 Q. That's the trigger for all this.
8 A. Yes.
9 Q. That is what thought and that's what the parents have
10 remembered from your discussion with them, that very
11 high in the explanation was some sort of viral
12 condition; would that be fair?
13 A. Triggering all the events?
14 Q. Yes, but a viral condition.
15 A. Yes.
16 Q. When you get the autopsy report, you have another
17 opportunity to revisit things. In fact, you have ticked
18 the box at the back, which means that you could have
19 revised the death certificate, could you not, in the
20 light of that information?
21 A. Yes.
22 Q. So then when you get the autopsy report back, it becomes
23 quite clear that whatever they found as any kind of
24 viral presence was very, very low grade. In fact, if
25 you had discussed it with them -- and you might well

48

1 have, I don't know -- but they presumably would have
2 told you what they told the chairman, which is it
3 certainly was nowhere near a level that would have
4 contributed to her death and, in fact, Dr Herron was of
5 the view that, you know, it was marginal whether it
6 really was there. It was all very subtle, if I can put
7 it that way. So that's the information you get back.
8 Does that not cause you to pause and think, "Well, if
9 it's that subtle, maybe that wasn't the trigger, so
10 maybe something else was going on"?
11 A. Dr Webb and I wouldn't have met with the parents until
12 we had discussed the post-mortem results and I don't
13 know what was discussed. I do know the CSF, which
14 albeit post-mortem -- and which has a funny protein
15 level -- showed an increase in white cell count, and
16 I believe Dr Webb and I perhaps over-interpreted the
17 changes that were noted on the post-mortem report, but
18 certainly when we went to talk to the parents, we seem
19 both to have felt that the issue was a viral illness
20 starting seizures, some encephalitis and inappropriate
21 ADH complicating the whole issue, causing low sodium,
22 adding to the cerebral oedema, which any of the two
23 other conditions could have caused, and the vicious
24 circle that is set up.
25 Q. I presume that's going to be another in your catalogue

49

1 those who were on the night shift -- talked about the
2 heavy burden that was on them.
3 A. Uh-huh.
4 Q. I think it was Dr Bartholome who talked about the 115
5 beds or so she was covering. She was the most senior
6 doctor. She was also very, very conscious she had to
7 keep a close eye on the junior doctors and what they are
8 doing, can't just expect them to be getting things
9 correct all the time. So you are overseeing them,
10 looking at the patients, making perhaps quite serious
11 decisions about children in that way, and that was
12 a burden, and I think the inquiry's experts, certainly
13 Dr MacFaul, thought it was intolerable that she was
14 required operate like that in terms of the implications
15 for patient safety.
16 A. Yes.
17 Q. And Dr O'Hare wasn't in a very much better position.
18 Just from Claire's point of view things, things weren't
19 so acute for Claire then as they were on the evening of
20 the Tuesday.
21 A. Yes.
22 Q. That's something that Dr Bartholome thinks has been
23 raised. We haven't seen, again, the evidence of anybody
24 thinking about what the implications of that might be
25 for the safety of sick children. Is that something that

51

1 of criticisms of note taking, because if you had
2 a meeting like that that satisfied both of you that your
3 original view was correct and had, if you like, been
4 confirmed to a degree by the post-mortem report, none of
5 that is recorded anywhere.
6 A. No, it is not and the information of the meeting with
7 the parents is not recorded anywhere, just the two
8 letters that went out as a result of them.
9 Q. So then if we then move away from the issue of the
10 referral to the coroner and how the limited post-mortem
11 occurs and the feedback from that to the parents and all
12 those issues, which I presume, as you have -- as I have
13 been putting them to you and you have been coming back
14 to me, you are conceding some deficiencies in those
15 areas.
16 A. Yes.
17 Q. Is there anything else that you think you could have
18 reflected on, could have done differently, could have
19 been the subject of review, but didn't appear to happen?
20 A. You need ...
21 Q. Let me help you in the way I was going to. We are
22 coming close to a break, I know, but perhaps you can
23 assist with this.
24 A. Yes.
25 Q. I think, to a person, the junior doctors -- certainly

50

1 you think should have been given greater attention?
2 A. I think it was being given attention and I think it's
3 been given attention from when I was even a registrar,
4 because I covered 125 beds. Although the surgical side
5 looked after their surgical side, the staffing levels in
6 the Children's Hospital for junior doctors were
7 extremely stretched, and I believe there were
8 discussions with Commissioners around how to address it.
9 In 1999, when we got our new PICU unit, new guidance had
10 come out from standards in care around PICU and we
11 finally got -- I think it was two additional doctors to
12 allow us to set up a separate rota for PICU from the
13 others. I also remember I think it was 1999 that
14 Ian Carson and I met with Commissioners for the first
15 time to talk about the European working time directive,
16 and the fact that if our juniors were doing 96 hours
17 a week, then to try to get them to even 48 hours, we
18 needed double the junior doctors. And I have worked
19 those wards. I know how stressed it would be, and
20 I still to this day don't know why nobody phoned the
21 consultants. When you got really pushed -- so if I had
22 been the reg, which I had been a few years before, on
23 the ward, and I couldn't really get do things, I would
24 have phoned the cardiologist or neurologist. To this
25 day, I am still phoned -- I have gone in one night and

52

1 spent six hours in casualty simply because casualty,
2 which I am not responsible for any more, couldn't cope
3 but the reg asked would I come in and help. So the
4 staffing levels were very difficult.
5 THE CHAIRMAN: Let me check I understand this: this issue of
6 staffing levels was going on for years before Claire?
7 A. Yes.
8 THE CHAIRMAN: Was it a funding issue or was it because
9 there weren't junior doctors who were available to be
10 employed if the funds were there?
11 A. Recruitment was much better in 1996 because we didn't
12 have some of the EEC restriction around us and a lot of
13 Indian doctors wished to come over for two or three
14 years' experience to gain higher qualifications. So
15 you -- it was possible to recruit overseas doctors for
16 a limited period of time. So that meant --
17 THE CHAIRMAN: So it was a funding issue then?
18 A. There were funding issues. The junior --
19 THE CHAIRMAN: Doctors were available from wherever, but
20 there weren't funds to engage them; is that right?
21 A. Yes, and I think when we finally got the money for PICU,
22 we actually brought in what is called clinical fellows.
23 They were not training posts. The number of posts for
24 training reflects the needs of the consultants, not the
25 needs of the service, if you follow me. So if you know

53

1 levels are slightly better. They are still very
2 stretched, but they better.
3 THE CHAIRMAN: Are there three registrars on at night
4 instead of one?
5 A. There is a -- there is an experienced doctor in PICU.
6 Regs are gone. There is two years -- you qualify and
7 you do two years foundation. Then you have run-through
8 training, which is 7 years. So you would like people in
9 PICU to at least be year 3 to 4 of the run-through
10 training. It doesn't always work that way. So you have
11 a stand-alone PICU rota, but with the consultants in
12 an awful lot because the experience is not high. You
13 have A&E with a consultant or experienced doctor on
14 until midnight-ish. They will stay if it is busy. Then
15 you have the reg who should be at least three years into
16 their run-through training, if not four years into their
17 run-through training on for the medical wards, and the
18 surgical wards are much more self-reliant and you are
19 much less likely to be involved with them than in 1996.
20 THE CHAIRMAN: Thank you.
21 MS ANYADIKE-DANES: Just one final point that, because I am
22 very conscious of the time and your need for a break,
23 and that is the changes that you have talked about, they
24 are all several years after the event.
25 A. Uh-huh.

55

1 you are going to have ten vacancies, you make sure 10
2 juniors are coming out skilled. So your training posts
3 are geared towards the consultant requirement in the
4 future and therefore other posts need to be brought in.
5 They are called staff grades or specialty doctors or
6 clinical fellows, which are non-training, but are people
7 with two to three years' paediatric experience.
8 THE CHAIRMAN: To what extent did the restrictions imposed
9 by the working time regulations help to the argument to
10 the Commissioners that the numbers have to be increased?
11 A. Well, I think there were two things. Firstly, they knew
12 they had to double the number of doctors. You know, the
13 level of staffing was incomplete, but they also then --
14 there was a lot of work -- this was not sitting out on
15 its own for junior doctors. So we had the whole issues
16 around appropriate staffing for specialties and
17 sub-specialties. The surgeons were bidding for
18 additional doctors to help the surgical end. The
19 surgeons were throughout really 2004, 2012, all the way
20 through, they have been taking a much more direct
21 consultant hand-on care to their patients with them
22 being managed much more by them. So the whole picture
23 of the children being admitted, the type of child being
24 admitted, because we have so few beds, and how they are
25 being managed is different now from 1996. The staffing

54

1 Q. But it would seem that in Claire's case, possibly the
2 thinness of cover, if I can put it that way, during the
3 night was an issue for her care. It may well have
4 been -- I have no idea -- that Dr Bartholome was so tied
5 up she didn't have an opportunity to contact anybody she
6 wanted to do that. If she was caught up doing whatever
7 it was she was doing, if that's the case, then the cover
8 for children like Claire was too thin; would you accept
9 that?
10 A. Yes.
11 Q. Yes. So then if you've done your review -- I don't mean
12 your case note review -- your review of her case and you
13 have made your presentation, is not one of the issues
14 that must have been in your mind: this could be
15 dangerous?
16 A. Yes, the staffing levels in children were dangerous.
17 They were very difficult and that's why consultants are
18 very willing to come in if there is any question. I
19 have still no idea why neither consultant -- be it via
20 nurse or SHO -- were not consulted.
21 Q. I understand that, but the point I am going to next is:
22 if that's recognised they were dangerous and, in fact,
23 in Claire's case that might have been relevant that,
24 thinness of cover, is that not something that you want
25 to be pushing up the line to your clinical lead at that

56

1 time and even maybe the medical director and ensuring
2 that that's recorded somewhere: "this is a potentially
3 dangerous situation"?
4 A. And I believe there is something with Dr Mulholland in
5 1996 which identified problems with medical staffing.
6 Q. So you think that was done?
7 A. Yes, I do think.
8 Q. And was it identified as a particular problem, not just
9 the general thinness of cover, but a particular problem
10 in this case?
11 A. I can't tell you because I have no recollection and
12 there is no documentation.
13 Q. If you were going to make that point arising out of
14 Claire's case, is that something that you would record
15 somewhere as opposed to have a discussion over coffee
16 with your medical director or clinical lead?
17 A. I don't -- no, I have no -- there is no documentation
18 that I have recorded anyway.
19 Q. I appreciate that. I am asking you what the practice
20 was or what the form was. If you wanted to raise
21 an issue like that of concern arising out of a patient
22 of yours who died, how would you do that?
23 A. It would be done through the mortality meeting and
24 through the directorate meeting.
25 Q. And does that mean, because we know that sometimes these

57

1 background and it may well be that Dr Steen can assist
2 you. You will recall that Dr Steen was contracted to
3 work ten sessions: eight in the community and two on
4 call.
5 THE CHAIRMAN: Yes.
6 MR FORTUNE: Whether that has an impact on clinical care
7 within the hospital as opposed to within the community,
8 if you want that addressed now, it's clearly something
9 that Dr Steen can discuss and give evidence.
10 MS ANYADIKE-DANES: Sorry to interrupt. I was going to
11 raise that matter later. That's a matter that is
12 perhaps is not subject to a one or two-sentence answer.
13 So I was going to raise that later, bearing in mind how
14 long Dr Steen has been giving evidence, but I have that
15 point.
16 MR FORTUNE: We are talking about concessions and I am
17 trying to clear the wood.
18 THE CHAIRMAN: Let's get the quick point out of the way,
19 because it will impact on how much more needs to be
20 developed tomorrow.
21 MR FORTUNE: Finally this --
22 THE CHAIRMAN: If what you are saying is about getting the
23 concessions out of the way and Miss Danes is saying she
24 wants to ask more than one or two more questions on
25 this, let's see what the concession is, because that

59

1 meetings are not minuted for various reasons --
2 A. Uh-huh.
3 Q. -- but something like that, is that the sort of thing
4 that you would expect to find recorded in writing
5 somewhere?
6 A. Yes, and junior doctors -- the directorate meeting ...
7 I believe, at that stage, part of the agenda for the
8 directorate meeting included junior doctor issues and
9 the junior doctors had a representative which came to
10 that meeting and lots of issues around staffing, etc,
11 would have been raised in the directorate meeting.
12 MS ANYADIKE-DANES: Mr Chairman, I am conscious of the time.
13 MR FORTUNE: Sir, can I deal with three matters to assist
14 both with you and my learned friend?
15 THE CHAIRMAN: I am about to let Dr Steen go for the day but
16 if you can address them briefly, that's fine.
17 MR FORTUNE: Dr Steen is going to address them.
18 First, we have the chronology which is to be found
19 in Dr Rooney's witness statement at 177/1. It's page 34
20 and onwards. The question you posed to me on Thursday,
21 sir, was: do I have specific instructions as to the
22 authorship of that chronology? The answer is yes.
23 Dr Steen was and is the author of that document.
24 THE CHAIRMAN: Thank you.
25 MR FORTUNE: Secondly, sir, a matter that has been in the

58

1 will affect the follow-up questions tomorrow.
2 MR FORTUNE: Okay. Dr Steen?
3 A. That's a document -- I think I developed that.
4 THE CHAIRMAN: Thank you very much.
5 A. I was asked to do what was called a patient journey, so
6 I think that's a patient journey or the chronology.
7 MR FORTUNE: [Inaudible: no microphone] working in the
8 community.
9 A. Working in the community. Two posts went in 1995:
10 one in south and east Belfast and one in north and west
11 Belfast. Both posts were eight sessions in the
12 community and two in the hospital. They were put in --
13 new funding with good reason because it was recognised
14 that children with complex chronic disease, when
15 admitted to hospital, were being seen by different
16 doctors for short periods of time and there was no
17 continuity of care. So the main thrust was to give
18 a link from community paediatrics, which deals with
19 the whole gambit of educational medicine, vaccinations,
20 public health, child protection, but also chronic
21 illness and chronic disability. The idea was to give
22 better continuity of care. So Dr Nan Hill went into
23 south and east and I went into north and west in 1995.
24 We had two sessions for acute services, including on
25 call. I moved from my post in April -- I think it was

60

1 April 1997. By that time, it been recognised that two
2 sessions could not allow you to do acute on call, that
3 the risks associated -- the fact you were chasing your
4 tail. You were in at 8 o'clock in the morning trying to
5 see patients before you went to the community. You
6 couldn't give continuity of care. You were too
7 dependent on juniors and others following it. That was
8 recognised, so when I moved in 1997, I -- there was
9 a deal done so that the person who replaced me in the
10 community had six sessions in the community and four in
11 the hospital. The other posts, south and east post, was
12 also redefined to give three sessions in the hospital.
13 Other posts going in -- these were all Eastern Board
14 posts -- to the Ulster Hospital gave even more sessions
15 to the community. The college now recognise if you are
16 going to be a community paediatrician and do acute on
17 call, there should be a 50:50 split. So it was very
18 difficult.
19 THE CHAIRMAN: The college is the Royal College of
20 Paediatricians?
21 A. And Child Health.
22 THE CHAIRMAN: Yes.
23 A. Their advice now is it's a 50:50 split because it is
24 recognised if you are actually going to give continuity
25 of care to inpatients, you actually need to programme

61

1 herself is concerned, she has already told you -- and
2 she will repeat it, no doubt, that she remained Claire's
3 consultant throughout and, as far as she is concerned,
4 Dr Steen, what does that mean?
5 A. Well, that means I was responsible for every element of
6 her care and therefore when there's failures in her
7 care, I have to accept responsibility for it. I was
8 guided by Dr Webb for her neurological status, but I was
9 her consultant.
10 MR FORTUNE: That's the third point and the concession.
11 THE CHAIRMAN: Thank you very much.
12 Thank you, doctor. I think, if this is a convenient
13 point, we will leave your evidence for tomorrow morning.
14 A. Uh-huh.
15 THE CHAIRMAN: Thank you very much indeed.
16 A. Thank you.
17 MR FORTUNE: Can I seek your leave, at an appropriate time,
18 to ask Dr Steen how she is? I do not wish to discuss
19 the evidence, but I do wish to enquire about her state
20 of health.
21 THE CHAIRMAN: Yes. Thank you very much.
22 Doctor, thank you for coming this morning.
23 A. Thank you.
24 (The witness withdrew)
25 THE CHAIRMAN: We will take a ten-minute break and we will

63

1 time to be in the hospital.
2 THE CHAIRMAN: So the advantage of giving a continuity of
3 care for chronically ill children outside the hospital
4 is clear, but the enthusiasm in 1996 to do this had to
5 be rebalanced --
6 A. Yes.
7 THE CHAIRMAN: -- because it adversely affected the
8 continuity of care of the children in the hospital?
9 A. Of the acutely ill, yes.
10 THE CHAIRMAN: Thank you.
11 A. I think Allen Ward's team were particularly affected in
12 that the only consultant who was there for any
13 significant time of the week was Dr Redmond and even on
14 a Friday she was in Downpatrick. Dr Reed was between
15 the nursery and there and the hospital and I think he
16 had only maybe one or two sessions in the hospital -- in
17 Children's. Most of his sessions were in RJMS Nursery.
18 Dr Hill and I were basically in the community. So that
19 Allen Ward team, it was difficult.
20 THE CHAIRMAN: Thank you very much. There is a third point,
21 Mr Fortune.
22 MR FORTUNE: I will lead this, if I may.
23 Sir, you have heard a lot of evidence about the
24 involvement of Dr Webb and his three visits to see
25 Claire during the afternoon. In so far as Dr Steen

62

1 then hear from Dr McBride.
2 (11.30am)
3 (A short break)
4 (11.40am)
5 (Delay in proceedings)
6 (11.50 am)
7 THE CHAIRMAN: Okay. Miss Danes?
8 MS ANYADIKE-DANES: Could I call Dr McBride, please?
9 DR MICHAEL McBride (called)
10 Questions from MISS ANYADIKE-DANES
11 THE CHAIRMAN: Thank you.
12 MS ANYADIKE-DANES: I think it is still just good morning,
13 Dr McBride.
14 A. Good morning.
15 Q. Dr McBride, do you have your CV there?
16 A. I do indeed, yes.
17 Q. Thank you. Before I come to that, you have made two
18 statements for the inquiry. The series number is 269.
19 The first is dated 14 September 2012. Then you made
20 a second statement dated 9 November 2012, which
21 essentially was to provide substantial documents that
22 you felt might be of assistance to the inquiry; is that
23 correct?
24 A. Well, it was to answer two specific questions in my
25 first witness statement, it was to provide any e-mails

64

1 relevant to this case. So I asked that the Trust carry
2 out an e-mail trawl of any relevant e-mails during that
3 period and that was the product of that trawl.
4 Q. But your substantive statement is the first one where
5 you deal with the issues?
6 A. That's absolutely correct, yes.
7 Q. And subject to anything you say now in your evidence, do
8 you adopt those statements as your evidence?
9 A. I do adopt those statements, yes.
10 Q. Thank you very much indeed.
11 Your CV is to be found at 311-041-001. We can see
12 that from September 2006 until the present day you were
13 and are the chief medical officer for Northern Ireland.
14 A. That's correct.
15 Q. There are some very helpful indications in your CV as to
16 essentially the development of matters since that period
17 of time, some of them your own initiatives. I am not
18 going to ask you about those because what we are really
19 dealing with are the matters that concern Claire's case
20 and therefore it's really, so far as your involvement is
21 concerned, when you were the medical director?
22 A. Okay. Thank you for that clarification.
23 Q. It's not because those things aren't relevant, they are,
24 but just not to this phase of the investigation, if
25 I can put it that way.

65

1 appointed to the post. My recollection is that it was
2 in the July or August of 2002, but I stand to be
3 corrected on that.
4
5 Q. Thank you. We might be able to find that in a different
6 way. Under the "key achievements", which we find on
7 that page, 004, I would like to ask you some questions
8 about some of them. If we take the first one, the
9 introduction of integrated governance strategy, can you
10 say exactly when you introduced it and what it would
11 have involved in 2004, say?
12 A. I think I have covered this in my first witness
13 statement. That's 269/1, I believe, on page 19. If
14 that could be called up or if that would be helpful to
15 the inquiry to look at the information contained within
16 that.
17 Q. Uh-huh.
18 A. Essentially, as you are aware, clinical governance and
19 the statutory duty of quality was introduced to Northern
20 Ireland in 2003 and that was following the consultation
21 document "Best practice, best care", which was a public
22 consultation around the introduce of a specific approach
23 ton ensuring the quality of health and social care
24 services with a view to setting explicit standards
25 within organisations, to be accountable for the

67

1 So from that point of view, the page I would like to
2 start on in your CV is 311-041-004. So I'd like to
3 concentrate there. That really says that in 2002 up
4 until September 2006 you were medical director. Can you
5 remember when in 2002 you became medical director?
6 A. I don't remember precisely. I believe it may well have
7 been in the summer of 2002. Sorry. Maybe I could
8 expand on that a little bit.
9 Q. Yes.
10 A. I think it was perhaps in August of 2002.
11 Q. August? Because I just noticed that the job description
12 for the post -- which we don't need pull up, but it is
13 to be found at 269/1 at page 24 -- and at page 26, which
14 is the concluding page, it gives that as January 2002
15 and the job specification, which comes immediately after
16 that on page 27, that also has January 2002. Is there
17 anything there that can confirm exactly when you were in
18 post? That you have, I mean.
19 A. Unfortunately no. Given that you have highlighted the
20 dates on the job descriptions, that would suggest that
21 my -- I mean, again there may well have been -- the job
22 description may be drawn up in advance of my applying
23 for the post. So that may have been the case. I am not
24 clear. I cannot recall the actual date of my
25 interviewing for the post and being successfully

66

1 implementation of those standards and a mechanism for
2 ensuring compliance of those standards, and particularly
3 with the establishment of the Regulation of Quality
4 Improvement Authority with independent inspection of the
5 quality of health and social care services.
6 I think on -- if I -- yes. Just prior to -- sorry.
7 Maybe if we could go to the previous page, page 18 of
8 the statement -- I apologise -- and maybe if we had 18
9 and 19 together. Would that be possible?
10 Q. Uh-huh.
11 A. Thank you. Yes. So that basically sets out the
12 evolution of clinical governance and indeed the duty of
13 quality in Northern Ireland from about halfway down
14 page 18 there you can see. Yes, that's highlighted.
15 Q. Uh-huh.
16 A. That was similar to the arrangements that were
17 developing in the rest of the United Kingdom. The
18 seminal document I, suppose, that was published was a
19 paper by Sir Liam Donaldson and Gabriel Scally, who
20 described the concept, as it were, of clinical
21 governance, basically making the point that the quality
22 of care that is provided in health and social care
23 organisations has the same corporate priority and should
24 have the same corporate priority as any other aspects
25 that was within the organisational span and control of

68

1 hospitals. So this was the start of a journey of
2 implementation.
3 The department at that time established a clinical
4 governance support team. They appointed a lead
5 governance risk lead to support organisations on that
6 journey to implementing clinical and social care
7 governance. There was of a baseline assessment which
8 all health care organisations, all trusts, were required
9 to carry out in 2002 with a view to going live with
10 clinical governance arrangements, I believe, from early
11 in 2003.
12 Q. Yes.
13 A. Sorry?
14 Q. Sorry. I appreciate some of that and you have been very
15 helpful in the way you have set it out in your witness
16 statement and, to some extent, we have been assisted by
17 the inquiry's experts who have addressed --
18 A. Oh, sorry. Okay. Apologies.
19 Q. No, no, no. They have addressed the period prior to
20 that so that we can see the lead into the period you are
21 talking about, so it is helpful.
22 A. Okay.
23 Q. What I particularly wanted to know is, under your key
24 achievement, you specifically referred to:
25 "Introducing an integrated governance strategy."

69

1 responsibility, overarching oversight at a corporate
2 level and then board level accountability --
3 Q. Yes.
4 A. -- to the chair and to non-executive directors.
5 Q. Would I be right in saying, given you have got it there
6 in 2006, that was one of the things you had done towards
7 the end of your tenure?
8 A. Yes. I think the other thing I would wish to
9 highlight -- probably maybe on the next page, I think,
10 page 20 -- I mean, it's just an example of how we were
11 seeking to ensure -- yes. There we are. Sort of
12 halfway down the paragraph there, a report in March
13 2006. We were also -- I mean, one of the difficult
14 niece relation to ensuring and assuring assurances
15 within an organisation around the safety and quality of
16 care is the difficulty in developing metrics, measures
17 that can assure ourselves on an ongoing basis as
18 executive directors of an organisation around the
19 quality and safety of care. What we are very good at in
20 the Health Service -- and we were very good at that
21 point in time -- was having a series of process
22 measures, process measures around how long people would
23 wait for certain procedures, how long they would wait
24 for surgery. What we did not have at that time was
25 a systematic evidence-based process by which we could

71

1 And I wondered if you had a date for that. I might
2 have missed it in your document, but I wondered if you
3 had a date for when you introduced it.
4 A. I believe it is in the document. If you look at the
5 second page, page 19, it is 2009, is it not, "integrated
6 governance strategy" -- sorry -- 2006 -- "and associated
7 structures and reporting arrangements". I subsequently
8 in my witness statement, 269/2, page 28, there is
9 an e-mail dated 6 October of 2005. Again, this
10 I suppose highlights the approach that we were taking
11 within the Trust at that time looking at what was
12 evolving in the rest of the United Kingdom in terms of
13 bringing together the various strands of governance.
14 All of those responsibilities that an organisation has
15 in terms of corporate governance, information
16 governance, research governance, clinical and social
17 care governance, and financial governance and control,
18 and bringing those together in an integrated governance
19 strategy aligned to accountability and performance
20 arrangements within the organisation and clear lines of
21 accountability -- with, you know, delegated
22 accountability within the organisation through
23 divisional directors and divisional managers up to the
24 executive team and then accountability to the Trust
25 board. So it was basically local accountability and

70

1 assure ourselves on an on going basis of whether or not
2 our services were safe, performing to a high level of
3 quality, and moving from that, a situation where when
4 something goes wrong, then you investigate to
5 a situation in a real-time ongoing measures of the
6 quality of care. So what we developed -- sorry.
7 THE CHAIRMAN: It is one thing to reduce the waiting lists
8 and get people treated more quickly, but the next step
9 is to make sure they are being treated well and the step
10 after that is, if they have not been treated well, to
11 sort out why they were not treated well and trying to
12 ensure this doesn't happen again in a system operated by
13 human beings.
14
15 A. Yes. The only qualification I would make, chair, is
16 that I would not suggest that is necessarily a hierarchy
17 of prioritisation. Certainly how long people wait for
18 a particular procedure can and often is a very good
19 marker of quality. Obviously if someone is waiting in
20 pain and distress for a procedure that's required,
21 that's poor quality care.
22 So process measures, if indeed we are measuring how
23 long people wait for surgery, if that's excessive, then
24 that's a marker of poor quality care. Indeed, I was
25 not, unfortunately, able to find a copy of this report

72

1 and I still haven't been able to find a copy of the
2 March 2006 report, but, as I say, I have found a copy,
3 last weekend, of one of the clinical indicator reports
4 which went, on a quarterly basis, to the Trust board.
5 So if that would be of assistance to the inquiry, I am
6 very happy to share that.

7 MS ANYADIKE-DANES: Yes.

8 A. Basically these are measures across all areas in the
9 hospital from intensive care, cardiac surgery,
10 Children's Hospital, around measures of quality of care.
11 We agreed these. These were evidence-based. We had
12 benchmarks, which I have alluded to here, with CHKS,
13 which is a comparative health intelligence company, and
14 we used statistical process control charts, which is
15 just a statistical analysis of all mortality across the
16 trust to ensure that when it was benchmarked against
17 similar sized organisations across UK, that our patient
18 mortality was within control limits; in other words, it
19 wasn't excessive. If it was becoming -- if it was going
20 above sort of the two standard deviations, obviously
21 that was an early warning that there's an area of
22 service we needed to look at and we would investigate
23 and seek to establish whether that was -- I mean,
24 I don't want to get terribly technical here -- whether
25 it was common cause variation. In other words, you will

73

1 A. We introduced that from memory, and again, as I have
2 reflected in my statement, towards the end of 2003 is my
3 recollection.

4 Q. Thank you.

5 A. It is difficult to be more precise about it than that.

6 Q. Then if I ask you. The review of -- I am going over the
7 page, 005. There was a review of clinical audit and
8 introduction of standard and guidelines. If we deal
9 with clinical audit, is that something that had been
10 undertaken between 2002 and 2004?

11 A. Again, I find difficult to answer precisely on that in
12 terms of timescales or dates. Apologies for that.
13 I think I suspect that it certainly was in the period
14 between 2002 and 2006. I am sorry I can't be more
15 specific than that.

16 Q. That's fine.

17 THE CHAIRMAN: These would inevitably have been evolving
18 during this time with drafts and pilots and so on.

19 A. Yes. I have no doubt that there would be. I mean, what
20 we established or what I established was -- again,
21 apologies for the passage of term -- I am struggling to
22 recall the term -- I think it was a clinical
23 effectiveness and guidelines unit. Obviously, I was
24 leading on this, but I was leading on it on behalf of
25 the Trust. What we were seeking to do it was,

75

1 see, in any process, variations over time, or whether or
2 whether that was specific cause variation, which showed
3 we had a problem.

4 Q. I don't mean to interrupt. You went on to deal with
5 a larger question than I necessarily wanted to deal
6 with.

7 A. I apologise.

8 Q. No, no. Although those are larger issue we do consider.
9 You are also dealing, now that I have established it
10 with you, at a slightly later period in time than I was
11 first wanting to establish. I am interested in knowing
12 where we stand from 2002 up to 2004. 2004 is your first
13 contact, if I can put it that way, with Claire's family
14 and what happened in relation to her treatment and its
15 aftermath.

16 A. Okay.

17 Q. But if I just ask you out of these -- if you bear in
18 mind that's my priority just at the moment. I am
19 looking to see which of these achievements had been
20 introduced in relation to that time frame. So if I ask
21 you, for example, still on that page 004, you led the
22 introduction of root cause analysis, RCA, to investigate
23 serious adverse incidents, SAIs. The introduction of
24 root cause analysis, had that happened at a period
25 between 2002 and 2004?

74

1 I suppose, develop audit from where its origins were,
2 which was -- and I exaggerate to make the point, so
3 I hope you'll allow me some licence do so -- where audit
4 was seen as something which doctors and nurses do in
5 terms of ensuring that they are assessing their care
6 against extant standards and those would be standards
7 often that come from Royal Colleges around appropriate
8 treatment. What we were attempting to do was actually
9 take clinical audit with guidance which had been issued
10 from a range of bodies, including the department, and
11 ensuring that we systematically used that information to
12 assure ourselves as an organisation that we were doing
13 the things that needed to be done and we were doing
14 those in the right ways. So we had a much more --
15 a view to having a targeted programme of clinical audit.
16 So at the -- I have mentioned earlier in my witness
17 statement of 269/1, we had mid-year and end-of-year
18 accountability reviews with all of the directorates, and
19 again that would have been in the period, certainly at
20 least from my memory, from 2002 through to 2006.

21 MS ANYADIKE-DANES: Uh-huh.

22 A. The clinical information, clinical indicator reports we
23 referred to would have been used within those
24 accountability reviews chaired by the Chief Executive so
25 that the Chief Executive was assured around the quality

76

1 of services and a range of other organisational
2 corporate objectives within the business plan and
3 indeed, during those accountability reviews, each of
4 those divisions -- whether that was women and children's
5 or whether it was medicine -- would have also been
6 required to produce a record of their audit ability at
7 this time and indeed were required to link their audit
8 activity to their divisional risk register in terms of
9 the risks to either non-achievement of particular
10 priorities or indeed risks in relation to some of the
11 services that they were providing.

12 So it was basically using, taking -- I suppose if
13 I could summarise -- taking audit from the realms of the
14 medical profession and saying, "Yes, it is the realms of
15 the medical profession in terms of ensuring ourselves,
16 as doctors, about the quality of the care that we are
17 providing", and basically ensuring that we were
18 utilising this as an organisational tool to provide
19 assurance within the organisation.

20 Q. You have just explained something I was going to ask
21 you.

22 In relation to all your initiatives or the key
23 achievements that you introduced, I presume that if you
24 are introducing an initiative like that, you are putting
25 in place a system to audit, monitor, evaluate those

77

1 there would be drafts and revisions and so on and so
2 forth. What I was asking you -- and I think you have
3 now just answered it -- was that you would put in place
4 systems to audit, monitor, evaluate the actual process
5 of implementation of those initiatives?

6 A. Well, absolutely. Again, that was the culture of the
7 organisation. The culture of the organisation was, as
8 indeed consistent with the department's policy, was
9 there are clear standards. Those standards need to be
10 implemented. There's accountability to the Chief
11 Executive and members of the board of that organisation,
12 myself included, are included for the implementation of
13 those.

14 Q. Thank you.

15 If I can now take you to your job description, which
16 is to be found at 269/1, page 24 it starts, and if we
17 could perhaps pull up page 25 alongside that. The
18 first -- it is quite small, but I think we can all read
19 it.

20 The first is your accountability. You were
21 accountable to the Chief Executive and, in fact, later
22 on in your witness statement you talk about the meetings
23 you would have with the Chief Executive and sometimes
24 the chairman of the board.

25 A. Yes.

79

1 initiatives and then report back as to how they need to
2 be, in any way, altered or improved in response to the
3 information you are getting. So I understand that you
4 had a clinical audit process, but did you audit your
5 initiatives, if I can put it that way, and if you did,
6 is there the evidence of that in reports or minutes or
7 something of that sort?

8 A. Obviously I think one of the difficulties -- and
9 I apologise for this in terms of preparation of my
10 statements -- was the difficulty in getting information
11 and particularly records --

12 Q. Uh-huh.

13 A. -- which would remind me of sort of the development of
14 some of these areas. So I would have no doubt that if
15 indeed those minutes are available or those notes of
16 meetings that it would demonstrate the evolution of
17 those processes. As I say, I have found some records
18 which may be of interest in relation to one particular
19 division around their accountability review --

20 Q. Yes.

21 A. -- and their audit, which I am very happy to make
22 available to the inquiry.

23 Q. I think that would be helpful, Dr McBride. This is not
24 just a trail of how you developed a particular
25 initiative, with which I think you have helped, and

78

1 Q. And we will come to specific areas where I would like to
2 ask whether that subject constituted a report to either
3 of those, but anyway that's your reporting line. It
4 seems from the job description you really were either
5 coming in to introduce change or you were coming in to
6 manage it and further it, if I can put it that way;
7 would that be fair?

8 A. I think it was both.

9 Q. Yes.

10 A. I think again, as I have explained -- I have attempted
11 to outline the development of clinical governance across
12 the UK, in Northern Ireland and the Royal. I think my
13 predecessor had certainly been at the forefront of
14 developing clinical and social care governance in the
15 Trust. Certainly, I think we were recognised as
16 an organisation at that time as being at the forefront
17 of that. I think that we were committed to continuing
18 to do that because it was the right thing to do. We
19 were very conscious of our duties and our
20 responsibilities and our accountability for the services
21 that we provided.

22 Q. Yes. Leaving aside the first two things, which are to
23 assist in the formulation of policies and strategies and
24 so forth, and providing effective leadership in all
25 areas relating to clinical governance, I wonder if you

80

1 can help me on the second page under item 9. You were
2 required to work with the director of nursing -- and
3 that would have been Miss Duffin at that time.
4 A. No, that would have been Miss Deidre O'Brian.
5 Q. Sorry. I beg your pardon -- and the clinical director
6 to ensure all aspects of clinical governance are
7 embraced by management and membership of the clinical
8 directorates. What sort of level of contact was
9 required to achieve that between you and the director of
10 nursing and the clinical directors?
11 A. Sure. Obviously with the passage of time I can't recall
12 the exact names of various meetings or indeed the
13 frequency of those. Certainly --
14 Q. Let me help in this way. For example: would you have
15 had monthly meetings?
16
17 A. We would have regular meetings. If I could develop
18 that? Certainly as an executive team, we would meet at
19 8.30 on a Monday morning, informal meeting, is my
20 recollection. That wasn't a minuted meeting, it was
21 a -- We would have discussed the week ahead and the week
22 that was and any emergent issues. We would have --
23 Q. Sorry. Pausing there. You said "any emerging issues".
24 What are the sorts of things you would expect them to be
25 bringing to you or you would be wanting to discuss with

81

1 I can't recall exactly when that divisional structure
2 was put in place. The divisional directors and clinical
3 directors remained accountable to the Chief Executive
4 and the clinical directors were professionally
5 accountable through to the divisional director and there
6 was a line of professional accountability through to me.
7 There was also then regular meetings obviously of the
8 Trust board and again the frequency of those --
9 Q. I will come to that slightly later on.
10 A. Okay.
11 Q. Under that paragraph, you have a meeting with the
12 associate medical director or at least you assist --
13 with the associate medical director, you are ensuring
14 a proper system of clinical audit for assessing and
15 reviewing the quality of services provided.
16 Is that the same sort of contact that you were just
17 helping us with in relation to the associate medical
18 director?
19 A. Yes. I mean, it would have been. Again, obviously with
20 the passage of time, I am sorry. I can't provide any
21 more detail of that.
22 Q. No, no. I am just --
23 A. That would be the nature of that work and also to ensure
24 that guidelines were implemented effectively across the
25 Trust --

83

1 them?
2 A. Well, it was an opportunity basically not to have any
3 formal discussion about any matters but basically to
4 have an opportunity in a room to say, "Actually, I need
5 talk to you about something. Can we arrange a time?".
6 That was the format. It was not a formal briefing. It
7 was basically a meeting of the Medical Director, Chief
8 Executive, director of nursing, director of HR, the
9 divisional directors, as they were, and the directorate
10 managers and it lasted probably no more than 30 minutes.
11 So it was a very short meeting. As I recall, that was
12 on a Monday morning, but again I may be remiss in that.
13 Q. But out of that, you might develop meetings to discuss
14 in more detail somethings that had arisen?
15 A. Yes, and that was the purpose of it.
16 Q. So it was a scheduling meeting in some respects.
17 A. No. It could be used for that and sometimes was. There
18 were regular meetings of the executive team. Again, my
19 apologies. I can't recall how frequent those meetings
20 were, but those would be the executive directors within
21 the organisation and also attended by the divisional
22 directors. I should add that the clinical directors, as
23 is mentioned here, those organisational arrangements,
24 evolved and clinical directors remained, but over and
25 above that, there was a tier of divisional directors.

82

1 Q. Yes.
2 A. -- clinical guidelines.
3 Q. One of the things you also do with the associate medical
4 director -- was that Mr Walby at the time?
5 A. No. That specific -- sorry. The reference -- is this
6 the reference at 12 or the reference 14?
7 Q. Well, I am actually going deal with the reference at 12
8 at the moment.
9 A. Okay. The reference at 12 was Mr Walby, yes.
10 Q. What I want to ask you then is: with him, you are
11 providing claims investigation and management service
12 for claims of a clinical nature and so forth and to
13 assist the coroner. What was your role in assisting
14 coroner?
15 A. I had very little contact with the coroner. I mean, the
16 nature of my responsibilities were such -- as you can
17 see from the job description, they were quite
18 wide-ranging and obviously the hospital was a large and
19 complex organisation. So there was a system of
20 delegated, I suppose, accountability within the
21 organisation. Mr Walby was accountable to the Chief
22 Executive in relation to his responsibilities. There
23 was a line of professional accountability to myself in
24 that he was my associate Medical Director.
25 Q. Sorry. What I am actually --

84

1 A. But I would not have been involved, you know, directly
2 or on a day-to-day basis in relation to matters
3 pertaining to the coroner.
4 Q. Did you have any responsibility at all is what I am
5 trying to get at because the way it is framed suggests
6 you might because you are doing something in connection
7 with Mr Walby. I am just trying to find out what your
8 particular role was.
9 A. Again, just to go back on that, I am not saying I didn't
10 have responsibilities in that area. That's not the
11 point I was making. I am basically saying the associate
12 medical director had lead responsibility in that. He is
13 accountable to the Chief Executive for the execution of
14 those responsibilities. There was a line of
15 professional accountability to myself. I certainly
16 would have had an oversight of those arrangements.
17 I think that is the point I am making --
18 Q. I understand.
19
20 A. -- although there was no line management accountability.
21 Q. But you would be expecting him to keep you in the loop,
22 if I can put it that way?
23 A. Absolutely.
24 Q. Yes.
25 A. And he did.

85

1 structure and when you came on board in 2002?
2 A. Again, I don't have the organisational structure in
3 front of me for comparison.
4 Q. I understand.
5 A. And I have not seen this before. So --
6 Q. I don't want to put you in a difficult position. I am
7 content that you can reflect on that at some other stage
8 and maybe we can get some assistance as to what was the
9 structure for 2004.
10 A. I mean, if the answer -- if the question is around
11 accountability lines --
12 Q. Yes.
13 A. -- accountability lines, and I am not certain whether
14 this is seeking to represent accountability lines and
15 reporting lines, but certainly the -- and I think it
16 demonstrates, as I mentioned earlier, the accountability
17 of executive directors to the Chief Executive of the
18 Trust and indeed executive directors and the Chief
19 Executive's accountability to the Chairman and the
20 board, which was comprised of the non-executive
21 directors and the executive directors. So that overall
22 structure is correct. It would be the same in those
23 accountabilities.
24 In terms of the structure below that, in the blue
25 boxes, that changes and evolves over time and certainly

87

1 Q. Thank you. I was not suggesting he didn't. It is just
2 your expectations.
3 Then if we look at 19, one of your roles is:
4 "Liaising with key doctors outside the Royal,
5 including the CMO."
6 Did you have regular meetings with the CMO or were
7 these just as matters arose that you wanted to bring to
8 her attention?
9 A. Again my recollection is that there were regular
10 scheduled meetings with the chief medical officer.
11 Indeed it was her -- Dr Campbell at that time -- given
12 her other wider responsibilities at a regional and
13 indeed national level, at occasions those meetings would
14 be chaired by a deputy, but certainly those were regular
15 meetings. Again, I can't recall the frequency of those.
16 Q. Then if we pull up an organisational structure that we
17 had to sort of guide us for 1995/1996, it is
18 303-043-510. If we can just enlarge that a bit. You
19 can see the basic structure of it and where the medical
20 director sat, who was then Ian Carson. You see the
21 director of finance, director of nursing and medical
22 director and so forth. You can see corporate affairs is
23 over that side and you can see the chief executive,
24 Mr McKee, and the chairman.
25 Were there material difference between that

86

1 was not the structure and certainly wasn't the structure
2 at the time I left the organisation and the names,
3 clearly, were different.
4 Q. Of course. Can I ask you this, though: you had liaison
5 with corporate affairs/corporate communication when you
6 were medical director at the Trust.
7 A. That's correct, yes.
8 Q. And what sorts of issues did you liaise on?
9 A. It would have been a range of issues, particularly, for
10 instance, if -- I think the corporate affairs -- from
11 memory, again, this is -- had a wide range of
12 responsibilities. It wasn't just in relation to media
13 and the media side of things. It was also in relation
14 to matters which involved engagement with the public,
15 whether that was in relation to a consultation on
16 a proposed reconfiguration of service, which obviously
17 I would contribute to and be involved in. So
18 developing, for instance, a plan for the provision of
19 perhaps surgery or a different model of providing
20 surgery and engaging with the local community in that
21 discussion. It might also -- their responsibilities
22 would extend into, you know, engaging with the media in
23 relation to, for instance, outbreaks of infections that
24 might occur --
25 Q. Yes.

88

1 A. -- significant events that may have occurred. And
2 clearly, as the medical director -- and clearly this was
3 an established pattern -- sorry -- an established
4 practice -- that often when matters of that nature arise
5 and are a cause for public concern, then the medical
6 director, you know, has a key role in explaining both
7 what has happened, why it has happened and providing
8 appropriate reassurance and reassurance on the action
9 that has been taken.

10 Q. Thank you. I wonder if I could bring you back to
11 item 20 in your job description? That's 269/1 at
12 page 26. There we are. Thank you. You can see:
13 "Taking responsibility for some aspects of the
14 public image of the Royal hospitals, dealing with media
15 and the local community particularly where clinical
16 matters are to the fore."

17 If we just leave aside the local community for the
18 moment. If you can help us with what are the aspects of
19 the public image of the Royal hospitals in relation to
20 the media that would bring you to be involved --
21 obviously they are going to be clinical -- and how early
22 would you expect to be brought into something that's
23 going to hit the media in relation to clinical issues?

24 A. I am not certain I would interpret that as you have.
25 I think "public image" is much wider and much broader

1 that period clearly there was a lot of engagement with
2 the media both in terms of seeking to explain what
3 happened, why it happened, and ensuring that we were
4 communicating what we were doing to put that right. So
5 that would be the nature of the sorts of incidents.

6 Q. Perhaps if I take -- when you said, probably rightly,
7 that I had taken a rather narrow view of the public
8 image ... Well, let's take something that might,
9 depending on when you actually came into your post, but
10 it would have happened either at that time or just
11 before it, which is the introduction of the
12 hyponatraemia guidelines. They were issued in March
13 2002 by the CMO. Do you recall when you came into post
14 what role you played in ensuring that those guidelines
15 were complied with, implemented, the appropriate
16 education was provided and that you had some way of
17 auditing the extent to which they were being complied
18 with? Would you have been instrumental in any of that?

19 A. I can't recall the details from that time, but again
20 from memory -- and again I stand to be corrected on
21 this -- my under -- my recollection, as I said earlier,
22 was that I took up post in the July or August of 2002.
23 Again, I acknowledge the date of the job description
24 which you drew to my attention. What I do recall is
25 that communication from the department some time in

1 a term, I would suggest, than "interaction with the
2 media". I mean, the media is but one aspect of it.

3 Q. Yes, but that's the aspect I want your help on.

4 A. Well, as I was explaining, later, my responsibilities
5 were in relation to some of the wider aspects. I would
6 often be brought into matters if indeed there was
7 a matter, I suppose, pertaining to a clinical issue that
8 had arisen, and I would be asked to perhaps engage with
9 the media in relation to explaining, as I said earlier,
10 what had actually happened or what we understood had
11 happened, why we understood that had happened and
12 actually what it was, as an organisation, that we were
13 going to do to put that right. So that was certainly
14 a frequent requirement.

15 For instance, if I think back, just as you asked,
16 one of those was around endoscopy. As you know, there
17 was a significant problem identified in relation to the
18 decontamination of endoscopes. That obviously caused
19 It is one of those systems

20 issues which had arisen, very complicated origins of the
21 problems, and I won't go into the detail, but clearly we
22 had a large number, thousands of patients who were
23 concerned and anxious about the risk -- or any risk --
24 of blood-borne viral infections. We set up a helpline.
25 We brought people back for clinics and, indeed, during

1 2003, I believe, seeking assurances.

2 Q. Yes.

3 A. It might have been earlier, it might have been 2002,
4 I can't recall, but some time in that period between
5 2002 and 2003 after the publication of the guidance --

6 Q. Yes.

7 A. -- and their dissemination, seeking assurances from the
8 trust around their full implementation.

9 Q. Yes.

10 A. As I recall, that correspondence obviously would have
11 gone to the Chief Executive and indeed I probably would
12 have been tasked with seeking those assurances from the
13 various areas of the hospital that were relevant.

14 Q. Well, would you have been tasked with the role of
15 putting in place some sort of system whereby you could
16 audit their compliance with them or monitor their
17 compliance, evaluate how well the education around them
18 was working, where they were cited, and so on and so
19 forth, all with a view to ensure that you could -- not
20 you personally -- but the Trust could, when required by
21 the CMO, give some confirmation that what she had wanted
22 to happen in relation to those guidelines, was, in fact,
23 happening? Would that have fallen to you to put those
24 systems in place?

25 A. It certainly would have fallen to me on behalf of the --

1 probably on behalf of the Chief Executive to ensure we
2 got those assurances from the hospitals where those
3 guidelines were relevant. I personally would have not
4 at that time -- again, I can't recall the detail of
5 this, but I would not, at that time, have walked into
6 individual units to ensure that the wallcharts, et
7 cetera, were being prominently displayed. I would have
8 sought an assurance from the relevant clinical director
9 or divisional director that the guidelines had been
10 implemented at that time.

11 Q. It is the system I am asking you about.

12 A. Sorry?

13 Q. It is the system I am asking you about. I don't suggest
14 you had the time or it was appropriate that you wandered
15 around to see where the posters were stuck. Was it part
16 of your role to set in place --

17 THE CHAIRMAN: I think that's what Dr McBride was saying.

18 It was your job to get the assurances from each
19 relevant director or unit, which you could relay to the
20 Chief Executive, so that the department could be
21 reassured that the guidelines were being followed.

22 A. I think that's the point I was trying to make. It is
23 not to diminish the fact that it is important that
24 someone is walking around and ensuring -- the inference
25 being that that isn't important. That is important. It

93

1 A. I can't recall back that far in terms of the exact
2 details of that, but certainly, if indeed I was seeking
3 assurance on behalf of the Chief Executive to provide
4 that assurance to the department, in that delegated
5 system of accountability, there would be a requirement
6 and obligation on those from whom that assurance was
7 being sought to ensure those arrangements were in place.

8 Again I can't recall the exact timeline, but I know
9 that there were audits of implementation of those
10 guidelines. I can't recall -- and again I would be
11 incorrect were I to expand on that any further because
12 I can't recall any detail. There were certainly
13 external audits of compliance.

14 Q. You're quite right, the RQIA audited that.

15 A. Yes, at that time, as I recall.

16 Q. The first time they did that was in 2008. That was
17 their summary validation report. Then they had another
18 report in 2010. What I was trying to see was whether,
19 internally, you set up a system, but I think you have
20 taken us as far as you can from your recollection.

21 So if we go back to the media issue. As you know,
22 in 2004 UTV aired the programme or documentary "When
23 Hospitals Kill". When did you first know UTV was going
24 to air a programme like that and how did you know that?

25 A. I believe I first became aware, from memory, the day

95

1 is important that someone is walking around and actually
2 checking add ascertaining that the guidance is in place
3 and it is displayed prominently and people are following
4 it.

5 My responsibilities, given the delegated system of
6 accountability, which I described earlier when we were
7 going through my job description, and indeed the
8 development of integrated governance, it would have been
9 in that delegated system a responsibility to seek those
10 assurances and provide those assurances to the Chief
11 Executive then and basically to the Trust for onward
12 communication to the department.

13 Q. I understand that. What I was wanting you to help me
14 with was whether, apart from routinely asking the
15 appropriate people to whom ultimately devolved the
16 responsibility, whether these things were now in place,
17 were people complying with them, what was the incidence
18 of people not complying, what were you doing about it?
19 And apart from asking them in that way, was there some
20 more formalised system -- when you were talking about
21 the introduction of your clinical audit and so forth,
22 did you have a more formalised system for being able to
23 actually keep track of what was going on and what the
24 rate of complaints was?
25

94

1 before the programme was due to broadcast. So
2 I think -- from recollection, I believe the -- just
3 reading from the details here, the programme broadcast
4 on the 22nd. I believe I was made aware of the fact
5 that the programme was going broadcast on the 21st,
6 which was the day before. I was brought up to speed
7 that there had been an exchange of correspondence at
8 that time, I think, between the Trust and UTV in
9 relation to the planned broadcast.

10 Q. Yes. I might have framed the question badly. I don't
11 mean: when did you know that's when the programme was
12 going to go out. When did you know there was going to
13 be a programme like that?

14 A. As I say, as I answered earlier, the day before the
15 programme was broadcast.

16 Q. Well, you said that Mr Walby would keep you in the loop
17 and he did keep you in the loop of the very first fax
18 that we have found in the papers provided to us or the
19 first document, as I can see it, that relates to the UTV
20 programme. It is 141-034-001 and it's a fax which is
21 from the corporate communications, Christine Stewart, to
22 Mr Walby. You can see it is dated 26th May. What's
23 happening there is they are concerned about a television
24 journalists who is apparently making a bit of a pain of
25 himself in relation to and it says, "This Lucy Crawford

96

1 case", which certainly gives the impression it is not
2 something new. They are aware of what the Lucy Crawford
3 case is and that's what they are being pressed for
4 information about. But he didn't bring that to your
5 attention, that they were making a documentary?
6 A. I have no recollection of that being brought to my
7 attention. I mean, I stand to be corrected on that, but
8 my recollection is the first time I became aware of the
9 documentary was the evening before it was broadcast.
10 Q. Then there's a bit more. It goes on on 24 September and
11 that's at 141-032-001. This is also from corporate
12 communications for Mr Walby's information. She has been
13 getting enquiries from the press about Lucy Crawford.
14 UTV may be doing a programme and she wants the coroner's
15 final verdict. This doesn't jog your memory at all?
16 A. No. I mean -- I honestly don't recall being made aware
17 of that. I may be mistake in my recollection, but
18 I honestly have no recollection of that.
19 Q. Well, then in October matters get to a stage on
20 7th October when Brangam Bagnall provide a letter. It
21 is 141-028-001, and Brangam Bagnall at that stage were
22 the lawyers acting for the Trust and they are concerned
23 about the way the programme might be going to portray
24 the Royal Group of Hospitals:
25 "On the basis of the information which is contained

97

1 Going back to that part in your job description
2 which clearly refers to your interaction -- just give me
3 one moment. It is item 20:
4 "Taking responsibility for some aspects of the
5 public image of the Royal Hospitals, dealing with the
6 media and local community, particularly where community
7 matters are to the fore."
8 That would seem to tick that box, the exchange
9 between the solicitors; would you not agree?
10 A. Certainly there are clinical issues there, yes.
11 Q. Well, not only that --
12 A. And significant clinical issues at that.
13 Q. Sorry?
14 A. Significant clinical issues at that time.
15 Q. Yes, a very serious allegation is being made against the
16 royal that it misled the coroner. The solicitors, on
17 behalf of UTV, are referring to that as the highest
18 public interest and that's what they propose to include
19 in that documentary, but you don't recall knowing about
20 that?
21 A. No. Again, as I have stated earlier, I have absolutely
22 no recollection of that communication or that series of
23 communications or engagement with the Trust. Again my
24 recollection, as I stated earlier, was that it was
25 immediately prior to the broadcasting of the programme.

99

1 within the e-mail, I refer particularly to the following
2 statement:
3 "I have to point out that in the forthcoming
4 programme, we will be relying on documentary evidence
5 including statements made under oath which clearly
6 proves that the Royal did mislead the coroner'.
7 "My clients trenchantly denies that."
8 The solicitor is seeking a retraction, otherwise
9 they will consider their options. That's quite
10 a serious stage to be reached because what's being
11 suggested was the Royal was involved in a cover-up.
12 That was not brought to your attention either?
13 A. I have honestly no recollection of that being brought to
14 my attention at that time.
15 Q. Then the response to that, 12th October 2004, reference
16 141-029-001: they don't accept their journalist has
17 acted in any unreasonable fashion. This is back from
18 the UTV solicitors:
19 "The matter under investigation in the proposed
20 Insight programme is of the highest public interest.
21 Prior to transmission, an offer is again given to the
22 Royal to put forward any possible explanation for the
23 failure to tell the coroner in April 2000 that
24 Lucy Crawford had died from dilutional hyponatraemia.
25 Any explanation would inform the programme makers."

98

1 Q. Well, if that's the case, would you not have wanted to
2 have known about something like that earlier?
3 A. Again, I suspect that -- I mean, certainly it is a
4 matter I suppose with -- I mean, looking at the series
5 and trail of communication, I think certainly it is
6 a matter which I would have wished to have been aware
7 of, yes.
8 Q. And if you had been aware of it, what would you have
9 been seeking to do?
10 A. I think it's very difficult at this point to look back
11 to that time and determine what I may have done.
12 I think certainly I would have wanted to know certainly
13 the details of the particular case or cases that were
14 concerned.
15 Q. Yes.
16 A. I would certainly want to know what the nature of the
17 concerns were. I suppose my primary consideration on
18 this would be that the nature of the impact that such
19 a documentary would have in relation to wider public
20 concern, you know, getting back to my --
21 Q. Exactly?
22 A. -- the role as in my job description, and particularly
23 as it related to public confidence in the service that
24 was provided. Certainly that would be me --
25 THE CHAIRMAN: Would you, as the medical director, not be

100

1 called up to front the Royal's response?
2 A. I think it is very likely that would be the case.
3 Q. From the documentary, when it was transmitted, it showed
4 one of the doctors in the Royal being doorstepped in the
5 car park.
6 A. It did.
7 Q. It is strange this news never reached you prior to the
8 day before it was broadcast because I am presuming that
9 that doorstepping of the doctor in the car park did not
10 take place the day before it was broadcast; it is likely
11 it was done before then.
12 A. I accept that and accept the points you are making.
13 I certainly do not recall being advised or informed of
14 this prior to ...
15 THE CHAIRMAN: Then when you did find out on the day before
16 the programme that the programme was about to go out, do
17 you recall being told any of this background that there
18 had been these exchanges going on for the last couple of
19 months and, "We have a doctor who has been doorstepped
20 in the car park because apparently requests for
21 interviews were not responded to"?
22 A. I don't recall that level of detail in the discussion.
23 I do recall a discussion and I was certainly briefed on
24 the day before the broadcast of the broad details of the
25 broadcast and the nature of the allegations that would

101

1 THE CHAIRMAN: He is in the press office?
2 MS ANYADIKE-DANES: Yes, he is in the press office. Thank
3 you, Mr Chairman. So it is one press officer to
4 another, essentially. 20 September 2004. What it says
5 is:
6 "I have just spoken with Dr Bob Taylor, consultant
7 anaesthetist in PICU, who was involved in the management
8 of Adam Strain and gave evidence at the inquest."
9 Okay?:
10 "Following a detailed examination of the issues
11 surrounding patient AS [Adam Strain], there were no new
12 learning points and therefore no need to disseminate any
13 information."
14 I am sorry that you are having to hear it from me
15 and we don't have it up to look at.
16 THE CHAIRMAN: We will see if we can get a hard copy for up.
17 MS ANYADIKE-DANES: Here we are. (Handed). Just because
18 nobody else has it, for the benefit of everybody else,
19 while you are doing that, I will just read the third and
20 final paragraph:
21 "Our hospital has an established structure for the
22 teaching of the management of fluids to doctors in
23 training. However, should those doctors continue in the
24 treatment of children when they leave the Royal, it is
25 their responsibility to stay up-to-date in current

103

1 be made. I believe at that time I did inform the
2 department of that from memory. The programme was being
3 broadcast at that stage and certainly there was,
4 I suppose, little opportunity for me to intervene to do
5 anything at that point. Again, that is my recollection
6 of the sequence of events and the timings.
7 MS ANYADIKE-DANES: That's the point, isn't it, Dr McBride,
8 why you would have wanted to know beforehand, because
9 you have just explained that if you had known
10 beforehand, you would have made some investigations.
11 You would have tried to find out what the background is,
12 what the nature of those cases are and why an allegation
13 like that is going to form part of programme.
14 I can pull you up another document. I wonder if it
15 would help. It slightly predates when you said you were
16 first alerted to it. It is 023-045-105. I don't know
17 why that's not coming up: shall we try that again.
18 023-045-105. No? Okay.
19 Well, I will have to tell you what it is. It's
20 an e-mail dated 20th September 2004. It's from
21 Christine Stewart, who you have already seen her fax in
22 relation to corporate communications. It is going to
23 Colm Shannon at the department; okay?
24 A. Uh-huh.
25 Q. What it says is --

102

1 management techniques. I hope this is helpful."
2 So that's the e-mail going?
3 A. Yes.
4 Q. What seems to have happened is, although we don't know,
5 is that the department obviously wanted some information
6 in relation to the Adam Strain case. Christine Stewart
7 at the Royal is providing that information, having
8 spoken to Bob Taylor.
9 What I wanted to ask you is: had you known that the
10 programme was going out and was going deal with three
11 children, all of whom ultimately died at the Royal, and
12 one suggestion in this case is that there was -- this
13 case being Adam -- that there was a cover-up in terms
14 of -- rather that the coroner had been misled, would you
15 not have wanted to put in place some means of finding
16 out exactly what happened and would you not have wanted
17 to know who was going to be the source of that
18 information as opposed to leaving it to a press officer
19 to go and find out for herself what happened?
20 A. Certainly, I mean, as medical director, I would have
21 wished to have been aware of this.
22 Q. Yes.
23 A. Certainly. I was not involved in any of those
24 discussions. I certainly don't appear to be copied into
25 this e-mail.

104

1 Q. No, no.
2 A. I wasn't aware of that. I have no doubt that others
3 within the organisation obviously may have been aware
4 and were engaged and seeking to engage clearly with the
5 producers. Certainly that -- to my recollection and to
6 the best of my recollection, that was not drawn to my
7 attention.
8 Q. I understand, but would you not have expected there to
9 have been some sort of discussion about, "Well, if this
10 programme is going to go out about these three children,
11 let's find out exactly what happened so we can prepare
12 ourselves. We know where we might be vulnerable and
13 where we should be making concessions or where we
14 consider we acted appropriately"? Some structure for
15 fact finding, at the very least, should have been
16 established, would you not think?
17 A. Certainly I think -- I wouldn't quite put it in those
18 terms, in terms of establishing whether we were
19 vulnerable and where we give concessions. I think the
20 primary priority here is in relation to -- certainly
21 from my perspective, would be the wider public concern
22 that there would be in relation to the safety of
23 services within the Children's Hospital. The fact that
24 there were, you know, children currently in the
25 Children's Hospital receiving fluids, children about to

105

1 Christine Stewart knows to go to Dr Bob Taylor?
2 A. I can't answer that. I don't know.
3
4 THE CHAIRMAN: If she did that, she must have been getting
5 a clear direction from somebody who -- either she has
6 looked into who treated Adam and found Dr Taylor's
7 referred to, or she's been given some steer from inside
8 the Royal, which is entirely legitimate for her to be
9 given that steer, which leads her to Dr Taylor, but it
10 doesn't lead her to others who took a different view
11 about whether anything should be learned. Those other
12 people are within the Royal.
13 A. I think that would be a logical conclusion. I think it
14 would be unfair to, as you say, Christine Stewart in her
15 capacity as a press officer -- one would surmise she was
16 acting on a source of advice she had received in terms
17 of where to seek that information.
18 THE CHAIRMAN: Yes.
19 A. Absolutely, and indeed in terms of the information that
20 was being conveyed, clearly Christine Stewart was not in
21 a position to comment on the accuracy or otherwise of
22 that.
23 MS ANYADIKE-DANES: But that's why somebody needs to
24 establish how we are going to go about finding the
25 information. The other point that it raises -- this is

107

1 come into hospital for surgery, that would have been my
2 primary consideration.
3 Q. So if I take you on that point, so what you would
4 presumably want to know is what happened? Why were
5 lessons, if that is the case, not learned, and how have
6 we improved from that period, because you have cases
7 that span 1995, 2000 and 2001 in those three with Adam,
8 Lucy and Raychel. So why I'm asking you about this is
9 what has happened is that the press officer has gone to
10 ask the very person in the Adam Strain case who actually
11 did not, until sometime this year, accept the coroner's
12 verdict. So if you were looking for an independent view
13 as to exactly what happened and how it came to be that
14 there may not have been the appropriate lessons learned,
15 that may not have been the most reliable source to go
16 to.
17 A. I am not sure what to comment on as a question.
18 Q. The question is: should you -- not necessarily you; if
19 it is not brought to your attention, you can't be
20 involved in it -- but should there not have been some
21 way of the Trust establishing for itself what happened
22 at the very least?
23 A. I think certainly that would be a reasonable course of
24 action I would suggest, yes.
25 THE CHAIRMAN: Perhaps a more fundamental point: how would

106

1 the information she receives, that there was a detailed
2 examination of the issues surrounding that patient and
3 there were no new learning points and therefore no need
4 to disseminate any information.
5 Following on from the point that the chairman put to
6 you, that actually wasn't the view of Dr Murnaghan.
7 Dr Murnaghan thought there were things to be done. Not
8 only did he think that, but what he intended to do was
9 to establish a seminar afterwards where you would bring
10 together the likes of Dr Taylor, Dr Hicks and so forth,
11 and they would have a seminar and they would extract
12 actually the learning points to disseminate. For
13 various reasons, that didn't actually happen, but that
14 was his intention. So the information that Christine
15 Stewart is being given to pass on to the department may
16 be seriously flawed, but what I'm seeking from you is
17 the system or the structure that the Trust would have
18 put in place to ensure that it identified the
19 appropriate information and passed that on to the
20 department.
21 A. I honestly can't answer that. As I said, I wasn't, to
22 the best my recollection, involved in those discussions
23 at that time. My earliest recollection of being aware
24 that the programme was being broadcast was, I believe,
25 on the day before the broadcast. I have no recollection

108

1 of being briefed or consulted prior to that date, but,
2 I mean, I stand to be corrected on that, but I honestly
3 have no recollection.
4 Q. If that's the case, is that not some sort of failing in
5 the Trust that they didn't alert you, the very person
6 who might have assisted in ensuring that the information
7 was appropriately gathered and passed on, that you
8 weren't alerted until it was really too late to have
9 much say in?
10
11 A. Certainly in retrospect I would have wished to have been
12 involved earlier, yes.
13 Q. I think you are right about the -- certainly Mr Walby
14 seems to have spoken to you on the 20th and you see that
15 from 141-026-001.
16
17 A. Sorry. I can't see anything.
18 Q. It is going to come up. I hope so?
19 A. Okay.
20 Q. This is endorsed on the bottom of an earlier e-mail,
21 which is from Jo McGinley, but you can see down at the
22 bottom in Dr Walby's hand:
23 "20th October. Spoke to McBride."
24 Is that what you were referring to, the time you
25 were first alerted to the programme?

109

1 advised -- I provided a short summary of the cases
2 that -- of the names of the children that were likely to
3 be mentioned in the programme and I was advised,
4 I believe, in relation to the engagement that there had
5 been with UTV in relation to the broadcast and I was
6 made aware, as I recall, of the nature of the
7 allegations that were being made.
8 Q. So you knew what the issues were?
9 A. In so far as the information was relayed to me at that
10 time. I mean, it would be, I think, unfair to say that
11 I had a broad grasp of the detail, but certainly I was
12 made aware the programme was being broadcast, it was in
13 relation to a number of deaths that had occurred and
14 previous inquests and I was made aware that there were
15 allegations going to be made in relation to the Trust
16 misleading the coroner.
17 Q. Thank you.
18 A. From memory.
19 MS ANYADIKE-DANES: Mr Chairman, I am about to go on to
20 a slightly different ...
21 THE CHAIRMAN: Let me just ask you before we leave that
22 point: although the documentary was broadcast in 2004,
23 doctor, it featured significantly Adam's death in 1995,
24 Lucy's death in 2000 and Raychel's in 2001 and there was
25 particular focus on the fact that it was only after

111

1
2 A. Yes.
3 Q. Can you remember what he told you?
4 A. Yes. As -- again, I can't recall the exact details of
5 the meeting, but my recollection is that the meeting
6 took place in my office. I believe that Peter Walby was
7 present. I believe that there may have been someone
8 from the press office. I am not certain whether or not
9 there were representatives from the Trust solicitors at
10 that time, but I certainly was briefed in relation to --
11 I don't know if it was on that date or, as I say, the
12 immediate run-up to the programme, but I was certainly
13 briefed in relation to the three cases.
14 Q. You are quite right. We will come to briefing. There
15 was an e-mail. I think it is to be found at 269/2 at
16 page 65. Yes. If you come to the one from Jo McGinley,
17 dated 20 October, and you are Ccd in it. So is Peter
18 Crean, Bob Taylor, Donncha Hanrahan and Heather Steen.
19 It tells you:
20 "The programme is due to go out tomorrow night at
21 9.00 pm".
22 And so on. Then you CC that on to Mr Walby the next
23 day. What can you recall of what Mr Walby told you or
24 what you were told during that briefing session?
25 A. As I believe -- again, as I recall that, I was

110

1 Raychel's inquest that more facts had emerged about
2 Lucy's death a year earlier, and that led to Lucy's
3 death being referred to the coroner out of sequence, if
4 you remember that. I am just wondering because that did
5 involve -- Adam was only treated in the Royal and he
6 died there, but Lucy and Raychel came into the Royal,
7 one from the Erne and one from Altnagelvin, and both
8 eventually died in the Royal. By the time they each
9 reached the Royal, their position was beyond saving.
10 Do you remember being aware of any of the issues, in
11 particular, about Lucy in 2001, 2002?
12 A. I have to say I don't. Again I think the first occasion
13 that I became aware of some of the details, and again
14 I was at that meeting. I had an update in relation to
15 the UTV documentary. I don't recall any of the
16 details -- being previously aware of the details up
17 until that point. That's my recollection.
18 THE CHAIRMAN: Okay. Thank you. We are going to break for
19 lunch. Do you mind if we cut it to 45 minutes; is that
20 a problem? Is that okay? So we will come back at 1.45.
21 Thank you.
22 (1.00 pm)
23 (The short adjournment)
24 (1.45 pm)
25 MS ANYADIKE-DANES: Good afternoon.

112

1 A. Good afternoon.
2 Q. I had been asking you about that e-mail and what you
3 might have wanted or would have perhaps even expected to
4 see in place if the Royal was going to prepare itself
5 for understanding the issues that were likely to be
6 aired in that programme.
7 You did then know from the e-mail I put to you right
8 towards the end that it was actually going to go out on
9 the 21st and what time it was going to go out.
10 A. Yes.
11 Q. Did you watch it then?
12 A. Again I just refer back to my witness statement.
13 I believe I did watch it that evening. Again, certainly
14 to the best of my recollection yes.
15 Q. I presume you would have wanted to.
16 A. Certainly given that I was aware it was going out and
17 given the nature of the concerns that were being raised
18 in the documentary, absolutely. So that's why I'm
19 certain -- almost certain I watched it that evening.
20 I would be surprised if I didn't.
21 Q. I understand that. When you watched it or ultimately
22 realised what was in it, if I can put it that way, what
23 was your immediate reaction to what ought to be
24 happening as a result of it?
25 A. I suppose it's very difficult, given the time that has

113

1 confidence.
2 A. I honestly, thinking back now, don't recall the exact
3 detail of the discussions that occurred at that time.
4 There were certainly discussions I recall at the --
5 there was certainly a briefing to the Trust board in
6 relation to the documentary. In relation -- in its
7 aftermath. I don't know how soon that meeting was
8 following the broadcasting of the documentary and the
9 Chief Executive at that time briefed the board around
10 the documentary and the nature of the allegations that
11 had been raised.
12 Q. Well, did you at least want to get hold of the records
13 in relation to those three children at the very least
14 and see exactly what they disclosed as to what had
15 happened and what lessons should have been learned that
16 may not have been learned?
17 A. I don't believe I did that at that time. I can't recall
18 doing that. I don't remember exactly the timescales. I
19 am sure you have the details, perhaps, there, but I do
20 recall certainly being aware that very shortly after the
21 broadcasting of the programme we were aware of ongoing
22 police investigations following the allegations that had
23 been made. I recall I was aware that a number of
24 members of the medical staff in the Children's Hospital
25 had been interviewed by the police, as I recall, and

115

1 elapsed, to remember what exactly was going through my
2 head at that time. I suppose there were a couple of
3 issues which I believe immediately occurred to me. One
4 was the one I mentioned earlier in relation -- firstly,
5 I did watch the documentary. I remember certainly the
6 impact of particularly the interview with one of the
7 mothers of the children that had died, which I think was
8 particularly poignant and obviously -- so that
9 registered with me. I was certainly concerned in
10 relation to the nature of the allegations that were
11 being read in the documentary and, as I mentioned
12 earlier in evidence, I was concerned what the potential
13 impact of those allegations might be by way of public
14 confidence in the services that we were providing and,
15 indeed, the integrity of those that were providing those
16 services.
17 Q. Yes.
18 A. I must say at the time I recall being somewhat
19 incredulous around the scale of the allegations that
20 were being made. I certainly do remember being -- that
21 I was very concerned. I think that's ...
22 Q. Yes. What steps did you want to take as a result of it?
23 I presume you thought that something ought to be done.
24 At the very least, finding out better what had happened
25 and perhaps addressing that issue of public trust and

114

1 I remember that shortly thereafter -- again I don't
2 remember the timescales -- that there was
3 an announcement of this public inquiry, but again I
4 don't recall that period of time, whether that was --
5 and I am sure you probably have those details.
6 Q. What I am trying to say is why isn't it a natural thing
7 do to say, "Let's get hold of the medical notes and
8 records. There is an allegation, not put too fine
9 a point on it, that all these children died of
10 a condition called hyponatraemia, which seems to have
11 passed by unrecognised in our hospital. Either it was
12 something that happened in our hospital or that process
13 had already started before they came to the hospital and
14 they died there, but there is some learning that seems
15 not to have carried forward?"
16 THE CHAIRMAN: Sorry. By the time of the documentary, this
17 was a matter of awareness because the hyponatraemia
18 guidelines been published. So it can't be that you
19 didn't know that -- it can't be -- you must have been
20 aware of hyponatraemia. Whatever you recall
21 specifically about the guidelines coming out, you would
22 inevitably have been aware, I take it, they were out.
23 A. Yes.
24 THE CHAIRMAN: And hyponatraemia had emerged, as an issue,
25 much prominently than it had done before.

116

1 A. That's absolutely true, Mr Chairman. My understanding
2 at that time was clearly following the guidelines coming
3 out in 2002 and around the assurances the department had
4 sought and we had provided was that clearly there was an
5 issue around the use of hypotonic saline in children in
6 particular and that at a particular point in time -- and
7 obviously these are matters for the inquiry to properly
8 consider -- there was a lesser degree of awareness,
9 shall we say, in relation to the risks associated with
10 that.
11 MS ANYADIKE-DANES: Dr McBride, that's not the point I am
12 asking you about.
13 A. Yes.
14 Q. Yes, that had happened and, as a result of what happened
15 if relation to Raychel and Lucy, the CMO set up
16 a working group and ultimately guidelines were published
17 in March 2002. That's not the point I am asking about.
18 The point I am asking about is your process, lessons
19 learned: at some point you would have thought you are
20 going to have to deal with the question of how this
21 could have happened in succession, three cases, and we
22 don't appear to have appreciated it was happening, and
23 properly disseminated information to alert others in the
24 community, whether it's just at our hospital, in other
25 hospitals, that there is a risk in relation to these

117

1 Q. Yes.
2 A. If it's the latter point, obviously the systems were, as
3 I explained earlier in taking you through the governance
4 arrangements within the organisations, were very
5 different now. I think there was a sense that whilst
6 the development of clinical governance and the
7 development of integrated governance was very much
8 a journey right across the United Kingdom, that we had
9 much more robust arrangements at present, i.e. at the time
10 of the broadcast of the documentary in 2004 than were in
11 place back in 1996. That's not to say there weren't
12 arrangements in place. It would be fair to say they
13 were less systematic in 1996.
14 Q. Precisely. All I am asking is whether you wanted to get
15 the papers up so you could see what failings there were,
16 if any. I am going to come to when the department
17 actually asked to you get the papers.
18 A. Sure. If I could expand on that: I think the point
19 is -- and perhaps I have not communicated it terribly
20 clearly -- I think the point ... As I understood it, as
21 the chairman intervened, the learning in relation to the
22 risks associated with the use of hypotonic saline had
23 already been identified. That learning already been
24 disseminated to the Health Service in Northern Ireland
25 and indeed disseminated in the Health Service in

119

1 matters. So it's the lessons learned point and
2 dissemination that I'm really asking you about.
3 A. Sure.
4 Q. Because that was one of the things in the -- in the
5 programme, and that's why I'm asking you: did it not
6 occur to you that -- not necessarily for to you do it
7 personally, but to call up the files so that you can see
8 what actually happened in the aftermath of those
9 children's cases?
10 A. I suppose maybe if I am understanding you correctly --
11 we are maybe talking about two separate elements in
12 relation to this in terms of learning. One was: what
13 was the immediate learning in relation to clinical
14 practice and how was that captured, identified,
15 disseminated in or around the time of those deaths back
16 in 1995/1996.
17 Q. Uh-huh.
18 A. I suppose the latter point is also around: what were the
19 systems -- maybe that's the point that you are making --
20 Q. Yes.
21 A. -- that were in place at that time --
22 Q. Yes.
23 A. -- which should have, could have, identified what those
24 issues are and disseminated that information within the
25 organisation and more widely.

118

1 Northern Ireland ahead of other parts of the United
2 Kingdom in that it had been identified here first.
3 I think I suppose my response to your question was:
4 there was a sense that that was a problem which had been
5 identified. Guidance had been issued, that guidance had
6 been implemented. The vulnerability in the system had
7 been addressed.
8 Q. Okay.
9 A. The question in relation to an analysis or understanding
10 of the governance arrangements at a time in 1996 when
11 those governance arrangements no longer existed was not
12 something which I suspect was viewed as -- would have
13 been a fruitful exercise in that those arrangements were
14 now much more robust. I think again there is also the
15 point that -- I don't know the timescales -- events very
16 rapidly overtook us in terms of, as I mentioned earlier,
17 we were aware of active police investigations at that
18 time following the allegation of the documentary and
19 shortly thereafter the Minister announced the public
20 inquiry.
21 Q. Let's pull this up. This is the letter from
22 Clive Gowdy, the permanent secretary, to the chair of
23 the Trust, 127-002-001. Here we are. It is dated 28
24 October, just within a week of the programme going out.
25 You can see what it says:

120

1 "The UTV Insight programme of last Thursday evening
2 made a number of allegations associated with the tragic
3 death of Lucy Crawford. The department is currently
4 considering how it should respond to these allegations.
5 Without prejudice to the outcome of these deliberations,
6 there is a need to ensure that all relevant records and
7 documents are secured so that, if necessary, they can be
8 made available for independent examination."

9 Then it goes on to say:

10 "... the department now requires you, as chair of
11 the Royal Group of Hospitals Trust to take whatever
12 steps are necessary to secure and keep safe all
13 documentation which is within the custody or control of
14 the Trust ... pertaining to the death of Lucy Crawford,
15 Raychel Ferguson or Adam Strain."

16 Then it goes on, in quite some detail, to enumerate
17 what those documents may be. Then over the page, if we
18 pull that up, 002:

19 "I would further require that you confirm to me in
20 writing that your organisation has taken the necessary
21 action and secured all relevant information by Friday,
22 5 November."

23 Then it says who it is being copied to. Why I was
24 asking you the question before and then have drawn your
25 attention to that is I have taken your answer to be

121

1 information. That would be my interpretation of that.
2 Q. Oh, yes. That's exactly correct. All I am asking you
3 is: given that the department thought there was still
4 some investigation that needed to be carried out in
5 relation to these three deaths and what their
6 implications are, given that they happened in the Royal,
7 did the Royal not think that at the very least it should
8 be calling up these documents in relation to these three
9 children and carrying out its own investigation?

10 A. Well, again, I don't believe that the letter suggests
11 that. If anything, it suggests that what is required of
12 the organisation is to secure the records and indeed
13 that the department is giving active consideration to
14 an independent review. Again, I can't recall the exact
15 discussions or indeed any discussion that has happened
16 at that time. I certainly wasn't party to anyone
17 between the department and the Trust in relation to or
18 indeed other organisations in relation to the plans for
19 the public inquiry. I don't know at that stage what
20 discussions, formal or informal, there had been in
21 relation to the consideration of a public inquiry.
22 I just don't know.

23 Q. I understand that.

24 THE CHAIRMAN: Let's move on. We have a lot of ground to
25 cover have this afternoon.

123

1 that, in terms of the lessons learned and how these
2 things happened and so forth, maybe the time has passed
3 and you don't feel -- I think you used the word
4 "fruitful". Here is a department that certainly feels
5 there is something that warrants investigation. In
6 fact, they've talked about independent, if necessary,
7 investigation. So the department thinks there is
8 something that needs to be investigated. It happens to
9 be in the Children's Hospital where all the three
10 children who are the subject of the documentary actually
11 died. Now that you see that, can you not see that maybe
12 the Royal itself should have been securing the documents
13 and instituting its own investigation?

14 A. With respect, I don't think that's what the letter
15 was -- unless I am misinterpreting. Again it was
16 a letter to the Chair Undoubtedly that letter would
17 have been discussed between the chair and Chief
18 Executive. I can't recall being party to that
19 conversation or indeed whether my views were sought.
20 They may have been; I just can't recall. My
21 interpretation of the letter is that the department is
22 signalling that it's actively considering what further
23 steps need to be required in relation to the allegations
24 that have been raised. It is basically directing that
25 the Trust take necessary action to secure all relevant

122

1 MS ANYADIKE-DANES: There is just one last point I have been
2 asked and that is: did you provide the confirmation in
3 writing that was sought? I beg your pardon. Do you
4 know if the confirmation was provided?

5 A. Certainly when a letter of that nature comes from the
6 department, I would certainly anticipate a letter of
7 confirmation was provided. I certainly don't recall
8 that.

9 Q. Would you expect to see a letter like this?

10 A. I may well have seen -- sorry. This letter or the
11 response?

12 Q. Well, both. Would you expect to see a letter like this?

13 A. I mean, the letter was addressed to the chair of the
14 Trust.

15 Q. Yes.

16 A. In such circumstances, it would not necessarily have
17 been copied to me as medical director. I mean, I have
18 no doubt that I was probably aware of this. I can't
19 specifically recall. I don't certainly specifically
20 recall being copied into the letter or indeed the
21 response. I may have been, but I wouldn't -- I wouldn't
22 expect necessarily.

23 Q. Okay.

24 A. I mean, just to expand upon that, because it is
25 an important point, I mean, obviously the department was

124

1 directing the letter to the chair of the board of the
2 organisation, who would liaise with the Chief Executive.
3 So this was clearly done on accountability lines into
4 the organisation. You know, I and the other executive
5 directors in the organisation are accountable to the
6 Chief Executive. So that was the direct mechanism for
7 the communication to be formally made into the
8 organisation.
9 Q. At any point, did it occur to anyone in the Trust that
10 there might actually be other cases?
11 A. It certainly didn't occur to -- well. Sorry. I don't
12 know how to answer that.
13 THE CHAIRMAN: I am not sure if it is helpful. Let's be
14 more precise. I am not sure if it is helpful to ask
15 Dr McBride if at any time it occurred to anybody in the
16 Trust, which employs thousands of people.
17 MS ANYADIKE-DANES: Those people in the trust who would have
18 the responsibility for governance issues. Sorry.
19 I should have been clearer about that.
20 A. Okay. Certainly, as I think back, I certainly have no
21 recollection of any discussions of that nature. I think
22 that certainly, as this was a very rapidly evolving
23 situation -- I mean, these were very serious allegations
24 that had been raised. This was a deeply disturbing
25 documentary, which raised very significant questions.

125

1 case there were queries from the public?
2 A. Again with the passage of time, I don't honestly recall
3 that. Certainly I believe the -- I would have been
4 surprised had there not been discussions of that nature,
5 because again that is something which, given the range
6 of service that the Royal provided over the years, there
7 had been experience of other --
8 Q. Did it involve you, those sorts of discussions?
9 A. Certainly those in the more recent past that I can
10 recall, yes. I honestly can't recall whether I was
11 involved in those discussions at that time.
12 Q. Okay.
13 A. But certainly generally when those were of clinical
14 concern and clinical matters, yes, I would have been
15 involved in those, yes.
16 Q. Well, in due course, Claire's parents do contact the
17 Royal.
18 A. They do, yes.
19 Q. And is that brought to your attention that they have?
20 A. It is, yes.
21 Q. And you set up or you institute a review the case notes.
22 A. Yes.
23 Q. I think there's an e-mail from you that might help.
24 It's from you to Dr Steen and I think we see it at
25 witness statement 177/1 at page 54. We may just have to

127

1 The department and clearly, you know, the Minister had
2 intervened. I think the -- again this is -- I mean,
3 again I suppose I am trying -- I don't clearly recall.
4 So I am just trying to fill in some of the detail, but I
5 think there was probably a sense that this was something
6 that was going to be subject to a significant
7 independent process. There could be -- if indeed there
8 was going to be an independent process looking at this.
9 Q. Uh-huh.
10 A. And again it would be conjecture on my part and maybe
11 that would be inappropriate, but I think that we as
12 an organisation would be anxious not to seek to
13 compromise or prejudice any other process that the
14 department might want to put in place.
15 Q. Uh-huh.
16 A. And certainly what was being required of the
17 organisation and was being directed from the highest
18 level from the permanent secretary of the department to
19 the chair was that the action required was to secure all
20 records and the department's giving consideration to the
21 next steps.
22 Q. You have described it as deeply disturbing and that very
23 serious allegations were made and there were very
24 serious issues involved. When you did see it, did you
25 have any thoughts as to what ought to be put in place in

126

1 blow that up. It is actually the one at the bottom
2 I think. Do you see there "2nd November"?
3 A. Yes.
4 Q. It's your e-mail to Heather Steen. Then if one looks at
5 the second paragraph:
6 "... enquiry from parents in relation to the death
7 of their daughter ... from the brief description of the
8 case that I received there would appear to be a causal
9 element for SIADH with the presence of a low-grade
10 meningoencephalitis at post-mortem. Whether or not
11 fluid and electrolyte balance was a contributory factor
12 would need to be established."
13 Then you go on to say:
14 "Can I ask, in the first instance, to review the
15 notes? If there is any reason to suggest that fluid or
16 electrolyte management may have been a factor in this
17 case, then I would suggest that you ask Peter Crean, as
18 the clinical governance lead, Professor Ian Young,
19 Elaine ..."
20 That's Elaine Hicks, isn't it?
21 A. Yes.
22 Q. "... and Brenda Creaney to carry out a case note review
23 to determine whether this case needs to be referred to
24 the coroner."
25 So was the first information gathering, if I can put

128

1 it that way, really a case review from Dr Steen with her
2 then to decide whether she would wish to bring in those
3 other individuals that you've mentioned?
4 A. No. I mean, I think -- I mean certainly what I have
5 asked Dr Steen -- Dr Steen was the responsible
6 clinician. She was the treating clinician in Claire's
7 case. What I had asked her to do was look at the notes
8 and, indeed, if there was any suspicion of any
9 implication that fluid management may have been a factor
10 in Claire's deterioration and death, then what I was
11 suggesting clearly there was -- was advising, sorry --
12 was a number of other named individuals would assist
13 that process.
14 Q. Did you have in mind that they were a pool of people
15 from whom one would help or did you think it was
16 appropriate that perhaps if there was an issue to do
17 with fluid and electrolyte management that they would
18 all be contacted?
19 A. Well, my -- I mean, what I had intended was certainly
20 that the named individuals would all be contacted.
21 Basically, as we alluded to earlier, one of the
22 processes which certainly I led the introduction of in
23 the Trust was that of root cause analysis, which is
24 obviously a methodology which sort of takes a system
25 approach and uses a problem-based methodology to

129

1 she was a consultant neurologist.
2 Q. And Dr Steen took over from her effectively?
3 A. That's correct.
4 Q. Brenda Creaney, she is director of nursing; is that
5 correct?
6 A. Not director; she was, I think, divisional director of
7 nursing.
8 Q. So these were the people that you thought would be
9 appropriate to have involved in process; is that
10 correct?
11 A. That's correct, yes.
12 Q. Did you, in fact, know whether Dr Steen thought that
13 there was a fluid and electrolyte management issue?
14 A. I can't recall at that time. I mean, in terms of the
15 timeline on 2 November or subsequently.
16 Q. Do you know how it came to be that Professor Young was
17 involved to provide an opinion on that very issue and
18 that Peter Crean, Elaine Hicks and Brenda Creaney don't
19 appear to have been involved thereafter -- following
20 this suggestion. Do you know that happened?
21 A. I don't. Certainly, I know -- I think I can perhaps
22 assist, but I don't know with any certainty, but
23 certainly in respect of Professor Young, I recall that I
24 contacted Professor Young myself. Given that I was
25 looking for his expert independent opinion in terms of

131

1 identify what problems have occurred and what the
2 learning might be.
3 Clearly this was a case where Claire's parents had
4 raised very significant concerns in relation to the
5 cause of death. They were significantly concerned, as
6 I recall, that hyponatraemia and fluid management would
7 have been a -- was a factor in her death. Certainly
8 what I was indicating here was that -- a request to
9 Heather to have a look at the notes and to ascertain
10 whether there was any cause for the parents' concern.
11 Obviously with the benefit of the knowledge we had
12 in 2004 as opposed to that in 1996, and indeed if that
13 was the case, if there was any suggestion that
14 hyponatraemia and fluid management was a factor, to get
15 together a group of individuals to go through the case
16 notes and assist through that route.
17 Q. If we just deal with who these individuals were. Peter
18 Crean, he is the clinical governance lead at the time.
19 A. Yes.
20 Q. Professor Ian Young, he is at Queen's, but also has
21 a position at the Trust.
22 A. Yes. Yes, he is a professor of medicine and a clinical
23 biochemist.
24 Q. Elaine Hicks. Her position at that time?
25 A. Elaine was the former clinical director. At that time,

130

1 whether or not hyponatraemia and fluid management had
2 been a factor, he was the only one of those individuals
3 that I contacted. I didn't contact the other named
4 individuals.
5 Q. Do you know why it fell to you to do it and Dr Steen
6 didn't do it?
7 A. I suppose it was a -- I mean, I was asked -- I mean,
8 obviously all of the other individuals worked within the
9 Children's Hospital. Dr Steen was obviously Claire's
10 clinician at the time, but she was also the divisional
11 director within the Children's Hospital in a managerial
12 capacity. Professor Ian Young, you know, was
13 independent from the Children's Hospital. He didn't
14 work in the Children's Hospital. As a professional
15 courtesy, I contacted him and asked if he would assist
16 in this.
17 Q. The reason I ask you this is the way this appears to be
18 framed is if those people were only going to be
19 contacted if Dr Steen thinks there is a fluid and
20 electrolyte management factor in the case. So if, for
21 example, she had contacted you and said, "Well, I have
22 had a look at those notes and actually there is nothing
23 in that point. There isn't a problem with that, it's
24 something else", then presumably you wouldn't be
25 troubling Professor Young.

132

1 A. I mean, maybe if we could go back one step. I think
2 it's in my witness statement, 269-1. I think I was
3 asked -- I don't know if it's in the early pages that
4 have -- whether or not I had actually considered
5 Claire's notes. Obviously, I am not a paediatrician. I
6 am not an expert in fluid and electrolyte management,
7 but I had considered Claire's notes and certainly, on
8 the basis of my consideration of those notes, I felt
9 that there was at least the possibility that, looking at
10 the notes from the perspective of 2004, that fluid
11 management and hyponatraemia may have been a factor in
12 Claire's death. Now, obviously I was not in a position
13 to provide an expert interpretation, but certainly it
14 was something which needed to be considered, and in my
15 view, either we could exclude that, and if we couldn't
16 exclude it, then we had both a statutory and a
17 professional duty to report Claire's death to the
18 coroner for further independent investigation.

19 So essentially I was asking Dr Steen consider the
20 notes as the treating clinician, to form a view, because
21 she was clearly better placed than I was as an adult
22 physician and someone who had never worked with children
23 and someone who would have been very intimately aware of
24 other factors and clinical aspects of Claire's care, but
25 certainly I had every expectation -- maybe that's too

133

1 certainly this is something that needed a closer
2 examination.
3 Q. Thank you. So far as you are aware, were the other
4 clinicians ever contacted?
5 A. I honestly don't know the answer to that. I think --
6 I suspect what happened, and that's why I mentioned
7 earlier that it may be conjecture on my part. I don't
8 know exactly when Professor Young became involved in
9 terms of considering the notes, but certainly it rapidly
10 emerged, I think, once we had Professor Young's input
11 that certainly hyponatraemia and fluid management could
12 not be excluded as a contributory factor and clearly
13 then events had overtaken us at that point. There was
14 clearly a requirement then to report Claire's death to
15 the coroner for further independent investigation.
16 Q. Professor Young didn't provide a written opinion and I
17 think in your witness statement, or in the witness
18 statement at 178/1, page 3, that's his -- we don't need
19 to pull this up -- he says his advice was given verbally
20 over the telephone.
21 A. I don't certainly recall --
22 Q. Oh, well, let's pull it up. 178/1, page 3.
23 THE CHAIRMAN: You don't recall that?
24 A. I don't recall whether the information was conveyed by
25 telephone or whether it was subsequently at a meeting.

135

1 strong a way of putting it -- I certainly felt that if
2 indeed my initial consideration of the notes and my
3 non-expert view was that that couldn't be excluded, then
4 I felt that there was a need to carry out a more
5 in-depth analysis of the notes and indeed that that
6 would require a multidisciplinary input from a range of
7 individuals.

8 Q. Yes. So far as you can recall, did you actually have it
9 a little higher than it couldn't be excluded?

10 A. Sorry?

11 Q. Did you have it any higher than it simply couldn't be
12 excluded? Did you actually have it as factor
13 potentially?

14 A. Certainly what I recall at the time was I certainly saw
15 the cause of death as being cerebral oedema.

16 Q. Uh-huh.

17 A. I recall noting from the records that fluids low in
18 sodium had been administered and I recall that there was
19 at least one low serum sodium in the chart. Now, I am
20 not an expert --

21 Q. No, I understand.

22 A. -- but certainly at least from that sort of very
23 superficial consideration of the notes -- and I use
24 "superficial" not in any sort of casual sense, but
25 certainly from a level of my knowledge -- I felt that

134

1 I mentioned this in my own witness statement. I do
2 recall a meeting in and around when I was asked --
3 I certainly recall requesting a meeting and, from
4 memory, I do recall a meeting in and around 6 November,
5 which was prior to the meeting with Claire's parents.
6 So I certainly met with him at that stage to discuss his
7 expert opinion and interpretation.

8 Q. What Professor Young says is:

9 "My recollection is that this advice was given
10 verbally by telephone and that no specific written
11 advice was provided to him."

12 That's to you. Does that recollect with you not
13 recalling you ever having received written advice?

14 A. I thought the question you were asking was in relation
15 the telephone conversation that -- this is in relation
16 to written advice.

17 Q. Yes.

18 A. I certainly did not receive written advice from
19 Professor Young, if that is the question.

20 Q. Yes, it is. Given the view that he formed and the
21 significance of that view, did you think that it would
22 be appropriate to receive that in writing?

23 A. I think, I mean, that didn't occur to me at that time to
24 receive that in writing. I certainly didn't request it
25 in writing. I have to say it didn't occur to me to

136

1 request it in writing. I suppose I felt that what there
2 was now was a requirement to refer Claire's death to the
3 coroner for further independent investigation to
4 determine what the cause of death was and certainly, as
5 indicated in my own witness statement, which you may
6 wish to pull up, in relation to coroner's inquest -- the
7 referral to the coroner -- I felt that was the
8 appropriate thing to do at that stage. So I think
9 events rapidly overtook us. Once we had identified that
10 there was a clear requirement to report the death to the
11 coroner, then that's what we did.

12 Q. Yes, that's correct. You did do that. I am just
13 wondering because there has now emerged, between the
14 recollections of you and Professor Young, some slight
15 differences as to exactly what happened and so forth in
16 relation to this. Probably not very significant
17 differences.

18 A. Sorry. The differences are?

19 Q. Let's do them quickly since --

20 THE CHAIRMAN: I agree with you; they are not significant.

21 MS ANYADIKE-DANES: We can move on.

22 The issue was, because these sorts of things can
23 happen, is it not always prudent to have these sorts of
24 things reduced to writing, but we can move on.

25 One of the issues was whether the decision had

137

1 I think at page 7, at (e), you see my response --

2 Q. Yes.

3 A. -- which I have indicated. I think also if you -- if we
4 go across to the minute of the meeting of 7 December as
5 well -- I am just trying to find it -- it's 10 is it?

6 THE CHAIRMAN: That's Mr and Mrs Roberts' list of issues.

7 A. Apologies.

8 THE CHAIRMAN: Don't worry. I know where you are taking us
9 to, you just have slightly the wrong reference.

10 A. Apologies. Certainly, if we were to look at the meeting
11 of 7 December. Don't worry. I have given you the wrong
12 reference. Apologies.

13 MS ANYADIKE-DANES: 089-002-002 is the start of it. It is
14 on the first page.

15 A. I think it might actually be on page 3.

16 Q. I think if you go on to the next page --

17 THE CHAIRMAN: Paragraph 5 actually. I am sorry. It is the
18 next page again, 004. It is page 3 of the note, but not
19 page 3 of our ...

20 Q. It is in the third paragraph on this page:

21 "Professor Young advised Mr and Mrs Roberts that the
22 Trust wants to be completely open about this case and
23 therefore will have to approach the coroner for advice
24 on the best course of action".

25 So this was Professor Young saying that the Trust

139

1 already been made to report or refer the matter to the
2 coroner, or whether during the meeting with the
3 families, or the family, they were going to be asked
4 about that, their view was going to be sought as to
5 that. That seems to be a point of difference. The
6 reason why I ask you is: surely the family's -- let me
7 just give you the point. Surely the family's view as
8 to whether it should or should to the be referred to the
9 coroner is irrelevant.

10 A. Absolutely. I think -- maybe if I could -- I mean,
11 I wouldn't quite put it in those terms. Well -- I mean,
12 I think that I was very sensitive to the fact that we
13 had parents who were distraught and I understood, from
14 what information been communicated to me by
15 Professor Rooney, who were both dignified but upset and
16 distressed following the documentary in relation to the
17 similarities to Claire's death. They had raised genuine
18 concerns. I certainly was not going to refer Claire's
19 death to the coroner without them being aware that the
20 Trust now had decided and directed that that would
21 happen. I mean, if I could refer to my witness
22 statement 261, page 7, if I may.

23 Q. Of course.

24 A. And I think if we also pull up the minutes of
25 7 December, if we could, in the second box, 089-003-007,

138

1 was going to contact the coroner and it would then be
2 for the coroner to decide whether to hold an inquest,
3 which is the normal way forward.

4 A. I think if you go to the e-mail to Professor Steen we
5 had up a moment ago, I think it states on the second
6 page -- I can't remember the exact wording -- I think it
7 also clearly states that if hyponatraemia and fluid
8 management, can't be excluded, that we would be
9 referring the case to the coroner. Indeed, it is also
10 reflected in the letter to Mr and Mrs Roberts dated
11 17 December, 139-145-001. So I think that certainly
12 I was absolutely clear, as I mentioned in my witness
13 statement, just where you read the second
14 paragraph there:

15 "In such circumstances, it is necessary for the
16 Trust to report the death to the coroner for further
17 investigation. I can now confirm --"

18 What I am simply advising and stating in this letter
19 is that:

20 "With your permission, we have communicated to the
21 coroner that you are content with this ..."

22 I was well aware in terms of previous dealings with
23 the coroner that he would wish to be sensitive to the
24 views of the family and, indeed, I was very conscious of
25 the circumstances in which the family had approached the

140

1 Trust. I certainly wanted the family to be aware of the
2 fact that we had determined that we were sending the --
3 Q. We are at cross purposes. I think you, in your
4 evidence, have always been absolutely clear that once
5 you got the information from Professor Young, this was
6 going to have to be a matter that was referred to the
7 coroner. The only point -- and we don't need to go into
8 it in greater detail -- is just a finessing point as to
9 how Professor Young thought he was presenting it to the
10 family. I only wanted to raise that because, if things
11 are reduced to writing, then it becomes less easy for
12 there to be differences of view as to what's going on,
13 but the chairman has a point. So we don't need deal with
14 that.
15 A. Okay.
16 Q. But what I wanted to ask you about, though, was a point
17 that Professor Young has made. We see it at
18 139-153-001. Thank you very much indeed. This is from
19 Professor Young to you and this is dealing with
20 a meeting in relation to Dr Steen. So he has met with
21 Dr Steen in the afternoon. They have reached some
22 measure of agreement about the role of hyponatraemia.
23 Then it goes on. She is going to present the clinical
24 journey, he is going to deal with fluid issues. Then he
25 says:

141

1 certainly it was -- I mean, I think we are talking about
2 sort of shades here. I don't think there was any
3 fundamental or major difference of view that may well
4 have been a factor.
5 THE CHAIRMAN: It was described last week as a matter of
6 emphasis.
7 A. That was my interpretation and that was my
8 understanding. I mean I know that -- I have been trying
9 to follow some of the proceedings, but certainly that's
10 not -- my recollection was there was no major
11 disagreement here. What there was was, you know, shades
12 of emphasis in terms of the relative contribution
13 hyponatraemia played. That was not for the Trust to
14 determine. What I felt our responsibility was was to
15 ascertain whether or not we could exclude hyponatraemia
16 and fluid management as a contributory factor and, if we
17 couldn't exclude it, then we had a requirement, both
18 a statutory requirement and a professional
19 responsibility, which I have outlined in my witness
20 statement, to refer the matter to the coroner because in
21 my view it was for the coroner to investigate and
22 determine the cause of death and the relative
23 contributions.
24 Q. Do you know if there was any note made of that meeting
25 that was ever provided to you?

143

1 "Heather has definite views about the significance
2 of the fluid management, which are not quite the same as
3 mine."
4 Did you know what those views were?
5 A. I think my recollection of Claire's case is that it was
6 complex. There were clearly a number of at least
7 differential diagnoses that were being considered and
8 indeed being actively treated. Obviously the inquiry
9 will look at the details of those and it is for the
10 inquiry to determine that, but it is an important point,
11 because I think that complexity, and indeed in any
12 clinical situation where there is complexity, there will
13 often be a difference of level of significance to one
14 factor or another factor. Certainly, you know, if the
15 question is: was there significant disagreement between
16 Dr Steen and Professor Young, no. That was not my
17 impression, but I think that there was a difference of
18 interpretation, given the relative significance of the
19 hyponatraemia and fluid in Claire's death. I think it
20 was simply no more than that.
21 Q. Did you understand what that difference was? That was
22 my question to you.
23 A. I think in terms of -- I think that Professor -- my
24 recollection is that Professor Young felt that it may
25 have played a greater role than Dr Steen felt, but

142

1 A. I don't recall any note being provided to me. I mean,
2 I appreciate with the passage of time that has been
3 a difficulty in assisting the inquiry. I appreciate
4 that obviously memories of what was said and when and to
5 whom at times has been problematic. Certainly, I think
6 it's a reflection -- meetings of this nature would not
7 always have been minuted or noted. Clinical notes, yes,
8 but interactions of this nature would not always have
9 been recorded.
10 Q. When you hear there's a fluid management issue and that
11 that might have played a role, that's a matter within
12 the control of the clinicians. So that could bring with
13 it suggestion of lack of appropriate care, potentially
14 even negligence; isn't that right?
15 A. I suppose that's one possibility, yes.
16 Q. Yes.
17 A. But I think that -- Mr Chairman, if you'll allow me to
18 expand: this was a matter which we had now referred to
19 the coroner for further independent investigation.
20 Q. Yes.
21 A. I mean, I had made that decision. It was right and
22 proper that the coroner investigated it.
23 Q. Yes. I am not --
24 A. Irrespective what have come thereafter, it was now
25 a matter for the coroner to investigate with appropriate

144

1 independent expert opinions to form a view and indeed
2 whatever the outcome of that process was was the outcome
3 of that process.
4 Q. That's a slightly different point and we will get to the
5 difference between what the Trust should or ought to
6 have been doing and what the coroner does and when those
7 things happen. That's a slightly different point, but
8 at this stage, if you are told there's a fluid
9 management issue, particularly a significant one,
10 I think you have just accepted that that could involve
11 negligence. So the next thing that happens after this
12 e-mail that you have received from Professor Young is
13 that there is the meeting with Claire's parents --
14 A. Uh-huh.
15 Q. -- on 7 December.
16 Dr Rooney, of course, goes that meeting. Dr Sands
17 goes to that meeting. Dr Steen and, of course,
18 Professor Young are there. Did you know before that
19 meeting took place who was actually going to be there?
20 A. I can't be certain, but I believe I did, yes.
21 Certainly, as I mentioned in my -- sorry -- indicated in
22 my witness statement, I believe there was a meeting in
23 or around 6 December.
24 Q. Yes.
25 A. And I -- in my witness statement, my recollection was

145

1 although again I may be mistaken in my recollection, but
2 I recall that Dr Steen suggested that Dr Sands be
3 present at the meeting.
4 Q. Yes, you are correct about that.
5 A. As I recall -- and that's why I assumed -- tried to put
6 back together again that Dr Steen was present at the
7 meeting on 6 December, or in or around 6 December,
8 because my recollection is that Dr Steen had suggested
9 that because Dr Sands knew the family and knew the
10 family and remembered the family from the time that
11 Claire was in hospital.
12 Q. Did it occur to you that if there was even a potential
13 issue to do with negligence, it might have been helpful
14 to have had another consultant clinician there? I mean,
15 Dr Rooney is playing a very specific role. She is there
16 supporting and assisting the parents and she is going
17 chair the meeting as well. Professor Young is playing
18 a very specific role from your point of view. You have
19 brought him in for specialist advice and he is going to
20 explain the view he has formed which has triggered your
21 decision to refer to the coroner. He is going to
22 explain that to the family. Dr Steen and Dr Sands --
23 Dr Steen was her consultant and Dr Sands was partly
24 involved in her treatment, but given there might be
25 a potential issue -- didn't know at this stage, but

147

1 that ... I think my recollection was that both Dr Steen
2 and Professor Young were at that meeting. Looking
3 through e-mail trails, et cetera, I see that that was
4 perhaps a mistaken recollection of who was present at
5 the meeting.
6 Q. From a governance point of view and from the other
7 responsibilities that you had as medical director, did
8 you have a view as to who you thought it was appropriate
9 should be at that meeting?
10 A. I mean, certainly, and again I've mentioned this in my
11 witness statement, what I'd asked was that
12 Professor Rooney would act to support and liaise with
13 the family.
14 Q. Yes.
15 A. I felt it was important there was a single point of
16 contact with the trust.
17 Q. Uh-huh.
18 A. Professor Rooney was someone who you knew and respected
19 professionally in her role as clinical psychologist and
20 had been of assistance in terms of assisting many
21 patients on some very difficult and challenging issues.
22 So I directed that she would act in that capacity to
23 continue to liaise and support the family. I indicated
24 that I wished her to be at the meeting and I indicated
25 that I wanted Professor Young and Dr Steen. I believe,

146

1 there might be -- did it occur to you it might be
2 appropriate to have another consultant clinician there?
3 A. It didn't in all honesty, but I suspect probably my
4 rationale was that -- and again obviously it is a matter
5 for the inquiry -- my understanding certainly from the
6 case note review was that we couldn't exclude
7 hyponatraemia and fluid management as a contributory
8 factor to Claire's death. We needed to refer her death
9 to the coroner for that to be confirmed or not.
10 Q. Yes.
11 A. My understanding was that the issue and the
12 vulnerability in that that may have created those
13 circumstances was that the practice as it was at that
14 time in relation to the administration of intravenous
15 fluids, particularly in children and particularly the
16 use of hypotonic fluids.
17 Q. Yes.
18 A. So in relation to -- I did not at that stage feel that
19 although again it remained to be determined by the
20 coroner, that there was likely to be issues pertaining
21 to clinical negligence. However, I accept that that --
22 your analysis that that may well have been the
23 conclusion following, you know, the coroner's inquest or
24 whatever the coroner's verdict was. Indeed, I suppose
25 with hindsight, there may have been other issues that

148

1 arose as a result out of the coroner's inquest. At that
2 time, my understanding was that it was an issue which
3 had arisen as a result of clinical practice throughout
4 the UK at that time in terms of the use of intravenous
5 fluids. That was my understanding, but I accept the
6 point that you are making.

7 Q. Thank you. Just give me one moment. (Pause).

8 So there is a meeting and the minutes are taken.
9 Did you see Dr Rooney's minutes of the meeting?

10 A. I can't recall whether I saw them, to be honest. I am
11 sure you probably -- I don't know if there is an e-mail
12 suggestion that I did. I don't honestly -- I don't
13 recall seeing the minutes, but I may well have been
14 copied in on them.

15 Q. Well, would you have wanted to know what happened?

16 A. Oh, yes. Let's be clear of this: I was kept fully
17 informed by Professor Rooney and, indeed, I indicated
18 that in my letter to Mr and Mrs Roberts on 17 December.

19 Q. If you were being kept informed in the way that's
20 recorded in the minutes -- if we pull up 089-002-002,
21 you can see that Dr Rooney felt that there were
22 questions that Mr and Mrs Roberts felt still remained
23 unanswered regarding Claire's death and that:

24 "They will be addressed and that the Trust will meet
25 with them at any time [it goes on] to help them in any

149

1 aware of that, yes.

2 Q. Well, did you see the letter that came back from
3 Mr Roberts, which is really -- in fact, you just pulled
4 it up thinking it was Dr Rooney's minute, but really
5 setting out what -- summarising what he says happened
6 and indicating the queries that remained for them. Did
7 you see that? I can put it up. In fact, I should do
8 that.

9 A. I can't recall whether I saw it. There is no reason why
10 I wouldn't have seen the letter, but I can't recall
11 actually ...

12 Q. I understand. Let me pull it up. It is 269/2, page 13
13 and if we can pull up page 14 alongside it. So there we
14 were. It is from both Claire's parents. It summarises,
15 in point form, the information that they gathered and
16 includes in that under those headings the further
17 queries that they have. If you didn't actually see this
18 letter, presumably the issues that it raises would have
19 been communicated to you.

20 A. I honestly can't recall in all honesty. I think that --
21 I mean, I was being kept apprised of this.

22 THE CHAIRMAN: Can I take it then, if you were being kept
23 apprised, that you would have known from
24 Professor Rooney, probably most directly from
25 Professor Rooney --

151

1 way possible and the Trust wants to be completely open
2 about the case. We will be happy to meet Mr and
3 Mrs Roberts."

4 That's the tenor of what's happening there and you
5 wouldn't demur from that?

6 A. No.

7 Q. That indicates that they still had questions, not
8 withstanding having the meeting with those people
9 present to try to help them with the queries. They
10 still had questions at the end of this meeting, and you
11 would have appreciated that.

12 A. Certainly from memory I was aware that following the
13 meeting there was a letter came that from Mr and
14 Mrs Roberts requesting -- with some further questions
15 seeking some further clarification on a number of
16 issues. I don't recall at the time -- sorry. I have no
17 recollection, but I note from the e-mails, because I
18 have looked at those e-mails on -- that are available,
19 that communication between Professor Young and
20 Professor Rooney in relation to that and how best to
21 address those questions and whether to write and answer
22 those questions or to arrange to meet with the family
23 again. So I can't recall being aware, but certainly, as
24 I have read through those, I feel -- I don't recall with
25 clarity, but I have no doubt that I would have been

150

1 A. Most probably, yes.

2 THE CHAIRMAN: -- that there had been a meeting, that Mr and
3 Mrs Roberts had come back with a list of queries and she
4 was going to liaise with Dr Steen and Professor Young in
5 responding to those?

6 A. I certainly would have been aware of that, yes, but
7 again I can't recall the specifics or the details of the
8 letter --

9 MS ANYADIKE-DANES: I understand.

10 A. -- not having been at the meeting or indeed being
11 familiar with the clinical details, I wouldn't have been
12 in a position to comment on that or ...

13 THE CHAIRMAN: Okay.

14 MS ANYADIKE-DANES: I understand, but if we deal with it as
15 a matter of process, you would have known a meeting
16 happened. Minutes were taken of the meeting and the
17 upshot of it was the parents had responded, they still
18 had further questions and issues and you were aware of
19 that.

20 A. Yes and it would have been highly irregular in the
21 circumstances if I had not been kept informed or
22 aware --

23 Q. And irrespective of what was happening with the coroner,
24 presumably in the requirement to be open and so forth
25 with the family, you would have wanted their queries to

152

1 be addressed in so far as they could be.
2 A. Yes. Absolutely.
3 Q. In one -- although you didn't see this or can't recall
4 seeing it -- you have, of course, seen it since, haven't
5 you?
6 A. Yes, I have.
7 Q. You will be aware, as one goes through it, that there
8 was more that concerned Claire's parents than just the
9 matter of hyponatraemia. If I give you an example.
10 A. Well, I see paragraph 4, yes: anticonvulsants and
11 antibiotics.
12 Q. If one looks at paragraph 10, for example, you can see
13 there -- well, actually if one looks at paragraph 6 --
14 let's go to that. Paragraph 6 is an issue as to how
15 accurate was the information they were being given as to
16 the seriousness of Claire's condition. You can see
17 that:
18 "During that time we were not unduly worried about
19 Claire's condition and no indication or concern was
20 directly expressed by any doctor."
21 So that's a concern as to communication between the
22 clinicians and the parents, which doesn't have anything
23 to do with hyponatraemia, but it is a matter to how you
24 keep parents informed. Then it goes on:
25 "If Claire's condition was considered as dangerous

153

1 an answer. If it was the intention that the Royal would
2 provide answers in so far as it could to these concerns
3 of the families or any family, then how was that going
4 to be addressed? How were these broader concerns, so
5 far as you were aware going to be addressed? You dealt
6 with the hyponatraemia one, but how were these broader
7 concerns going to be addressed?
8 A. I think if I take a step back, because I think there's
9 a point of context, chairman, which I think might be
10 helpful in terms of understanding the issues at that
11 time.
12 Q. Uh-huh.
13 A. At this time -- I think if you go back to my e-mail of
14 2 November, I certainly had at least a sense that
15 Claire's death required to be reported to the coroner.
16 Obviously, that remained to be established from the case
17 note review. Subsequently, that was established and we
18 subsequently did that. At that stage the public inquiry
19 had also been announced. At that time there was also
20 a police investigation ongoing in relation to the
21 allegations that had been made following the UTV Insight
22 documentary, and if could I maybe call up some e-mails
23 which -- sorry. Maybe if I call up witness statement
24 269/1, page 9, it may be the next one. Apologies,
25 chairman. I seem to be giving you -- I think it is

155

1 or serious on Tuesday the 22nd, why was this concern not
2 urgently highlighted to my wife and I? Why was Claire
3 not admitted to intensive care if her condition was
4 serious?"
5 So that's another issue as to whether she should
6 been admitted to intensive care earlier. That's
7 a separate issue. Then if one goes down to 10, where
8 I was taking you to, they ask -- you see that
9 paragraph is about three separate but unnumbered
10 paragraphs. About halfway down the first one they talk
11 about how they:
12 "... struggled for over eight years to understand
13 and accept how an unknown viral infection could be the
14 cause of Claire's death and are again devastated to
15 realise that hyponatraemia now appears to be a more
16 accurate cause. Will the cause of Claire's death be
17 reviewed by the Belfast Royal Hospital?"
18 That's one issue. They want to know what the
19 hospital is going to do about that. They already know
20 you have referred it to the coroner. Then they ask the
21 question:
22 "Why did it take the broadcasting of a television
23 programme to raise issues and concerns regarding the
24 death of our daughter?"
25 That's an issue that requires, they would consider,

154

1 page 13. Apologies. Yes. Just the middle paragraph,
2 about halfway down 27 there:
3 "My experience with Claire's case ..."
4 I mean, at that time right across the UK and indeed
5 locally there was quite a significant view in relation
6 to coronial processes in terms of the investigation of
7 hospital deaths and death certification, as you will
8 have been aware from the loose(?) review which extended
9 into Northern Ireland, the subsequent Home Office paper.
10 Indeed, there were local plans to review the coronial
11 system at that time. The difficulty in the -- in
12 Claire's case is that there were a number of potential
13 issues here in terms of parallel investigations and the
14 potential for that, particularly in relation to
15 investigations that were now underway or would be
16 shortly underway, subject to the view of the coroner,
17 the potential for police investigations thereafter,
18 depending on the findings of the coroner, and indeed
19 I had, I think, a real, you know, sense that -- from
20 certainly Mr and Mrs Roberts at that time that they
21 wished this inquiry to consider the death of Claire. So
22 it was quite clear that this was -- this case and the
23 context in which it was happening was very difficult
24 and, as I have highlighted there on page 13, it was
25 certainly not a situation I had encountered before.

156

1 I had been a medical director in the Trust for two years
2 at that stage. There was no guidance in relation to
3 what course of action to take in such circumstances.

4 In terms of which investigation had priority, I was
5 very conscious of the potential to compromise or
6 prejudice any subsequent statutory investigations,
7 whether that would be as a result of the
8 PSNI investigations or indeed as a result of
9 investigations of this inquiry. If you look at -- if
10 I could call up perhaps -- I think it might be helpful
11 to illustrate the context -- witness statement 262,
12 pages 68 and 70, and I think we will see in the first of
13 those there's an e-mail from me to the department.
14 I think it's the -- sorry. I don't know if you can go
15 back through the sequence of that. Sorry. That is the
16 reply. Anyway I suppose this makes the point,
17 essentially, on 13 October, I was writing to the
18 department in relation to another case indicating that
19 there was a need for clarity and guidance in relation to
20 deaths which required more than one organisation to be
21 actively involved in an investigation of the
22 circumstances of those deaths.

23 Clearly, as an organisation, when such incidents
24 occur, our priority is patient safety. Our priority, as
25 I indicated when I was medical director in the

157

1 why you are referring to that is because -- if you give
2 us page 69 as well, please -- this is when you talked
3 about going back through the trail [OVERSPEAKING] --
4 this is the bottom half of page 69.

5 In effect, one of the sources of this concern is:
6 "At a recent inquest, an internal root cause
7 analysis been used and, from the Royal's perspective,
8 had perhaps added to the complexity or difficulty of the
9 inquest."

10 One of the tensions here is: if you want people to
11 speak freely in terms of root cause analysis, will they
12 speak freely if that is not a privileged document and
13 then ends up before the coroner? In a sense, it is
14 a variation on something we have been hearing about over
15 the last number of weeks about grand round reviews and
16 so on, where people may not speak freely if they then
17 realise they or their colleagues are going to be
18 criticised.

19 A. The point is not in relation to one of privilege. You
20 see in the bottom paragraph there on page 68 I am very
21 clear that we had sought advice. There is no issue of
22 privilege. I am saying it would be counterproductive,
23 indeed difficult, to claim privilege. The point is
24 these documents are publicly available in the public
25 domain. My concern was that we were actually going to

159

1 organisation, was to seek to investigate those deaths,
2 to ensure lessons were learned, to ensure that we could
3 prevent a recurrence.

4 Claire's death was somewhat unusual in that the
5 death had occurred in 1996. It was now being brought to
6 my attention. As a result of the parents -- and that is
7 absolutely correct -- raising concerns, it had been
8 referred to the coroner, but there was no guidance in
9 relation to how such complex investigations should be
10 conducted to ensure that any patient safety issues were
11 identified and that learning was disseminated, to ensure
12 we didn't prejudice or compromise any police
13 investigations or indeed subsequent investigations by
14 this inquiry.

15 Again you can see here that I'm requesting --
16 I think you can see it in the earlier version of this
17 e-mail -- that we needed a memorandum of understanding
18 between all parties, which allowed us to proceed to
19 ensure that those responsibilities of each consideration
20 were met without compromising any other investigations.
21 Sorry -- if I could finish, please, because I think it
22 is an important point.

23 Q. Of course.

24 A. I think I have referenced this also -- sorry, chair.

25 THE CHAIRMAN: I am just clarifying with you. The reason

158

1 lose an essential tool for analysing when things went
2 wrong, when harm occurred to a patient, i.e. root cause
3 analysis. If indeed, and I don't think there was
4 a clear understanding of what a root cause analysis was
5 designed to do, the process, the methodology, and
6 I suppose the point that I was making in relation to my
7 e-mail, that the root cause analysis is an approach -- a
8 problem-based approach to identify the learning, and the
9 point I was making was it would not be something which
10 would stand up to the rigors of a judicial or legal
11 process in terms of an examination of what was within
12 that and, in this particular incident, the case of root
13 cause analysis was used to cross-examine witness -- to
14 question -- sorry -- I beg your pardon -- to question
15 witnesses in the coroner's inquest. My concern was
16 there was clearly a need for parallel investigations in
17 some instances. We, as an organisation, to protect and
18 safeguard patient safety would be required to
19 investigate patient safety incidents in real time,
20 irrespective of whether or not that case had been
21 referred to the coroner in real time, because we need to
22 identify a learning. Clearly there may be circumstances
23 where that case may be also investigated by the police
24 and the exchange and response from Ian recognises the
25 fact that things have -- I think he mentions the word

160

1 "have moved on", "rapidly escalated", and the need to
2 have guidance out to the Health Service on what to do in
3 these very difficult and challenging circumstances.

4 I suppose in my response back on the 27th, I refer
5 to root cause analysis. I refer to the need to ensure
6 that we keep all of those interests in our minds in the
7 way forward. Now I think the department did expedite
8 and take forward the development of that memorandum of
9 understanding. It is outlined on in my witness
10 statement 269, on pages 335 to 337. I think it is
11 important to consider that because I think it provides
12 an important context. I mean, there were ongoing
13 discussions from October -- my recollection is October
14 onwards -- in terms of what have would be required
15 within that --

16 Q. Can I ask you this?

17 A. Sure.

18 Q. Firstly, at that time, October 2004, there was no
19 PSNI investigation into Claire's case.

20 A. No, there wasn't. Not that I was aware of, no.

21 Q. Nor for that matter had Claire's case been accepted as
22 a case to be investigated under this inquiry.

23 A. That's correct, yes, although certainly, as I mentioned
24 earlier --

25 Q. No, that's what they wanted.

161

1 an issue that is flagged up. That's paragraph 4.
2 That's not something the coroner is going to make
3 findings about.

4 A. I accept, yes.

5 Q. The coroner wants to know the statutory remit that the
6 coroner has. So those sorts of things are things that
7 were important to Claire's parents and what I'm asking
8 is --

9 A. Yes.

10 Q. -- would it not have been possible to say, "Now some of
11 the things you are asking", if it be the case, "that we
12 don't really want to address at the moment, because the
13 coroner is going to investigate that, and we would not
14 want to do anything at that would hinder the efficacy of
15 his investigation, but you have asked us some other
16 things and we are going to into those things and see
17 what answers we can provide you about those concerns".
18 Would that not have been a possible strategy?

19 A. It would have been a possible strategy, yes. I think it
20 was the complexity which I've sought to describe,
21 which --

22 Q. Yes.

23 A. -- I think is certainly unique in my experience.
24 I certainly never encountered a situation like that
25 before, nor indeed since, and certainly foremost to my

163

1 A. Yes, that's what they clearly wanted.

2 THE CHAIRMAN: That's what Mr and Mrs Roberts were
3 specifically asking for.

4 A. Yes.

5 MS ANYADIKE-DANES: Then if we come back down to the detail
6 of what's in Mr and Mrs Roberts' letter, I will address
7 the parallel investigations in a minute with you, but if
8 we deal with what's in the letter, there are things in
9 that letter that are not the sorts of matters that
10 a coroner would investigate, but they are matters that
11 are governance matters and which the Trust might want to
12 be able to furnish an answer to the Roberts.

13 For example, issue in relation to paragraph 10: why
14 did it take a father to watch a UTV programme to bring
15 this to the Trust's notice? Why did it happen in that
16 way? Well, that's something that you could legitimately
17 be asking the clinicians, "How did that happen?", and it
18 is not necessarily something that the coroner is
19 particularly concerned about, if one thinks about the
20 legislative basis of what the coroner's process is
21 about.

22 A. Sure.

23 Q. And there may be other things like that. For example:
24 why was it that the communication or the recording of
25 communication with the parents wasn't better, which is

162

1 mind was a distinct possibility at that stage, given
2 that there was already an ongoing police investigation
3 into the allegations arising out of the UTV documentary,
4 that there was a distinct possibility there would be
5 a police investigation potentially into Claire's case
6 and a distinct possibility this would be a matter this
7 inquiry would consider. Indeed, that was minuted at the
8 meeting of 7 December. The Trust offered to facilitate
9 referring the matter to this inquiry.

10 Q. Yes.

11 A. So that's something I was very alive to and I think the
12 issue of the memorandum of understanding is very
13 relevant in that context.

14 Q. I appreciate that and I was just asking if there was not
15 a way of in the spirit of addressing distraught parents
16 who had had to find for themselves, if you like, the
17 position and bring that a number of years afterwards
18 only to hear what they were hearing, whether it would
19 not have been possible to assist them with some of their
20 concerns, but if I can bring up the answer that
21 Dr Rooney, as she then was, provided to the parents.
22 That can be found at 089-006-015. I mean in relation to
23 this paragraph 10. There you can see.

24 So paragraph 10, if you recall, dealt with, apart
25 from other matters like, "Will the cause of Claire's

164

1 death be reviewed by the Belfast Royal Hospital?". It
2 is also asked why it took the broadcasting of
3 a television programme, etc. Then if you see how it's
4 dealt with in paragraph 10.

5 So the case has been brought to your attention.
6 A review of Claire's notes was carried out. Independent
7 advice sought from a Queen's University professor of
8 medicine. I am going to come to that in a minute. As a
9 result of that, the coroner has been fully informed:

10 "It will now be now be up to the coroner to further
11 review the medical aspects of Claire's case as he feels
12 appropriate."

13 And:

14 "The coroner had not been informed at the time as it
15 was believed that the cause of Claire's death was viral
16 encephalitis."

17 But what's not there is these things that are not
18 really germane to her cause of death and so forth that
19 is going to be within the coroner's purview. There is
20 no independent case as to how that's going to be
21 addressed for the Roberts. Even to say, "We can't
22 actually deal with those bits at the moment because we
23 are afraid it is too deeply implicated in other things
24 that the coroner is going to look at". So there's no
25 guidance on that part from [sic] the family.

165

1 A. I am not certain. I mean, I wasn't at the meeting and I
2 don't know how Professor Young was introduced or
3 introduced himself.

4 Q. I don't think the minutes disclose that he is a Trust
5 employee.

6 A. Yes. I mean, I have to say I had sought
7 Professor Young's advice because he was someone
8 I regarded and someone who was regarded -- and indeed
9 I think he is described in his evidence -- someone who
10 was clearly -- had both clinical expertise and academic
11 experience in clinical biochemistry and particularly
12 fluid management.

13 Q. This is not an issue as to his competence and expertise.
14 I beg your pardon. I am asking a very specific
15 question. Did you not think you could have disclosed to
16 the parents that he was also a Trust employee?

17 A. I didn't think there was an issue in relation to that
18 being disclosed or not being disclosed. To be honest,
19 I did not consider the fact he was a joint appointment
20 between the Queen's University and the Royal Hospitals
21 as something that would have compromised his ability to
22 provide an independent opinion to me. I had known
23 Professor Young for quite a number of years. He was
24 someone I had the highest regard for his professional
25 standing. I knew his professional integrity. I knew

167

1 A. And the date -- sorry. That was 25 January in that
2 letter; is that right?

3 Q. This is Dr Rooney's letter and this is 12 January.

4 A. Oh, 12 January. Sorry.

5 Q. Yes.

6 A. I accept the point you are making. Mr and Mrs Roberts,
7 when I now again consider the letter that you have put
8 up, certainly were raising a range of other issues --

9 Q. Yes.

10 A. -- which were separate from what had actually caused
11 Claire's death.

12 Q. Yes, and there might have been a way to address those.

13 A. I accept there may have been a way. Just to reference
14 what I said earlier, there was a degree of complexity --

15 Q. I understand.

16 A. -- which by way of context ...

17 Q. Yes.

18 A. But I accept there were other issues that they were
19 raising, yes.

20 Q. Thank you.

21 Now in terms of Professor Young's own position,
22 Professor Young, of course, was a professor at Queen's
23 but he was also a Trust employee. Is that something
24 that, in the spirit of transparency, that might have
25 been disclosed to Claire's parents?

166

1 when I requested an expert opinion from him that I would
2 get an independent expert opinion and therefore I did
3 not feel his employment status was a factor I should
4 have given consideration to when approaching him for
5 said opinion.

6 THE CHAIRMAN: You made the point earlier that he had not
7 been involved in Claire's case before and, from his
8 evidence, he had barely any involvement with any
9 children in the Children's Hospital. So while he does
10 work for the Trust in a limited regard while he is also
11 working for Queen's, the extent to which he is involved
12 in anything in the Children's Hospital was negligible.

13 A. Yes. Again he was -- that was the point I made in my
14 witness statement. He was independent from anybody
15 involved in the case previously and independent from the
16 Trust. I appreciate there is an issue around perception
17 and --

18 Q. We need not take that any further. You can see there is
19 an issue of perception. We don't need to take that any
20 further.

21 Can I put to you some criticisms that the inquiry's
22 governance expert has made in relation to the meeting
23 and maybe you can assist with them?

24 A. Sure.

25 Q. Or at least give you the opportunity address them since

168

1 they are there in his report. One sees them at
2 238-002-015. There we are. I think if one goes down,
3 I think one can pull them up as:
4 "Consideration should have been given to
5 commissioning an independent written report of a
6 paediatric neurologist."
7 And that:
8 "Professor Young may not have been regarded as
9 independent."
10 Well, we don't need to go further in that.
11 That:
12 "His views should have been reduced to writing,
13 especially in the light of his disagreement with
14 Dr Steen."
15 You have answered that. You said it was a shade of
16 difference. Then he has queried about whether he was
17 the correct choice, but you have expressed your view
18 that's and you have said why:
19 "An external expert should have provided a written
20 report and should have attended the meeting."
21 That is the suggestion.
22 The clinical paediatric lead --
23 A. Sorry. Can you just highlight that? I can't see that
24 on this page.
25 Q. I think may follow?

169

1 recollection.
2 Q. The fact that Dr Hicks wasn't present. I think I have
3 asked you about that and you've given your view and you
4 didn't think that that was particularly necessary.
5
6 A. I don't think that's the answer I gave. I think you
7 asked did I know why they weren't present or involved.
8 Q. Oh, I beg your pardon.
9 A. I said that was in relation to my e-mail of 2 November.
10 Q. Yes.
11 A. I said that I didn't -- I approached Professor Young. I
12 don't know if Dr Steen approached the others that I had
13 suggested. My recollection is that events rather
14 overtook us in terms of -- we had Professor Young's
15 opinion in relation to hyponatraemia has been possibly
16 a contributory factor and, in such circumstances,
17 I decided that the right course of action was to refer
18 it to the coroner --
19 Q. In my shorthand that's what I meant. You no longer
20 thought it was necessary in the way you had prior to
21 receiving Professor Young's opinion.
22 A. Well, by that stage -- clearly she had not been involved
23 up until that point. I mean, I would have known at that
24 point. Clearly she had not been involved and it would
25 have been inappropriate, I would suggest, to introduce

171

1 A. I am on 015. Sorry.
2 Q. No.
3 A. Maybe I am incorrect. At paragraph 61; is that right?
4 Sorry.
5 Q. Yes. There we are, but you have given your view as to
6 why you thought Professor Young was appropriate?
7 A. I think -- there is an additional point, if I may make
8 it here --
9 Q. Yes.
10 A. -- which is I think my understanding -- and again it's
11 obviously it's a matter the inquiry will consider --
12 that the vulnerability here may indeed have been the
13 practice in paediatrics at that particular point in time
14 right across the UK in relation to the use of
15 intravenous fluids. I think that my view was that,
16 contrary to Dr MacFaul's view, that indeed in seeking
17 an independent expert opinion from Professor Young, who
18 was not a paediatrician, but indeed that was perhaps
19 more appropriate. You know, he had the relevant
20 experience and indeed I think as a non-paediatrician he
21 had all the relevant expert knowledge in relation to
22 whether or not fluid management had played a part and
23 his view would not have been coloured by what was
24 practice at that time or not. Again, that was another
25 factor that I did give consideration to from

170

1 her into that meeting at that stage.
2 Q. It would have been inappropriate to have introduced her
3 into that meeting?
4 A. I mean, certainly this was a meeting -- are we referring
5 to the meeting with the parents.
6 Q. Yes.
7 A. She hadn't been -- I mean, she had not been involved up
8 to that date or to that time. She had not been
9 involved -- I mean, I had suggested she would be
10 involved in the case in open view. She had not been.
11 The meeting was taking place with the family. She was
12 not someone who was known to the family. I don't think
13 it would have been appropriate for her to be present at
14 that meeting without being involved in the case note
15 review, having any opportunity to consider the notes or
16 indeed having any former meeting or association with the
17 family. That's the point I was making.
18 Q. Well, as I say, you have given your view, and I am not
19 sure that the chairman feels it necessary for me to
20 expand on that with you.
21 THE CHAIRMAN: I don't.
22 MS ANYADIKE-DANES: Can we go now to the handling of the
23 complaint? Did you regard the communications from
24 Claire's parents as being a complaint?
25 A. No, I didn't.

172

1 Q. Why?
2 A. Certainly my understanding of the concerns that they
3 were raising -- they were significant concerns, but did
4 I not -- I think they were genuinely seeking answers.
5 I didn't have a sense that it was a complaint. I know
6 that sounds a little bit of an arbitrary distinction,
7 but certainly at that time I did not have a sense that
8 they were making a complaint. I suppose also at that
9 point in time the complaints process was what the
10 complaints process was. It has subsequently been
11 reviewed and changed.
12 Q. Did you not think that they were expressing any
13 dissatisfaction at all?
14 A. Yes, I know that's the definition within the 1996
15 policy.
16 Q. Well, if that's the definition, didn't you think that
17 they were expressing a dissatisfaction requiring a
18 response? In fact, if we pull it up, what I am taking
19 you to is "Complaints: listening, acting, improving.
20 Guidance on the implementation of the HPSS complaints
21 procedure (1996)", and it is at 314-016-019. It defines
22 a complaint as "an expression of dissatisfaction
23 requiring a response".
24 A. Uh-huh.
25 Q. Is that not what they were doing, expressing their

173

1 A. I take the point you are making, Mr Chairman. That was
2 not the experience of the complaints procedure at that
3 time. I think there were very significant complex
4 clinical matters being raised here, I suggest, I was
5 going to draw your attention to my witness statement,
6 269, pages 151 and 152, if I could, please. Just for
7 context, this is the "Making amends" document. This is
8 a document -- I accept it's a consultation document in
9 England, but there was no -- it is one of the documents
10 which arose during my e-mail search to assist the
11 inquiry.
12 At paragraph 25 there, it obviously lists the
13 impacts in relation to individual patients and relatives
14 following harm occurring in the Health Service, and
15 again, at paragraph 29, it lists the impacts in relation
16 to healthcare staff as well. It does make specific
17 reference to how the Health Service, certainly in
18 England, responds and that is in paragraph 26 there.
19 You know: lack of coordination, confused communications.
20 If you read down to paragraph 27, again I think it
21 probably puts the complaints process in the context that
22 it was at around that time:
23 "Trying to get an explanation through the complaints
24 system or making a claim for compensation currently adds
25 to the frustration and trauma for patients."

175

1 dissatisfaction as to what had happened and requiring
2 a response.
3 A. They were certainly raising concerns. They had not
4 written a formal complaint. They had not --
5 Q. Yes, I know they had not written a formal --
6 A. Certainly they were raising concerns around Claire's
7 care. Can I maybe draw up another document, which I
8 don't think, Mr Chairman --
9 THE CHAIRMAN: If you do that in just one second.
10 I presume the phrase "expressing dissatisfaction" is
11 set no doubt that way so that when people who are
12 outside the Health Service system and don't know what
13 the right form or the right mechanism is to make
14 a formal complaint, if they write in in terms which can
15 be understood as a complaint, that is accepted as
16 a complaint.
17 A. Yes.
18 THE CHAIRMAN: So it is do away with a degree of formality
19 and expectation, which would be inappropriate, so that
20 they can't say: actually, they might have written in
21 a letter of complaint, but it is not formally
22 a complaint, therefore we will not treat as such. The
23 purpose of this procedure is to move away from
24 hairline distinctions so that expressions of
25 dissatisfaction were treated as complaints.

174

1 These were very complex issues that the Roberts
2 family were raising in relation to Claire's death.
3 I don't think at that time that the -- and this is
4 a personal view from my experience of the complaints
5 process at that time -- that the complaints process was
6 the appropriate process or mechanism by which to address
7 those concerns. We did --
8 Q. Was this offered to them?
9 A. Sorry.
10 Q. Was it offered to them?
11 A. Again, I have only become aware of this following
12 through some of the communications in preparation for
13 the inquiry. I'm aware that there was a conversation --
14 at least I have seen sight of an e-mail now between
15 Mr Walby -- I think it is 139-161-001 -- following the
16 completion of the coroner's inquest. I think the
17 coroner -- again I don't recall this, I have to say, but
18 I had understand that at the conclusion of the coroner's
19 inquest the coroner had indicated there were other
20 matters which were rightly and properly matters to be
21 considered by the hospital complaints process. I think
22 here we see on the left an e-mail from Peter Walby to
23 Pauline Webb basically indicating the conversations that
24 he had with the Roberts family suggesting that they
25 write to the Chief Executive.

176

1 That would be normally the mechanism by which
2 a complaint would be --
3 Q. Sorry, Dr McBride. Is that not the point? Mr Roberts
4 has aired the same sorts of concerns that one sees in
5 his letter of 8 December, and they are being
6 perceived -- certainly by the coroner -- as in the realm
7 of the hospitals' complaint procedure.
8 A. And I think --
9 Q. Sorry. What I was going to then ask you --
10 A. Sorry.
11 Q. -- if that's the case, should not the Trust have simply
12 recognised the reality of what they had, which was
13 parents who were expressing dissatisfaction with what
14 had happened, both in terms of their daughter and also
15 the relationship with them. They did want answers, and
16 if they had not formally called it a complaint, was
17 there any reason why those who deal with these matters
18 simply could not have said, "Well, you know, here's
19 a complaints form", or whatever is the necessary thing
20 that puts them into the process?
21 A. I accept that certainly there's a responsibility on the
22 organisation to inform families of those processes.
23 It's not for families to ascertain or find their way
24 into those processes. The responsibility for that is
25 absolutely clearly for the Trust.

177

1 were looking at one death, I can entirely understand how
2 it can be at the back of your mind, "Well, this police
3 investigation might expand", and there are issues which
4 would complicate the picture, but from what I've read
5 and heard from Mr and Mrs Roberts, one of their big
6 concerns, which has caused them a lot of added grief, is
7 an unfortunate and perhaps entirely unreasonable sense
8 of guilt on their part that they went home on Tuesday
9 night.
10 A. I have heard that come across.
11 THE CHAIRMAN: That was raised by them as the sixth point in
12 their letter following up the meeting led by
13 Professor Rooney.
14 A. Yes.
15 THE CHAIRMAN: And it wasn't really dealt with at all in
16 their response and it is taken partly because of the
17 process, which this inquiry has taken -- which has been
18 too long. It has taken them until now to hear that
19 issue aired and to get some response on it.
20 A. Yes.
21 THE CHAIRMAN: The question I am getting to is this: even if
22 you can take one or two points and alleviate the
23 family's concerns or express some degree of acceptance
24 that things weren't as good as they could have been,
25 isn't that arguably better to do that at an earlier

179

1 Q. And who should have done that?
2 A. Well, I think certainly advice was given to Mr Roberts.
3 I think certainly --
4 Q. No, this is 2006.
5 A. It is 2006.
6 Q. Who should have done that in 2004?
7 A. I mean, I was basically adding -- the point I was making
8 earlier was I think if we look -- if you look at the
9 range of issues which were raised by the Roberts family,
10 the primary issue -- and there were other issues --
11 I accept that on reading through the letter -- but the
12 primary issue to my mind was what had caused Claire's
13 death. I accept the point that there were other issues
14 and whilst the guidance complaints document does state,
15 you know, that the complaints [sic] process can continue
16 whilst the complaints [sic] process is continuing.
17 If you look at the actual document around paragraph
18 2.1, it does state that this is not a comprehensive
19 piece of guidance.
20 THE CHAIRMAN: I think, doctor, the problem is this:
21 I entirely accept it was probably complicated in late
22 2004. This inquiry had been established. The police
23 were already looking at Lucy's death. It didn't -- it
24 took them until well into 2005 to decide to look at
25 Adam's and Raychel's, but being aware that the police

178

1 stage so that to the extent we will ever get peace of
2 mind, the process starts a bit earlier?
3 A. And I absolutely accept that and that certainly came
4 across very poignantly from Mr and Mrs Roberts, the fact
5 they weren't there when they felt they should have been
6 there, but then again they didn't understand the fact
7 they should have been there and how unwell Claire was
8 and I have heard that said.
9 The complaints process as it was -- and I suppose
10 that's the point I was trying to make -- right across
11 the UK, I don't think was fit for purpose at that point
12 in time for investigating the nature of the complex
13 issues that related to Claire's death. Bearing in mind
14 the complaints process is steered towards -- and still
15 is for that matter -- local resolution. So this was
16 an issue which would have been investigated and
17 considered and these issues would have been considered
18 as a matter internally within the organisation.
19 I thought they were a range of very complex issues.
20 I don't think that in the circumstances you describe --
21 you have said those complexities. My sense was that it
22 would have been very difficult to progress any of these
23 through the complaints process. For instance, there is
24 now clarity -- Mr Chairman, if you want me to go on --
25 THE CHAIRMAN: Go on.

180

1 A. The review of the complaints process does now make
2 clear -- it makes very explicitly clear in -- the 2009
3 complaints process makes very clear that with the
4 agreement of the coroner, that those aspects of
5 complaints which are not subject to consideration by the
6 coroner's inquest, the point that Ms Danes was making,
7 as well, can be considered by the organisation with the
8 agreement of the coroner while the coroner's inquest is
9 ongoing.

10 That clarity was not there in the earlier document,
11 in the 1996 policy document. So I think the complaints
12 process has evolved. If this were now, then clearly
13 those issues certainly could be -- certainly a greater
14 degree of certainty being examined in that -- then it
15 brings me back to the memorandum of understanding,
16 Mr Chairman. I think that is relevant because again
17 following the completion of the coroner's inquest --
18 sorry -- actually prior to the completion of the
19 coroner's inquest, the draft MOU, memorandum of
20 understanding, between the Department of Health, the
21 PSNI and the Court Service had been circulated to the
22 Health Service for consultation. That was in October
23 2005. I think it might be relevant, if time permits to,
24 consider that document. The reference I have --

25 Q. Before we consider that -- because that takes us ahead

181

1 which was following on from what the chairman had said,
2 was if you can see some discrete issues that are
3 troubling the family and aren't necessarily bearing on
4 the thing that the coroner's investigation covers, why
5 not try to address those in the interests of
6 confidence-building and transparency? Because what
7 seems to be clear from this family is that there was
8 a loss of trust, apart from anything else just because
9 of the way circumstances brought them to the Royal to
10 understand what happened to their child.

11 So if you are in that situation, isn't there all the
12 more reason to try and see if we can't address some of
13 the things that are truly concerning them, which are
14 unlikely to compromise the coroner's investigation?
15 This seems to provide some support for being able to do
16 that.

17 A. The policy document and reference 4.8 provides scope to
18 do that. If you then look at the supporting guidance,
19 which went along with that document, which is
20 April 2000, I think the practicalities of that at
21 an operational level were not, at that point in time,
22 clear. I mean there are many things that policy
23 documents state. It is quite another matter on how you
24 give effect to the scope that was given in that policy
25 and the document does make very clear -- and you are

183

1 in time -- and I am not saying it is not relevant --
2 please don't misunderstand me -- to consider it, but if
3 we stay with what the guidance was at the time -- in
4 fact, this is where I thought you were going to take us
5 to, which is in that same "Complaints: Listening,
6 acting, improving" document at 314-016-010. So when you
7 have a complaint, this has a specific provision in
8 relation to the coroner's cases. You see it at 418 and
9 it says:

10 "The fact a death has been referred to the coroner's
11 office does not mean that all investigations into
12 a complaint need to be suspended. It is important for
13 the Trust or the practitioner to initiate proper
14 investigations regardless of the coroner's enquiries
15 and, where necessary, to extend these investigations if
16 the coroner so requests."

17 So that seems to suggest that there was in 1996 a
18 way of proceeding with certain elements and even to do
19 that in conjunction with a discussion with the coroner,
20 just as in the same way you discuss with the coroner
21 whether, for example, parts of a body might be released
22 for transplant.

23 A. Sure.

24 Q. The Trust and the clinicians are able to discuss matters
25 with the coroner and they do. So what I was asking,

182

1 absolutely right -- that the importance of this document
2 is about that it's exercised in the spirit of which it
3 is intended. That was a point that the chair was making
4 as well.

5 Q. Yes.

6 A. I would say, however, that we did review the complaints
7 process for the simple reason -- and that was at a later
8 point in time -- I accept that -- because there wasn't
9 clarity around this particular issue and the department
10 has provided greater clarity around this particular
11 issue in terms of what aspects. I accept there was
12 provision to do that. There wasn't clarity in terms of
13 guidance and in terms of what aspects.

14 Q. I understand that, but given this particular family and
15 its circumstances, would it not have been possible to
16 discuss with the coroner and at least set out what they
17 were trying to achieve: if, Mr Coroner, you feel that is
18 going to be a difficulty, we can go and tell the family
19 this is what we would like to do, but we can't do it at
20 this moment in time. That is something that the family
21 have and is part of rebuilding the trust the family
22 originally had in their clinicians.

23 A. I accept what you are saying. My sense from the
24 meetings that had occurred following making contact with
25 the Trust again in 2004 was that those meetings had been

184

1 conducted in a way which -- I thought certainly they had
2 confidence that we were being open and transparent. Now
3 whether -- I appreciate the point you are making --
4 THE CHAIRMAN: I think some degree of confidence, some
5 degree of help was obtained by Mr and Mrs Roberts.
6 There may be an issue about how much confidence was
7 gained from meeting Professor Rooney and being in
8 contact with her, but it helped up to a point at least.
9 Okay.
10 MS ANYADIKE-DANES: Can I ask you now -- we sort of --
11 THE CHAIRMAN: The stenographer has been going from 1.45.
12 Can we take ten minutes, please?
13 MS ANYADIKE-DANES: Thank you. Sorry.
14 (3.32 pm)
15 (A short break)
16 (3.42 pm)
17 (Delay in proceedings)
18 (3.50 pm)
19 MS ANYADIKE-DANES: Dr McBride, in the interval I was asked
20 to put to you a very discrete number of points that
21 arise out of the evidence you have already given. If
22 you have been reading the transcript, you will know this
23 is something that happens. We try to keep up with
24 people's issues so they don't all come at the end in a
25 clutter of things that don't particularly hang together.

185

1 meeting or the sequence of events ..."
2 THE CHAIRMAN: When you do that, the stenographer types down
3 everything you say, which means -- it is the last four
4 lines.
5 MS ANYADIKE-DANES: I'm so sorry. It is the last four
6 lines. If we start with:
7 "I determined that in light of Professor Young's
8 opinion, the Trust would now refer the case to the
9 coroner. I asked that Mr and Mrs Roberts should be
10 informed of this decision at the meeting."
11 That is the meeting of 7 December. You are very
12 clear in your evidence that's what you wanted to have
13 happen.
14 A. Yes.
15 Q. What actually is recorded as having happened is the
16 penultimate paragraph of that minute, and the Roberts --
17 THE CHAIRMAN: Sorry. The minute is a little bit ambiguous
18 in this because on the left side of the screen
19 089-002-004, the third paragraph which starts:
20 "Professor Young advised ..."
21 The next line is:
22 "... and therefore will have to approach the coroner
23 for advice on the best course of action."
24 So those two paragraphs don't read perfectly
25 together.

187

1 The first is this question. It is a very net point
2 about the referral to the coroner and the family's
3 understanding of that.
4 If we can first pull up the minute, 089-002-004.
5 This is Dr Rooney's minute of the meeting of 7 December.
6 If you look at the penultimate paragraph:
7 "It was agreed that another meeting can be arranged
8 to give Mr and Mrs Roberts time to think about the
9 matter and any further questions they may have.
10 Professor Young stated that the Trust, in the meantime,
11 would not contact the coroner until Mr and Mrs Roberts
12 had decided what they wished to do. He added that the
13 coroner would obviously look at the case with a wider
14 view [and so on]."
15 So their take from that is that the Trust is not
16 contacting the coroner unless and until they have heard
17 from them. That's it, rightly or wrongly. That, I take
18 it, is not what you intended to be communicated to them.
19 A. If that's what's communicated, I have certainly no
20 reason to dispute what is documented in the minute. It
21 certainly was not my intent.
22 Q. We can see your intent. I think that's at 269/1,
23 page 20 and it is (b). Could we have those two things
24 side by side? I beg your pardon. Answer (b):
25 "While I do not recall the exact detail of this

186

1 MS ANYADIKE-DANES: They don't, but they do seem to make
2 more sense when you see what the Roberts actually did in
3 their letter of 8 December.
4 THE CHAIRMAN: Okay.
5 MS ANYADIKE-DANES: If one then pulls up 269/2 at page 14,
6 and then you see right down, the penultimate paragraph:
7 "It is clear from our meeting on 7 December that
8 senior medical staff are aware of the shortcomings ..."
9 Then they say:
10 "We therefore requested Claire's case is referred to
11 the coroner for urgent investigation."
12 Their view -- and I will stand to be corrected -- is
13 the reason they did that was they believed that what
14 they were being left with was the decision as to whether
15 it should go to the coroner or not. So that is how they
16 had interpreted what is recorded, which is no longer up
17 at the moment, but what was record in that minute.
18 A. I can understand that interpretation. I mean, if it
19 would be helpful, I don't know if I could pull up
20 an e-mail which I think you displayed earlier, which is
21 I think the one of 2 November from myself to Dr Steen.
22 I think it is 141-003-001. That's dated
23 2 November 2004.
24 Q. Yes.
25 A. I think if you go on to the next -- sorry. I beg your

188

1 pardon. It is the -- that doesn't end there. It's the
2 next page following that. Sorry. Just reading from the
3 top, there is a paragraph missing. This is dated
4 2 November:

5 "We should also advise the family that if we
6 establish --

7 THE CHAIRMAN: You are away from the microphone.

8 A. My apologies:

9 "We should also advise the family that if we
10 establish a clinical issue which would suggest similar
11 circumstances to those cases previously reported that we
12 will be referring their daughter's case back to the
13 coroner, but will advise them in advance."

14 Certainly I was very clear from the outset that if
15 there was any consideration at all or indeed we couldn't
16 exclude hyponatraemia or fluid management as
17 a contributory factor to Claire's death, then we had
18 a very clear obligation.

19 MS ANYADIKE-DANES: I appreciate that and, as I said
20 earlier, when asking about this, your evidence has
21 always been clear about that. What's being
22 highlighted -- and I am being asked to draw it to your
23 attention -- is a potential communications issue. So
24 they felt, the family, that the decision rested with
25 them, the burden and obligation and decision rested with

189

1 point. I think that was my rationale for ensuring that
2 Professor Rooney was present at all of those meetings.

3 Q. I understand.

4 A. Because again the medical staff present were
5 communicating the clinical information. I felt it was
6 vital there was someone present who understood what was
7 being asked, how it was being asked and the information
8 that was being relayed was being done in a manner that
9 was readily understood by the parents and actually done
10 in an empathetic way. But I accept the minute does give
11 some question in terms of ambiguity there, but certainly
12 there was no ambiguity in terms of -- or indeed as I had
13 communicated it to those at the meeting around
14 6 December.

15 Q. The other thing I have been asked, just in fairness, to
16 point out, when I was dealing with the issue of
17 a complaint and whether certain things could have been
18 taken up and dealt with independently of the coroner's
19 investigation or inquest rather --

20 A. Yes.

21 Q. -- that I was asked to point out that the Trust had left
22 open the possibility of the family coming back, if they
23 wanted to do that, and that, in fact, Mr Roberts had
24 drafted a letter which he never sent, coming back, and
25 I suppose the point is to make that if the family had

191

1 them as to whether the case should be referred to the
2 coroner. That's the only point that I am making.

3 A. Sure.

4 Q. Which is why I had originally said -- you have written
5 it in e-mail, so it is difficult to know why it wasn't
6 clear, but there seems to have been some breakdown in
7 communication as to what was communicated to the family
8 or what the family understood from what was being told
9 to them.

10 A. I accept that from the point you are making and,
11 obviously, the points that have been read, but again
12 I was -- I also sent an e-mail on 15 December, which is
13 relevant to asking that -- inform Mr Walby that I had
14 asked ...

15 Q. From their point of view, just to follow on from that,
16 these are all issues to do with how the Trust manages
17 the clarity of its communications with families --
18 particularly when the families may be in quite
19 a distressed state -- to make sure that families
20 actually have understood what it is that you are trying
21 to communicate. In this case, the minute actually
22 doesn't help.

23 A. No. I accept that.

24 Q. Yes.

25 A. I mean, I think that was the point. I accept that

190

1 wanted to pursue it in that way, that it might have done
2 so. So I make that point in fairness, which is proper,
3 but if you will take it from me, the point I was
4 addressing was not so much that, but what the Trust's
5 own systems should have done when it recognised the sort
6 of concerns that were being addressed, but in fairness,
7 I point out the fact that the Trust had left their door
8 open, if I can put it that way.

9 A. We had, but certainly I don't feel at any time the
10 family should feel in the situation where it is for them
11 to take the lead. I think it is our responsibility to
12 ensure that we are supporting and facilitating and it is
13 our responsibility in ensuring that that door is open
14 and ensuring Mr and Mrs Roberts knew the way through
15 that door and through the appropriate channels.
16 I accept that.

17 Q. Then I just want to -- it really leads on from the
18 question I was asking about the complaints procedure,
19 and the possibility of addressing that simultaneously,
20 if I can put it that way, with the coroner pursuing his
21 inquest. That is there is a question as to the extent
22 which you could have and maybe should have investigated
23 Claire's death, and if there is, at what point you
24 should have been doing that.

25 A. Yes.

192

1 Q. I know that, in a way, matters moved on with Claire
2 after your tenure, if I can put it that way, but
3 nonetheless while you were there, did you form the view
4 that Claire's death was something, whatever came out of
5 the coroner's inquest, that should have been
6 investigated by the Trust?
7 THE CHAIRMAN: Sorry. The time sequence for this is in
8 October/November 2004 and the documentary has been
9 broadcast and Mr and Mrs Roberts have contacted the
10 hospital. Okay.
11 MS ANYADIKE-DANES: Yes, Yes.
12 A. I think the answer to that is certainly it would have
13 been my wish to have investigated Claire's death. The
14 question was of how and when.
15 Q. Yes, I understand.
16 A. I think there were a range of complexities. I don't
17 want to go into the detail of that again.
18 Q. Yes.
19 A. I think we have covered that. So I think it was
20 a question of how and when as opposed to if.
21 I mentioned the memorandum of understanding. I think it
22 is relevant and we will maybe come to that in due
23 course.
24 THE CHAIRMAN: We will certainly do that before you finish
25 this afternoon. Okay.

193

1 standards and practice, then it has that potential.
2 Q. Yes.
3 A. But certainly it would -- it's not, you know, equivalent
4 to clinical negligence, no.
5 Q. Well, I suppose if you were the family receiving
6 something that referred to a problem in the way that
7 your child's care was managed and that problem is
8 something that could have significantly contributed to
9 your child's deterioration and death, I think you'd be
10 getting the message that there was something under the
11 control, perhaps, of the Trust that has gone badly
12 wrong.
13 A. I think -- it's -- having re-read the letter, I think it
14 was an unfortunate expression to send to parents in
15 terms of -- to Mr and Mrs Roberts. I don't know. I am
16 sure they probably considered that and said -- asked
17 themselves what actually I meant by that. I think
18 I perhaps could have put it more clearly, but certainly
19 the inference was -- and again I have covered this in my
20 witness statement -- that there was a concern around the
21 management of hyponatraemia and the administration of IV
22 fluids. I mean, that was clearly what I was indicating.
23 Q. Yes.
24 A. But I should have been more specific rather than using
25 essentially what is medical jargon and it is perhaps not

195

1 A. Yes.
2 MS ANYADIKE-DANES: Then can I just put it in this way: in
3 some respects, we have covered some of this territory in
4 relation to complaint. Can I put it this way: if I had
5 asked you about whether you considered that perhaps
6 there was a potential for a negligence issue, just when
7 you heard that there was a fluid management concern, if
8 I can put it that way, you said, yes, but it wasn't
9 really at the forefront of your mind. By the time you
10 are writing to Mr and Mrs Roberts on 17 December, which
11 is 089-005-010. I think it is coming. There you go.
12 By the time you are writing, you have formed the view,
13 if you see the second paragraph --
14 A. Yes.
15 Q. "Our medical case note review has suggested that there
16 may have been a care management problem in relation to
17 hyponatraemia. This may have significantly contributed
18 to Claire's deterioration and death."
19 A care management problem is a way of saying
20 negligence, is it not?
21 A. I don't accept that.
22 Q. Sorry. Maybe that was too sweeping. A care management
23 problem can certainly import negligence.
24 A. There -- I mean, after investigating what the particular
25 problem is, if indeed that's a departure from accepted

194

1 the best way to communicate that concern.
2 Q. In fairness, Dr McBride, that might have done because,
3 by that time, Mr Walby, who has sort of been involved in
4 matters also in relation to this case in 2004, had
5 formed the view that if they had instituted a claim for
6 medical negligence, his advice would be to settle it and
7 to set it and to settle it --
8 THE CHAIRMAN: The timing is wrong.
9 MR McALINDEN: That was Mr Walby's view coming out of the
10 inquest, but certainly not in 2004.
11 THE CHAIRMAN: That's Mr Walby's view coming out of the
12 inquest, is it not?
13 MR McALINDEN: Yes.
14 MS ANYADIKE-DANES: Yes.
15 At that stage, after the inquest, to settle it
16 because of the blood test, because a blood test ought to
17 have been done earlier and, if it had been done earlier,
18 it might have disclosed low sodium levels, which could
19 have led to a whole chain of care and so forth that
20 might have avoid her deterioration and death. He forms
21 that view after the inquest. So at that stage I have
22 asked you about the investigation into Claire's death in
23 2004.
24 I am not sure you were entirely there at the end of
25 the inquest. Were you still in post.

196

1 A. I left -- I took up my new post in September. I think
2 I left the July or August. I had a period of leave, but
3 certainly, yes, I was there at the time of the inquest,
4 yes.
5 Q. Is that something you think should have generated
6 an internal investigation into Claire's death?
7 A. Which? Sorry.
8 Q. The fact that Mr Walby had formed the view, in the light
9 of the evidence at the inquest, that there was
10 essentially negligence?
11 A. I wasn't aware that that was Mr Walby's view.
12 THE CHAIRMAN: What's unfortunate, doctor, is that Mr and
13 Mrs Roberts didn't know. Mr and Mrs Roberts have never
14 sued. They have made it quite clear over the last
15 couple of weeks that they are not going to sue, but what
16 I understand really took them aback last week was to
17 hear Mr Walby saying for the first time that when he
18 came out of the inquest, he thought in terms that
19 a medical negligence case was open and shut and, if the
20 parents intimated an indication to sue, he would advise
21 the Trust to settle immediately.
22 A. I must say I had no discussions of that nature with
23 Mr Walby at that time. As a matter of fact, I think,
24 irrespective of what Mr and Mrs Roberts determined, it
25 is completely to my mind, you know, in terms of clinical

197

1 sorry -- by the Trust.
2 A. I mean, as I have said, I think, a few moments ago it
3 was a question of when and how as opposed to if. I mean
4 I think there were clearly matters which I certainly
5 felt we should investigate.
6 Q. Yes.
7 A. I wasn't aware -- I mean, if indeed Mr and Mrs Roberts
8 had come back or indeed we had proactively sought to
9 engage with them again following the coroner's inquest
10 and indeed it certainly should never arise that there
11 are circumstances where it is incumbent on the parents
12 to approach us.
13 Q. Uh-huh.
14 A. If indeed there were unresolved concerns, then clearly
15 following the completion of the coroner's inquest, when
16 the cause of death had been determined and the
17 contributing factors had been determined, at least as
18 the coroner saw it, and clearly, as we now know, there
19 are a range of other significant shortcomings that this
20 inquiry happens to have uncovered, which were not known
21 at that time, but clearly in terms of the
22 responsibilities for the Trust, I don't think that the
23 responsibilities to investigate had the -- irrespective
24 of what process that we used, no longer existed if
25 indeed there were matters which the coroner had raised

199

1 negligence, it is not relevant. I mean, at no time had
2 they indicated, that I was aware of, their desire, as
3 you have suggested, to pursue that route. They wanted
4 answers to questions. So I must say that I can
5 understand their concern and distress at hearing that.
6 It certainly wasn't something that I had heard until
7 reading through the transcript of the minutes. So it
8 wasn't something that I was -- is certainly wasn't in my
9 consciousness at that time.
10 MS ANYADIKE-DANES: That's very helpful. I am not for
11 one minute suggesting in any way that you should have
12 had in mind that they might institute proceedings.
13 I think you are quite right. There has been absolutely
14 no suggestion they would have and their evidence is they
15 wouldn't have. That's not what they wanted to know.
16 A. Absolutely not.
17 Q. I was taking it from a slightly different perspective,
18 which is to do with the role of the Trust in the
19 deterioration of their child's condition and her death.
20 And if a view had been formed about the role of the
21 Trust, is that something that you think was appropriate
22 to have led to an investigation into her death over
23 and -- an internal investigation, leaving aside what
24 the -- what the coroner had done for the statutory
25 purposes, an internal investigation into the Trust --

198

1 which were of significance or if there were matters that
2 the Roberts were still dissatisfied with.
3 The point I made in my witness statement at 269/1,
4 page 11, is important. Whenever we carried out the --
5 Q. I was going to take you to that. I am glad you have
6 pulled that up. If you look at number 22, we have asked
7 a series of questions: did you consider these things?
8 A. Yes.
9 Q. To which your answer really is those concerns that
10 relation to other aspect of Claire's care had not been
11 brought to your attention following the case note
12 review.
13 A. No.
14 Q. And to your knowledge, essentially, what the coroner's
15 expert witnesses had identified was fluid management and
16 if the coroner's investigation had disclosed those sorts
17 of things, then you would have addressed them. That is
18 essentially it, isn't it?
19 A. Yes, or indeed also the other point I would make is if
20 indeed our own case note review had identified anything.
21 Q. That's where I want to go first. That's where I want to
22 go to first. Let's look at that point about having it
23 brought to your attention following the case note
24 review.
25 Primarily, the case note review was being conducted

200

1 by Professor Young because he had the benefit not only
2 of having a specialism in the particular area you
3 thought was of concern, but he was to a degree
4 independent because he hadn't been involved in the care
5 of the child and, you know, he wasn't associated with
6 the case. That would be fair, wouldn't it?
7 A. Well, as I had indicated earlier, there was more than
8 Professor Young involved in the case note review.
9 Dr Steen was involved in the case note review and again,
10 as I alluded to earlier in my e-mail of 2 November, I
11 had advised that others should be involved. Those
12 others were not, in due course, involved. I don't think
13 there was anything --
14 Q. That's the point.
15 A. Sorry.
16 Q. If I may help with that. The point is: that to the
17 extent that anybody looked at the notes and records --
18 I mean anybody who had the sufficient expertise to do
19 so -- it is Dr Steen, who was the consultant and who may
20 be -- let's put it -- vulnerable to criticism arguably,
21 and it is Professor Young, but Professor Young was only
22 looking at the case notes for a particular purpose. He
23 is only really looking, as you put in your original
24 e-mails, for whether there was an electrolyte issue, was
25 there hyponatraemia, something of that sort. So all

201

1 those circumstances, as I said -- and I also indicated
2 in that e-mail of 2 November as well -- I mean, I was
3 very clear what our responsibility and obligation was to
4 do at that time, which was to report Claire 's death to
5 the coroner for an independent investigation, but
6 I accept the point you are making.
7 Q. Let's take a very simple point. The family wanted to
8 know why she wasn't referred to PICU earlier. That's
9 not something the coroner is going to look at in
10 particular. It was a concern for the family. And if
11 when the coroner -- sorry.
12 UNKNOWN SPEAKER: [Inaudible: no microphone].
13 A. If an admission to PICU would have had a material
14 difference to the outcome in this case, it is a central
15 issue that the coroner would have looked at if it had
16 been raised.
17 MS ANYADIKE-DANES: I can see that. Given that was still
18 a query that the family had raised in their letter to
19 you of the 8th -- I am just picking up these sorts of
20 things that one can distil from their letter. It has
21 not come out of the case note review. It is not
22 mentioned in the coroner's verdict and in the
23 proceedings, but it is not really addressed for the
24 family. All I am suggesting to you is, at the end of
25 that process, should you really have been saying:

203

1 these broader questions as to whether there was a drug
2 overdose, whether the recording was adequate, whether
3 the level of clinicians were appropriate, what was the
4 availability of EEG and CT scans, all of those sorts of
5 things, Professor Young wasn't involved in that. In
6 fact, he is absolutely clear that he was not looking at
7 things from a broader base. He was looking at things
8 from a very specific point of view.

9 In terms of the actual care, Dr Steen hadn't been
10 involved directly in the care but, as I say, you might
11 think that she was hardly independent to look at the
12 passage of Claire's time at the hospital from the
13 perspective of those sorts of issues. So the fact that
14 the case note review has not disclosed these broader
15 things, maybe that shouldn't have led to "and we don't
16 need to look at it."

17 A. I understand the point you are making. I certainly
18 advised what I expected to happen. That didn't happen
19 in terms of the range of individuals that were involved.
20 Q. I understand.
21 A. My recollection is that events sort of rather quickly
22 overtook us in terms of we had Professor Young's view
23 that he could not exclude that hyponatraemia and fluid
24 management wasn't a contributing factor to Claire's
25 death and may have indeed contributed to it, and in

202

1 because these issues have not come to light from those
2 two different processes, then we shouldn't look at them?
3 A. I mean, certainly -- and as I again have indicated,
4 I answered question 22. My primary consideration in
5 this was obviously patient safety. If there were issues
6 which had been identified in either the case note review
7 or the coroner's inquest which had wider
8 considerations -- if we set aside Mr and Mrs Roberts and
9 their concerns for a moment -- then absolutely,
10 irrespective of the complexities -- and we have
11 mentioned those already -- I certainly would have at
12 that point, you know, conducted an investigation or root
13 cause analysis into those circumstances, but no other
14 issues were raised. My understanding -- and indeed of
15 the case note review -- was that the issue that had been
16 identified was thought to relate to the practice in the
17 use of intravenous fluids in children at that time and,
18 in particular, in relation to the use of hypotonic
19 fluid.
20 Q. Dr McBride, because you would wanted the case notes to
21 be looked at by a broader group, if I can use it
22 neutrally --
23 A. Yes.
24 Q. -- than appears to have been the case, did you think
25 that the case notes had been considered from a broader

204

1 perspective than they, in fact, might have been?
2 A. Certainly that was my advice.
3 Q. Yes.
4
5 A. I certainly -- when I got the case note review back,
6 I don't believe that I was unaware of the fact that
7 others had not inputted into that process.
8 Q. I understand. I understand.
9
10 A. Certainly, my expressed wish and my advice was that the
11 others would be involved, but, as I say, I believe
12 events overtook us.
13 THE CHAIRMAN: I think the question, to try to bring this
14 together, is this: the coroner's inquest has become
15 an increasingly intensive exercise over the last ten
16 years or so.
17 A. Yes.
18 THE CHAIRMAN: But it is still different to an internal
19 investigation.
20 A. Yes.
21 THE CHAIRMAN: Because an internal investigation would pick
22 up issues like, for instance, communication with the
23 parent, which is not critical to the coroner. It might
24 pick up other issues too. It might pick up issues about
So whether in 2004, or as you are

205

1 factors, there was an opportunity there. I do accept
2 that. There were a number of other complexities at that
3 time which we have discussed previously.
4 THE CHAIRMAN: Of course, from your perspective one is you
5 were no longer there --
6 A. Well, that wasn't the --
7 THE CHAIRMAN: -- after --
8 A. Well, that's one, but I was there at the time of the
9 conclusion of the coroner's inquest, which was I believe
10 early in May of 2006.
11 MS ANYADIKE-DANES: Yes.
12 A. So I was there, but again it goes back to -- and
13 I mentioned this on a number of occasions -- the
14 complexities of the investigation of cases of this
15 nature, particularly when one or more investigative
16 process is underway, whether that's a police
17 investigation or whether it's a coroner's investigation
18 or indeed the need for an organisation to carry out
19 an investigation. There wasn't guidance at that time,
20 but the memorandum of understanding had been issued in
21 October 2005. I think it is pertinent.
22 THE CHAIRMAN: Let's look at that now.
23 A. I think it probably gives a sense of some of my thinking
24 and analysis at that time.
25 THE CHAIRMAN: Let's go to it now Dr Walby [sic] because

207

1 going to the inquest in 2005 and 2006, I think the
2 single broad question is: would it not have been a good
3 idea to have an investigation into at least some of the
4 issues, irrespective of the fact that the coroner's
5 inquest was due to be held in the relatively near
6 future?
7 A. In advance of the coroner's inquest?
8 THE CHAIRMAN: Yes, because some of those issues will not be
9 developed at the inquest.
10 A. Again, Mr Chairman, obviously -- I suppose my thinking
11 at that time was that the issues -- I accept the point
12 Ms Anyadike-Danes has made in relation to the other
13 concerns the parents have raised. My consideration at
14 that stage was all these issues were so intimately
15 intertwined in relation to the contributory factors to
16 Claire's death that my sense was that, you know, given
17 we were now some eight years following her death, we
18 needed to establish with certainty -- maybe that's not
19 the right word, with certainty -- we needed to establish
20 definitively the contributory factors and indeed that
21 was a matter for the coroner's determination.
22 Now I accept the point entirely that there is
23 a question following the conclusion of the coroner's
24 inquest. Once the coroner had made his determination in
25 terms of the cause of death and the contributory

206

1 I said we would go back to it.
2 A. I think it is 269/1, 335 to 337. The earlier
3 page I think gives the circumstances in which it
4 applies. I think -- but I think the particularly
5 relevant paragraphs here are in relation to paragraph 18
6 and possibly also on the next page. If we could see the
7 next page as well, which I think is 336. We will deal
8 with that. Paragraph 26 runs over the page.
9 THE CHAIRMAN: Let's stay where we are. Let's pick up the
10 first point. Is it paragraph 18 you want to pick up on?
11 A. Paragraph 18. Bearing in mind this was out for
12 consultation in October 2005. I mean, this was the
13 issue I alluded to in relation to the e-mail
14 correspondence of 13th October and my further e-mail of
15 27 October 2004, flagging up concerns around complex
16 considerations in terms of deaths such as Claire's where
17 one or more organisations are involved. Paragraph 18:
18 "Organisations continue to ensure patient safety or
19 client safety."
20 Again, I felt that I had that assurance in that we
21 had done the case note review and no other issues had
22 been identified and the vulnerability as I understood it
23 in relation to Claire's care was practice as it
24 pertained at that time. Again, might I just highlight:
25 "... but not undertake any activities that might

208

1 compromise any subsequent statutory investigations."
2 At 18.
3 MS ANYADIKE-DANES: Dr McBride, that's talking about until
4 the preliminary meeting. Where you were previously,
5 which is 334, I think, which starts -- this whole
6 section is called "Coordination of investigatory
7 activity". That tells you what to do when you have more
8 than one investigation involved and you see it at 14.
9 When that's the case, you are supposed to move on and
10 have a preliminary meeting. It is in the course of
11 the preliminary meeting when you can resolve how
12 things can proceed without the compromise and all
13 paragraph 18 is telling you is: maintain the status quo,
14 if you like, until you have been able to sort that out
15 in the preliminary meeting.
16 A. Miss Danes, that's the point I am making. Again, this
17 guidance was only issued by the department in 2006.
18 There was not guidance in relation to how to deal with
19 these very complex cases. What there was in
20 October 2005 was a consultation document.
21 Q. Uh-huh.
22 A. Indeed, where this information was shared in terms of
23 the department's thinking, a recognition of the
24 complexities involved here, and the department's
25 thinking and the work they were doing with the PSNI, the

209

1 members of staff who may subsequently give evidence at
2 court."
3 As I was saying earlier, I think where this is
4 relevant is once the coroner's verdict in relation to
5 Claire's death was made -- and I have mentioned this in
6 my witness statement -- with the benefit of hindsight --
7 I had no -- I had every realistic expectation that all
8 statutory processes, when I referred Claire's death to
9 the coroner back in 2004 --
10 MS ANYADIKE-DANES: In ease of you, the reference in your
11 witness statement is 269/1, page 13.
12 A. I had every reasonable expectation that any statutory
13 investigations would be completed in a reasonable
14 timescale. Now, given a range of complex factors which
15 certainly, you know, I am not necessarily fully familiar
16 with, that took, I think, much longer, as the chairman
17 mentioned earlier, than any of us would have wished, and
18 the fact that, you know, here we are in 2012 and Mr and
19 Mrs Roberts are still seeking answers to those
20 questions. I think that is not acceptable. I think
21 that context and that draft guidance which was out for
22 consultation, I suppose, is relevant in the fact that it
23 informed my thinking in relation to how we might proceed
24 here. There was -- I think it was an opportunity and
25 I think the opportunity -- and again this is why

211

1 Court Service, to actually develop this. So certainly I
2 was very much aware. I mean, if we go to paragraph 26
3 of that document, because I think it is relevant as
4 well, I think -- it might be -- it is over the
5 page actually, I think, on the next --
6 THE CHAIRMAN: If you can put ups 336 and 337. Thank you.
7 A. I mean, my -- I mean, I was aware of this document, this
8 consultation document in October 2004. It was prior to
9 Claire's inquest and, indeed, I was involved in some of
10 those discussions with the department and coroner at
11 that time in terms of the development of this, as were
12 other medical directors in Northern Ireland at the time
13 because we realised there was a complex issue and there
14 was no guidance anywhere in the United Kingdom at this
15 time in terms of advising trusts to deal with complex
16 cases such as that, but if you read paragraph 26:
17 "In such circumstances, the conduct of any further
18 Health Service investigation will need to be discussed
19 by the reached ICG(?) ..."
20 Remember there were no arrangements in place, there
21 was no guidance until February 2006:
22 "... So that the necessary further investigation by
23 the trusts [shall we read] can be conducted in such
24 a way as to avoid the danger of prejudicing the police,
25 coroner, and other investigations, by interviewing

210

1 I mentioned it and I indicated so in my witness
2 statement. I think there was an opportunity towards --
3 following the coroner's inquest.
4 Q. To do that?
5 A. Even though -- and indeed, at that time, we were aware
6 that there were police investigations ongoing, we could
7 have met with the police team. We could have used this
8 guidance which was published in February 2006, although
9 it had only just gone out. So we had no familiarity
10 with the use of it, and indeed we could have discussed
11 whether or not it would have been possible to carry out
12 an investigation at that time.
13 Q. Yes. No, I understand that and, in that part, the
14 penultimate part, "with hindsight and experience",
15 I think you are identifying something of that sort in
16 your witness statement.
17 The point I was asked to put to you, though, is:
18 once you had raised the fact that there was this
19 document, which I think you have said you were part --
20 well, you were involved in its development. Let's put
21 it that way. So you knew what was happening, and the
22 point that I'm asked to explore with you just briefly
23 is: even though the guidance was not finalised, so you
24 can't say it is now guidance that we all have to try to
25 pay some heed to, the intention was there that it would

212

1 be something like that because you all knew what the
2 issue was and whether or not you could not have
3 subjected Claire's case to an ad hoc arrangement where
4 you could, on a one-off basis, if I can put it that way,
5 have met with the relevant persons and ensured you could
6 move forward without compromising anybody's
7 investigations. That's just the issue I have been asked
8 to put to you.
9 A. And I think that's the point that I am alluding to there
10 at 27 in terms of that paragraph, "with hindsight and
11 experience", because I think that there was
12 an opportunity there to use this guidance, even though,
13 as I say, it had not been road-tested, as it were. It
14 would have required the agreement of the PSNI. It also,
15 Mr Chairman, if I might suggest, it may have required
16 some liaison with this inquiry, because obviously at
17 that stage we were aware that the coroner had been in
18 communication with this inquiry.
19 THE CHAIRMAN: It is a pretty frightening experience to go
20 back through the years, Dr McBride, but we were stayed
21 from 2005 until 2008 because of the police
22 investigations. So if anything had been done in two
23 thousand -- and it wasn't until we resumed in 2008 that
24 I added Claire's case to the inquiry.
25 A. Okay.

213

1 Q. He produced a signed statement -- and we don't need to
2 pull it up, but one sees that at 139-098-021.
3 A. That's correct.
4 Q. And in that statement, he includes the statement:
5 "I made the mistake of not seeking an intensive care
6 placement ..."
7 Maybe I will pull it up so it is not unfair.
8 THE CHAIRMAN: You had better.
9 MS ANYADIKE-DANES: 138-098-021. Can you see that?
10 THE CHAIRMAN: It is the bottom paragraph.
11 MS ANYADIKE-DANES: And it is struck through. There you
12 see:
13 "I made the mistake of not seeking an intensive care
14 placement for Claire before I left the hospital."
15 You can see that. This is Mr Walby's correction.
16 And he strikes that through and substitutes for it:
17 "Although I did not seek an intensive care placement
18 [et cetera] I am not sure whether she would have met the
19 criteria."
20 That reference I made to the mistake is signed by
21 Dr Webb and sent you to be transmitted, presumably, to
22 the coroner. Dr Walby amends that. He explains why he
23 does it --
24 THE CHAIRMAN: I think to be fair, we have to say to
25 Dr McBride that Mr Walby's position is that he received

215

1 THE CHAIRMAN: But there was at least the very strong
2 potential after the inquest and after the police
3 investigations for Claire's case to be added.
4 A. Yes, and I accept that.
5 MS ANYADIKE-DANES: I have just two more areas that I would
6 like to have your assistance with.
7 A. Sure.
8 Q. One of them is -- it rolls on quite nicely. One of them
9 is the whole area of assistance to the coroner. There
10 are two -- the point really relates to the statements to
11 be prepared for the coroner.
12 A. Yes.
13 Q. If you've read the transcripts, you will know that there
14 is an issue over the amendment to Dr Webb's statement.
15 Dr Webb --
16 A. I have attempted with other commitments --
17 Q. That's a lot of transcript to read!
18 A. I have other commitments to keep up, but I haven't been
19 able to --
20
21 Q. The matter is quite net. And that is that Dr Webb's
22 original signed statement -- he produced a statement for
23 the coroner. At that stage, he was no longer with the
24 trust; he was now in the south.
25 A. That's correct.

214

1 this statement. He thought it was inappropriate. He
2 made the alteration, which is set out there in pen, and
3 Dr Webb accepted that and then sent a revised version
4 back to the north and it was the revised version which
5 was received by coroner. So I think, in fairness to
6 Mr Walby, he did not refuse to accept or dictate this
7 amendment, but he suggested it and Dr Webb accepted it;
8 okay?
9 MS ANYADIKE-DANES: I was just going to go to that and give
10 you the quote:
11 I think it is not clear that it was a mistake and
12 would I allow others to judge that if they wished."
13 That was in the communication that Mr Walby sent
14 back. The reference is 139-096-001. We don't need pull
15 it up. I was going to give you that. He explained why
16 he had done that. In Dr Webb's evidence, he accepted
17 that and he included that revision, signed the document,
18 and sent it back.
19 What I was going to ask you about is: there is
20 a protocol about taking a witness's statement and one
21 sees that at 133-003-002. I was going to pull up
22 paragraph -- yes. Can we go to perhaps the next page of
23 that, 003? There we are. Sorry. Can you see
24 paragraph 7, which is the penultimate paragraph:
25 "Once a statement is signed, it must not be altered

216

1 without the express approval and consent of the witness
2 [and so on]."

3 This was sent out to all chief executives and it
4 says, at the top, 14 November 2002. What I wanted to
5 ask you was: were you aware of this document as part of
6 your role of assisting the coroner and so forth?

7 A. I honestly can't recall with the passage of time whether
8 I considered this document then or was aware of its
9 existence. I certainly wouldn't have -- I never had
10 recourse to refer to it. I can't, with all honesty, say
11 that I had recourse to refer to it during my time as
12 medical director or that I considered it. I know that's
13 not answering your question in terms of was I aware of
14 it --

15 THE CHAIRMAN: Let me ask you this in a slightly different
16 way. We know from Mr Walby's evidence and, before him,
17 Dr Murnaghan that they had quite a lot of interaction
18 with the coroner, if you'll pardon the phrase. They
19 were the link men at different times. To what extent
20 did you have direct contact with the coroner? To what
21 extent were you a link man?

22 A. I wasn't. I mean, I certainly had occasional contact
23 with the coroner. I believe I met him when I took up my
24 post in 2002. Certainly the coroner would have
25 communicated to me following a coroner's inquest in

217

1 Trust, so he is sending it up from the south. Were you
2 aware he performed that role? He looked at statements
3 and suggested amendments and revisions and so forth.

4 A. Certainly I was aware that the coroner requested that
5 Mr Walby assist in the collection of statements and
6 gathering of statements.

7 Q. Yes. I meant this aspect of it, really.

8 A. In terms of suggesting revisions --

9 Q. Revisions and so forth.

10 A. I mean, I think that, you know, I would have --
11 I suppose I've not previously considered this document.
12 I've not seen Dr Webb's statement and I've not seen the
13 proposed change.

14 Q. I understand.

15 A. Certainly I would not have expected any changes that
16 were material to the letter other than those that were
17 maybe one of formatting or --

18 Q. It might be argued --

19 A. Sorry?

20 Q. Sorry. It might be argued that removing a reference to
21 you believing that you had made a mistake about
22 something, particularly actually as you now know that
23 that reference to PICU is something that actually the
24 family had expressed a concern about themselves in the
25 8th December letter ...

219

1 terms of matters he felt were relevant and matters he
2 felt needed to be addressed. I can't recall whether
3 that was direct communication with me or if it was, you
4 know, written communication or whether those were
5 matters he was communicating to the department in
6 relation to some matters arising from a coroner's
7 inquest that needed to be addressed and I was copied
8 into that correspondence.

9 THE CHAIRMAN: But in terms meeting him in advance of an
10 inquest and agreeing to get statements from people or
11 who might have been an expert witness did you --

12 A. At no time would I have been involved in meetings with
13 the coroner in advance of inquests. At no time would I
14 have been involved in collecting statements, commenting
15 on statements, or facilitating statements. That -- I
16 didn't --

17 MS ANYADIKE-DANES: Did you know that as part of his role --
18 Mr Walby also had a role as a litigation manager, or he
19 was in litigation management.

20 A. He had a variety of roles and that was certainly one of
21 them.

22 Q. Were you aware that, as part of his role, he would, from
23 time to time, do this, look at the statements that were
24 being sent? In this case, it happened to be because
25 Dr Webb was no longer within the employment of the

218

1 A. I mean, well, I was considering that and I was -- you
2 know, the same question I suppose that you are posing
3 now: was that a material change or isn't it?

4 Q. Yes.

5 A. I mean, I suppose I was thinking that rightly those are
6 matters for the coroner to consider and obviously what
7 should be of value to the coroner is factual
8 information. I suppose one could argue that -- I mean,
9 you could argue it either way that, you know, what
10 Dr Webb was perhaps providing more than factual evidence
11 was providing an interpretation of what his actions were
12 and perhaps what he thought his actions should have
13 been, and obviously if indeed that was the case, then
14 one would have expected during the inquest at some point
15 in time that that would have arisen or indeed may have
16 been shared or been discussed at the coroner's inquest,
17 but again I haven't seen that before --

18 Q. I understand.

19 A. -- and I am not sure I can make any further comment on
20 it, to be honest.

21 Q. No. That's fine. The final points that I would like to
22 ask you about the coroner's process is that the coroner
23 issued a best practice or at least referred to best
24 practice in a letter dated 30th January to you I think,
25 and that's -- the reference is 129-007-001, and --

220

1 A. Can we have the following page?
2 Q. Yes, of course. I was just going to put that up. 002.
3 There we are.
4 A. I think there's a following page as well, but anyway two
5 at a time, yes.
6 Q. We will --
7 A. Sure.
8 Q. -- remove one of these as we work through it and get rid
9 of it that way. So what he is referring to is best
10 practice, and what had previously happened is as he
11 describes in that rather long first paragraph about how
12 statements were taken. Then he says that it has been
13 put to him that this approach:
14 "... did not constitute best practice, as the police
15 should interview those concerned as soon after the event
16 as possible and, where necessary, seize medical notes"
17 and so forth.
18 "I agreed that in future I would agree to a police
19 officer interviewing those involved. The present system
20 would be discontinued."
21 Then as you have referred to the next page, is there
22 a particular part of the next page you wanted to
23 highlight?
24 A. Well, it was just that -- I mean, the letter was
25 addressed to me, but it was also copied to all other

221

1 Q. Well, the coroner has -- I mean, I was actually coming
2 at it from a slightly different perspective. The
3 coroner has referred to that as best practice, because
4 there's an underlying concern about not doing things in
5 that way.
6 A. Yes, yes.
7 Q. That's the quality of the evidence that you receive and
8 so forth. Sorry.
9 MR McALINDEN: I wonder how far -- my learned friend has
10 said that the coroner has referred to it as best
11 practice. That might well be the content of this
12 letter. The facts are that up until the present time
13 the coroner still requests the Belfast Trust to collect
14 statements for inquests. That is up to the present
15 time. The system didn't change before Claire's death
16 and it hasn't changed after Claire's death. So if this
17 is an issue which is a live issue at this investigation,
18 then it is certainly an issue that should be addressed
19 to the coroner and should not be addressed to Michael
20 McBride.
21 THE CHAIRMAN: There are two points. First of all, the
22 letter doesn't actually say that this is best practice.
23 He says -- it says:
24 "It was put to me that this approach did not
25 constitute best practice and I agreed therefore in

223

1 medical directors in the trust, which I think is
2 an important point.
3 Q. Yes, yes, of course. What I wanted to ask you there was
4 it becomes clear from communications from I believe it's
5 Mr Walby that actually the new system that the coroner
6 has envisaged would come into practice and the present
7 system be discontinued didn't actually happen and that
8 continued on for quite some time and indeed continued on
9 over the period when the statements in relation to
10 Claire's inquest were provided to the coroner.
11 What I wanted to ask you about is what, if anything,
12 did you think you should put in place to reflect the
13 coroner's concern that what was happening at the time
14 was not best practice, and that he wanted the present
15 system or believed that the present system should be
16 discontinued?
17 A. I mean, my personal interpretation of that --
18 Q. Yes.
19 A. -- you know, those are matters for the coroner. I mean,
20 if the coroner wishes to conduct his investigations in
21 a certain way, then that's for the coroner to take that
22 course of action and, you know, it's not for us to have
23 a view or otherwise on that or indeed to seek to action
24 that. As you have indicated in the question, he
25 subsequently didn't action that.

222

1 future I would do something else. The present system
2 would be discontinued."
3 That hasn't been done between the coroner and the
4 police, as I understand it.
5 MR McALINDEN: At all between the coroner. To the best of
6 my recollection it certainly hasn't been done in
7 relation to the Belfast Trust or in relation to any
8 other trust in Northern Ireland.
9 THE CHAIRMAN: But if it is to be done, it has to be
10 effectively --
11 MR McALINDEN: It's an action for coroner; it's not
12 an action for the trust.
13 THE CHAIRMAN: It's an action for the coroner in conjunction
14 with the police and through them to the trust, but the
15 second issue is I think in broad terms there is a number
16 of issues. Particularly we may be coming to more in
17 respect of the aftermath of Lucy's case. I at least
18 have a view about the extent to which this inquiry
19 established by the Department of Health gives me a remit
20 to investigate the coroner's practices.
21 Miss Danes.
22 MS ANYADIKE-DANES: I'll move on.
23 THE CHAIRMAN: In fact, it might be a lesson -- it might be
24 an issue coming out of the inquiry report, which,
25 Dr McBride, might I suggest end up falling on your desk,

224

1 about whether there's a need to look -- to look back at
2 this issue, because -- to see if the coronial service
3 with Mr Leckey now as the senior coroner, whether that
4 is still the view, and if it is, what's to be done about
5 it, and if it isn't, how they have moved away from it,
6 but there are a number of issues on the edge of this
7 inquiry which involve connections between the Department
8 and its various trusts, on the one hand, and the
9 coroner, on the other.

10 A. Okay.

11 MS ANYADIKE-DANES: Yes, and from your -- from the trust
12 point of view presumably concerned -- if one's thinking
13 about the quality of the evidence, which is actually
14 what the whole thing is really driven by --

15 A. I accept that, yes.

16 Q. -- so if you're considering -- if that's the issue and
17 that you have a concern that there might be a tension,
18 if I can put it that way, between the same individual
19 who is there as a sort of a -- has a litigation role and
20 to manage that aspect as best as they can for the trust,
21 but on the other hand they're also charged with getting
22 out the information in the -- to the best possible
23 standard for the coroner, there's a tension there and
24 I suppose -- sorry. There is a potential tension there.

25 A. Yes.

225

1 was an approach that was going to be taken by the
2 coronial system. There as a whole -- certainly my view
3 was that that -- if that was the case, that needed to be
4 communicated, coordinated. There were some issues in
5 the letter, I -- you know, which -- in relation to --
6 and I appreciate that the comments are qualified by "in
7 certain circumstances and in certain deaths" in terms
8 of, you know -- and indeed it would apply in certain
9 circumstances. Potentially the hospital environment may
10 be treated as a scene of crime. There are all sorts of
11 issues in relation -- it takes us back to the memorandum
12 of understanding again -- in relation to both the
13 integrity of the evidential basis of information that
14 the coroner needs in relation to conduct investigations
15 into the cause of death, the integrity of the evidential
16 information which the PSNI or indeed the Health & Safety
17 Executive may require to actually form an informed view,
18 and I think this -- my recollection is that this got
19 subsequently taken forward in the work to development --
20 to develop the memorandum of understanding between the
21 Department, the PSNI, the Court Service and the Health &
22 Safety Executive.

23 Q. Yes. It could be landing on your desk. Just one point.
24 In fairness to you, you produced a document that might
25 clarify matters. It's called "Models" -- you probably

227

1 Q. What I am inviting you to consider is, irrespective of
2 whether the coroner had specifically instituted a new
3 system, recognising that that's the issue that's
4 involved, did the trust seek, if we are not involving
5 police officers, because that system hasn't been
6 established, can we make sure that maybe we have
7 an independence to the way the statements are taken, if
8 I can put it that way?

9 A. Again I would just answer that as I answered previously.
10 I mean, this was a letter simultaneously. You have to
11 understand it was a letter -- communication with the
12 Department. This was a letter that was addressed to me.
13 It went to all the trust medical directors. I actually
14 on considering that felt this was an action for the
15 coroner. I did not feel that there was -- you've got to
16 bear in mind that the -- Mr Leckey at that point was one
17 of and still is one of a number of coroners, and
18 I suppose there needed to be -- I wasn't certain when
19 I read that whether that was his view. I don't think he
20 was the senior coroner at that point.

21 THE CHAIRMAN: He wasn't. He was the Belfast coroner.

22 A. He was the Belfast coroner.

23 Q. There were other area coroners.

24 A. There were other area coroners. So I wasn't sure
25 whether that was his view; it was a collective view; it

226

1 remember it -- "Model for Learning Lessons" --

2 A. I did, yes.

3 Q. -- yes, on 27th April --

4 A. I did.

5 Q. -- 2006. If we just pull up, just to make the point
6 that you're dealing with now, 269-2 at page 348, there
7 you see it, "Sources of information for learning
8 lessons". If you look at sort of 9 o'clock, you can see
9 that in there is -- leaving aside the RQIA, you have got
10 coroners in there. So at some point presumably somebody
11 is thinking about, "How do we draw together those
12 sources of info..." --

13 A. Yes.

14 Q. -- "potential sources of information in the interests of
15 learning lessons and disseminating information better
16 and perhaps avoiding -- you know, minimising the risk of
17 incidents occurring again. I mean, I'm not asking you
18 to explain how you do it now, but is that the thinking,
19 that you knew that people were thinking there ought to
20 be some way of integrating those sources of information?

21 A. Well, this is the document that I led on development of
22 whilst Medical Director in the trust, recognising that
23 we learn lessons from a variety of sources, you know.
24 Again you will see complaints which we've discussed:
25 near misses, adverse events, root cause analysis and

228

1 external reviews, whether those are by the ombudsman, by
2 the coroner, or by a range of sources, and it's about
3 ensuring that we're capturing all of that learning and
4 then translate that into action. I think if you look at
5 the page before that in terms of what the purpose of
6 this was, I mean, this was -- this arose out of an
7 analysis. You know, in terms of the learning
8 organisation I think it's probably reflective of the
9 fact of what we were doing as a trust at that time. I
10 think the previous page -- sorry. I don't know if we
11 can see the previous page. You know, para 2.1. The
12 terms "lessons learned", these are often, you know,
13 bandied about, you know, "learning lessons", "lessons
14 learned", but unless actually you can -- you know, as I
15 say, unless you can demonstrate that those are actually
16 translated into tangible actions within an organisation
17 to ensure that whatever contributed to something which
18 happened previously, whether it's an adverse incident or
19 whether it's a complaint, then indeed that organisation
20 isn't learning and isn't putting in place effective
21 mechanisms to ensure that that vulnerability is
22 addressed.

23 That was the purpose of this work. We triangulated
24 a number of sources of information from root cause
25 analysis that we had carried out at that time into --

229

1 That's what I'm coming to. So there was that circular
2 in 2004 --
3 A. Yes.
4 Q. -- but the Department does not refer this as a serious
5 adverse incident to -- sorry -- the trust doesn't to the
6 Department in 2004. So then comes another circular in
7 2005.
8 A. Yes.
9 Q. One sees that at 068-001-251.
10 A. Yes.
11 Q. This is actually reiterating the previous one and it's
12 underlining the need for HPSS organisations to report
13 serious adverse incidents in line with PPM0604, which is
14 the document that we were just looking at. Now it
15 wasn't reported in 2005 either.

16 Now a key objective in all of this, of course, is
17 that lessons are learned from adverse incidents and the
18 quality of services is improved, and it may seek ... --
19 well, that's the purpose of it, and also because
20 the Department may seek clarification, and they may want
21 to do something further. Not to be called up, but the
22 reference to what I've just been citing is 139-045-005.

23 Then we asked and we know there were no
24 investigations into Claire's death prior to 2004.
25 That's okay, but if you then find out, "Well, when was

231

1 indeed into some patient deaths, and we had shared
2 those, as I have indicated in my witness statement, with
3 a number of bodies, with RQIA, with the Department, as
4 relevant. So we were an organisation which was seeking
5 to ensure that we were learning from the experience of
6 sometimes when things went wrong --
7 Q. Yes.
8 A. -- and actually incorporating that into -- into action.
9 Q. Then the final point I think I indicated to you, the
10 serious adverse incidents. I think -- I hope we can
11 deal with this reasonably quickly. In 2004 there was
12 a circular issued relating to it, and I think one can
13 find that at 061-2 at page 425. I hope so. There we
14 are. At paragraph 15 this is:
15 "The Department will expect urgent local action to
16 be taken to investigate and manage adverse incidents."
17 Now the Chairman has heard information from a number
18 of different clinicians, and there seems to be some
19 consensus that ultimately what happened in relation to
20 Claire could be characterised as a serious adverse
21 incident and, in fact, the trust did make that report
22 later on.
23 A. Yes.
24 Q. This is a question of timing. So there's no issue that
25 that was its character. This is a question of timing.

230

1 the reference of an SAI made in relation to ..." --
2 A. 28th March 2006.
3 Q. Exactly. I'm just going to ask you very briefly about
4 that. One sees the actual report, 302-164-003.
5 A. Yes.
6 Q. There it is. So that's the date when it happened, 28th
7 March 2006. As I understand it, though -- well,
8 firstly, why was -- why did you wait until then before
9 it was made, despite the earlier requirements?
10 A. I mean, I think it is relevant. I'm sorry. Apologies
11 if this seems like a rather long answer. We were
12 reporting it in 2006 --
13 Q. Uh-huh.
14 A. -- using that SAI format because of the matter of public
15 concern, and the reason and the rationale for reporting
16 at that time was the recognition that, given the
17 imminent coroner's inquest, there was likely to be
18 matters arising that would cause public concern. We
19 hadn't certainly and weren't sharing it with the
20 Department at that stage, because we felt that there was
21 matters that warrant regional action to improve safety
22 or quality. Again it goes back to the point I was
23 making earlier in relation to the case note review.
24 Notwithstanding the problems which have been identified
25 as a result of this inquiry, leaving those aside for one

232

1 moment, certainly neither as a result of the case note
2 review or indeed the coroner's inquest -- and I
3 appreciate, you know, you made the point earlier, which
4 I accept, in relation to the coroner's -- coronial
5 system and its function. No -- there were no matters
6 that were identified that suggested that there was any
7 additional learning at that point in time in respect of
8 Claire's care other than hyponatraemia and the use of
9 hypotonic fluids.

10 Now I accept -- and I think I've said this --
11 I would accept that the intention of the 2004 circular
12 -- what the Department's intention was that an SAI
13 should have been submitted at the -- at that time in
14 2004 and I accept that. I think there are -- there are
15 other matters of context which I think that are
16 important.

17 I mean, if we call up, if I may, 139-058-001 and
18 also at the same time 139-044-001, just to highlight
19 this is my being alerted -- the first of those --
20 sorry -- is at the bottom -- the last sentence -- sorry
21 -- there is my being alerted by Mr -- well, I'm copied
22 in actually, copied into an e-mail from Mr Walby,
23 indicating the impending or imminent coroner's inquest.
24 Again you will see at -- that that -- which is what I
25 understood to be the case, that the Department had been

233

1 Q. No. Sorry. I'm just dealing with the awareness point.
2 So what -- the Department would not have been aware of
3 those broader issues which, in fact, are part of the
4 broader issues that make it the sort of thing that you
5 should be referring as an SAI?

6 A. Well, I mean, I -- I mean, I think this is -- I mean, I
7 think that we just -- I think it is important to
8 consider this in the context. This was a circular which
9 had gone out in July of 2004.

10 Q. Uh-huh.

11 A. This was the introduction of a new process and
12 arrangement, and indeed the process and arrangement such
13 as it was prior to that would that be that the
14 organisations would contact the Department. So, for
15 instance, if a matter arose prior to the introduction of
16 the circulars that, for instance, I or another trust
17 Medical Director felt was relevant, had perhaps regional
18 significance or regional learning, we would have picked
19 up the phone and spoken to the Department about that.

20 THE CHAIRMAN: Like Altnagelvin did when Raychel died?

21 A. Yes. Okay. So we were here in the middle -- we were in
22 the transition between what was custom and practice and
23 now the Department saying, "Actually we now think we
24 need to do this differently".

25 I think the important point here is that had we

235

1 informed back in 2004 whenever we reported Claire's
2 death to -- to the coroner, and again you see the e-mail
3 of 4th April, again which I think is relevant.

4 So my understanding at that time was that the
5 Department was aware of -- and my recollection is that
6 the Department was aware of Claire's death. I accept
7 that the fact that the coroner has contacted the
8 Department, or indeed I may have had a conversation with
9 the Department, did not obviate the need, I say with
10 hindsight, for the trust to submit an SAI report, and
11 that was clearly I think now in -- reflecting on the
12 2004 circular, the intent of that circular.

13 I think there are a number of other pertinent
14 points, if I may, Chair. I think if you look at the --
15 so that was my understanding, that the Department was
16 aware, but we had not formally completed the pro forma
17 and sent that into the Department. That's correct.

18 MS ANYADIKE-DANES: Just before you move on can I just ask
19 you this: when you say the Department was aware, was it
20 -- did the Department ever get the correspondence that
21 the Roberts had sent in raising their issues?

22 A. No, no.

23 Q. Or the minute of the meeting with the --

24 A. No, and indeed to this day wouldn't. I mean, I think
25 we --

234

1 submitted an SAI at that time -- and I accept with
2 hindsight that's what the Department's intent would have
3 been --

4 Q. Yes?

5 A. -- and indeed it would have certainly -- we were sending
6 it up clearly in 2006, because public concern -- we were
7 referring to the coroner. We knew in December 2004 we
8 were referring it to the coroner. When you re-read the
9 circular, it does state "at the time of discovery" and I
10 accept that. There was no ... -- there was no mechanism
11 regionally in relation and indeed within the Department
12 at that time, nor indeed for that matter anywhere else
13 in the UK. I mean, yes, there was "Do no harm" 2001
14 NPSA established, but if you look at the assessment, the
15 National Audit Office assessment of how effective that
16 had been at that time, again it shows the difficulties
17 and challenges in introducing a regional system.

18 THE CHAIRMAN: I missed this a bit --

19 A. Sorry.

20 Q. -- because it seems to me that the Altnagelvin report to
21 the Department had dramatic effect. The Altnagelvin
22 report to the Department of Raychel's death had a pretty
23 dramatic effect of leading to the development of
24 a committee which put together hyponatraemic guidelines,
25 which, as you rightly said earlier, put us ahead --

236

1 A. It did, yes.
2 Q. -- within the UK on hyponatraemia. So there's a --
3 there's a pretty pertinent and reasonably recent example
4 of a report which -- which had major benefits to the --
5 to the children in Northern Ireland.
6 A. And I accept that. I think the wording of the 2... -- I
7 mean, I think -- I mean, the point I would make is if
8 you read in detail maybe, and I think it is important
9 that we read in detail the 2005 circular in terms of the
10 developmental nature of these arrangements that were
11 being taken forward, the 2004 circular, and it says so
12 at paragraph 7, if we look at the 2004 circular, was
13 seeking to build on existing incident reporting systems
14 which were in trust. There was no regional system at
15 that point in time. If you actually look at the --
16 sorry. I don't know. Isn't it WS061/2, is it?
17 Q. You want the 2004 circular?
18 A. Yes, please.
19 Q. Sorry. I beg your pardon. It is WS061/2 at page 425.
20 A. I mean, I think there is -- I mean, if you -- maybe --
21 could we start from the start of the circular, please?
22 Sorry. I don't know what the page number is.
23 Apologies. Paragraph 2.
24 THE CHAIRMAN: Go back one.
25 MS ANYADIKE-DANES: Go back one. Right.

237

1 "The HM coroner has obtained independent expert
2 reports."
3 And for that you might say, "We had obtained
4 an independent report in Professor Young", everything
5 else there could remain absolutely the same whether you
6 were doing that in 2004 or 2006.
7 A. Again I wanted to make this point and it is about
8 wording. I think if you look at the document, this was
9 a new system that was going out, and indeed if you look
10 at the 2005 circular and the 2006 circular, it makes
11 clear the development nature of these arrangements. We
12 had -- over a 21-month period the Department issued four
13 circulars in relation to SAI reporting. They issued one
14 in July 2004, which we were just looking at, one in June
15 2005, which you've referred to.
16 Q. Yes.
17 A. Indeed, there's important aspects other than
18 reaffirming. There's aspects recognising that there was
19 a need to clarify definition in relation to what
20 constituted an SAI. It alluded to in 2005 the
21 arrangements the Department was putting in place at that
22 time, and indeed you had a further revision of the
23 definition of an SAI and a new pro forma in 2006. Then
24 in September of 2007 you had the first regional guidance
25 in relation to SAIs, definition of SAIs. So this was

239

1 A. The page before, is that paragraph 2? Oh, sorry. There
2 it is.
3 Q. No, paragraph 2 is there.
4 A. Yes. I mean, this circular clearly indicates that this
5 is interim guidance. If you look at the final
6 paragraph, which I think is paragraph 19, it says that
7 the Department would keep this under review and welcomes
8 feedback. So this was very much initiating arrangements
9 for adverse incident reporting in Northern Ireland and
10 this was interim guidance.
11 Q. The -- sorry, Dr McBride.
12 A. No, it's okay.
13 Q. The fact is the Department wanted these things to be
14 referred to it, and for that matter it wanted them to be
15 referred urgently, and it defines serious adverse
16 incidents.
17 A. Yes.
18 Q. So the point that I am making to you is that was
19 a requirement, that you had to do that in 2004. Then
20 they followed it up in 2005 --
21 A. Uh-huh.
22 Q. -- and you ultimately do it in 2006. When one looks at
23 what you actually say on your report in 2006, and if we
24 just pull up that, 302-164-003, if you leave out the
25 first sentence under "Briefly explain", which is that:

238

1 very much -- either 2004 --
2 Q. I take the evolving points, Dr McBride. I do take that,
3 but it's with the -- sorry -- it's with the benefit of
4 hindsight. At the time -- you don't know how many more
5 of these you're going to have. So one lands on your
6 desk in 2004. That's the requirement that you're
7 supposed to notify.
8 A. Sure.
9 Q. Why don't you do it, otherwise the argument that you're
10 positing is that anybody who's got a potential SAI sits
11 tight to wait to see how many revisions we'll have in
12 our ongoing process.
13 A. No. Sorry. That's not the point I'm making at all,
14 Miss Danes. If we look at paragraph 2 again -- and I
15 think this is an important point -- there is a hierarchy
16 of priority that the Department is clearly -- is clearly
17 setting here. As you would expect, the Department must
18 be informed immediately about incidents which are
19 regarded as serious enough for regional action.
20 I made the point earlier in relation to
21 Claire's case note review. The point that we had
22 ascertained was that there was thought to be a problem
23 in relation to paediatric practice and the use of
24 intravenous fluids at that time. There was no
25 additional regional learning that was identified in the

240

1 regional -- in the case note review at that time. So
2 immediate action with incidents which were regarded to
3 be serious enough for regional action.

4 When we submitted the SAI report in 2006, it wasn't
5 because we felt that there was further regional action
6 needed. That regional action had been taken, as the
7 Chairman reminded us of, in 2002 with the Department
8 saying, "Here is guidance. Make sure that this guidance
9 is implemented". If we then go -- sorry.

10 THE CHAIRMAN: Does that mean that the reason -- to try to
11 summarise it, the reason for reporting it at that stage
12 is because the inquest is just around the corner?

13 A. It was on grounds of public concern.

14 Q. Yes, and the public concern is -- the concern is, "We're
15 probably going to get a lot of publicity in the fairly
16 near future about this inquest, because it's
17 another hyponatraemia inquest".

18 A. Well, I think that therein lies the point, but I think
19 when the circular went out -- things have changed now --
20 we -- there was concern in the service -- and I am only
21 reflecting what was the case at that time -- that this
22 circular conflated two things. One was which is about
23 serious adverse incidents, when something goes wrong and
24 in the immediate aftermath of the serious adverse
25 incident. So when something happens in the service,

241

1 Q. But when you were in --

2 A. That's the point I'm making.

3 Q. When you were in 2004, you already had a matter of
4 public concern. You'd had a documentary identify three
5 deaths relating to this particular condition and now you
6 knew there was potentially a fourth.

7 A. Sure.

8 Q. In fact, not potentially. The expert that you had
9 brought in told you, you did have a fourth.

10 A. Yes.

11 Q. So that -- that element of public concern --

12 A. And I --

13 Q. Sorry. Bear with me.

14 A. Sorry.

15 Q. -- is already there and you know that it's going to the
16 coroner. So once you've got all those things in place
17 why are you not referring it to the Department?

18 A. And I was seeking to explain that, and I've already
19 accepted the point, Miss Danes, that with hindsight it
20 was -- certainly it was the intention of the circular
21 and it should have been done, and I make absolutely --

22 Q. I understand.

23 A. But there is -- I mean, I think there's an important
24 context, if I may be allowed a few more minutes. If you
25 look then at the next sentence, it also draws attention

243

1 that the trust makes a decision as to whether or not
2 prior to even full investigation that that's something
3 that requires the Department to be aware of, because
4 there's significant regional learning.

5 The other element of this which was included was the
6 Department to be made aware of issues which were likely
7 to cause public concern. Now clearly there is
8 an overlap between those issues which may require
9 regional action because there's a patient safety issue
10 and issues which might cause public concern. Clearly
11 an overlap, but also this was being used to -- and again
12 if we come to annexe A, and we will come on to it in
13 a moment, it was also the vehicle that the Department
14 was using at that time for it to be made aware of
15 anything that was likely to arise in -- in -- of concern
16 in the media.

17 MS ANYADIKE-DANES: Dr McBride, the only thing that had
18 changed between 2004, when you got the first circular,
19 and now when you're submitting your report in 2006 is
20 the proximity of the inquest --

21 A. Yes.

22 Q. -- because everything else is the same.

23 A. Yes, exactly.

24 Q. Yes, exactly.

25 A. I accept that.

242

1 to the need for the Department to be informed, not
2 immediately informed, but to be informed. Okay? So
3 there's a difference of emphasis where a matter of such
4 seriousness that it is likely to cause public concern.
5 Okay?

6 Now if we then move to paragraph 16 of the same
7 circular --

8 THE CHAIRMAN: 425.

9 MS ANYADIKE-DANES: I think that's -- yes, I believe so, Mr
10 ...

11 A. Okay. In addition -- and it clearly defines those
12 circumstances which would be a serious adverse incident
13 --

14 Q. Uh-huh.

15 A. -- and it says if a senior manager considers it likely
16 so, the senior manager is to use judgment.

17 Q. Uh-huh.

18 A. If you then go to -- and I think this is where the
19 confusion arose, certainly at least in my mind -- if you
20 go then to annexe A of the same circular, it gives some
21 examples.

22 Q. I'm not sure I have that.

23 A. Sorry?

24 Q. I'm not sure I have annexe A -- sorry -- in terms of a
25 reference, but I can get it now.

244

1 THE CHAIRMAN: 427, is it?
2 MS ANYADIKE-DANES: It's 427. There we are.
3 A. Okay. Now I'm not saying this is correct or otherwise
4 in terms of interpretation, but I'm just pointing out
5 some of the internal inconsistencies as I interpret it
6 at least in that document.
7 If you look at examples of serious adverse incident
8 ...
9 Q. Yes. We have some of those, do we not, in Claire's
10 case?
11 A. I'm sorry. I'm not sure what you're referring to, but
12 just in reference to -- in relation -- in reference to
13 this -- in relation to examples, "Court proceedings",
14 the third paragraph down:
15 "Any incident which might give rise to serious
16 criminal charges, impending court hearings, including
17 coroner's inquest."
18 I suppose what I was doing was making the link,
19 making the judgment that the likelihood -- and the fact
20 that the SAI was reported -- Chairman, you're absolutely
21 right -- because of -- was of likely public concern.
22 What I was making the link to was the inference in
23 paragraph 2 of the hierarchy of priorities that the
24 Department was affording to the reporting of adverse
25 incidents. Those issues of public concern did not

245

1 Dr Ian Carson. That's my recollection. I may be
2 incorrect in that recollection. It's clear -- I think
3 the inference from the e-mail of 4th April may well be
4 that certainly Dr Carson had no recollection of that
5 conversation --
6 Q. Dr McBride -- sorry. Go on.
7 A. -- and indeed if I was having it informally, then indeed
8 it was -- you could argue that it was not appropriate
9 conversation or a matter on which to be relaying
10 information of that nature. Indeed, as I've said
11 already, with hindsight the SAI -- it certainly was the
12 intent of the Department that the SAI should have been
13 submitted in 2004.
14 MS ANYADIKE-DANES: Well, then just finally, if one looks at
15 the last sentence in that first paragraph before there's
16 a listing of examples:
17 "Where there are any doubts about an incident it
18 should be reported."
19 That's a precautionary principle. If you are in any
20 doubt, report.
21 A. Yes.
22 Q. Can I just ask you one -- this is my final question and
23 it really is a query about information, if I can put it
24 that way. After you sent or -- sorry -- after the SAI
25 report was sent in --

247

1 require immediate but needed to be drawn to the
2 attention of this Department. Indeed, as you see in
3 this paragraph, it is suggesting:
4 "... impending court hearings, including coroner's
5 inquest."
6 So that was context in my judgment, as per paragraph
7 16, that I felt the public concern was likely to arise,
8 and indeed it was in that context that when I got the
9 date of the coroner's inquest, that I immediately
10 informed the Department --
11 Q. Yes?
12 A. -- but again it was in the context of my -- and I've
13 mentioned this in my first witness statement, 269-1 --
14 Q. Yes.
15 A. -- that my understanding was that the Department was
16 aware of this incident, but we had not I accept formally
17 completed the SAI report.
18 THE CHAIRMAN: How was it? Do you think is this through
19 your meetings that you described at the start of your
20 evidence with the CMO, or grapevine, or what?
21 A. No. I mean, certainly -- my understanding was that the
22 Department had been advised by the coroner, and I have
23 a recollection -- I cannot be certain, and therefore --
24 but my recollection is that I had a conversation with
25 the Deputy Chief Medical Officer at that time,

246

1 A. Yes.
2 Q. -- it wasn't you who did it -- there were some e-mail
3 requests for information. Can we pull up, please,
4 269-2, page 9? There we are. You can see it. It's
5 from you to Dymphna Curley. It's dated 31st March 2006
6 and it says:
7 "Dear all."
8 So there's others who are in that line:
9 "The Department has been informed as per circular
10 HSS and have requested a further background briefing,
11 which I will provide."
12 Can you recall what that was about?
13 A. Again it's back to the --
14 Q. Sorry?
15 A. Sorry. I beg your pardon. Sorry. My apologies.
16 I think it's back to -- and again that would still be
17 the case today, that the -- to my knowledge that the
18 Department may require some additional information.
19 Clearly what we are submitting to the Department is
20 a pro forma and --
21 Q. No. They've actually requested it. That's what I mean.
22 It's not that they may do. They've actually requested
23 a further background briefing, and you said you are
24 going to provide it. That's why I was asking you what
25 was it and did you provide it?

248

1 A. There was certainly no written briefing provided.
2 Certainly what would have been custom and practice at
3 that time would have been that there would have been
4 a telephone contact made and a conversation would have
5 been had. I don't recall that conversation being made
6 or that conversation being had, but that would have been
7 the normal course of events. I suspect that explains
8 the e-mail between 28th March and then -- obviously
9 there was a conversation that happened, and I would
10 infer from that between myself and the Department -- and
11 then you see the subsequent reply of 4th April from
12 Mr Walby, but again that's me seeking to try to --
13 Q. I understand. Everything is trying to do that.
14 A. I am struggling to put together the strands of
15 information that's there.
16 Q. You probably will not have it now, because you have
17 moved on, but is that the sort of communication that
18 would be recorded in writing somewhere?
19 A. Now absolutely.
20 Q. And then in 2006?
21 A. Most probably not. Sorry. 2006?
22 Q. Yes.
23 A. Oh, I would have thought more probably.
24 Q. Well, should it be? Let's put it that way.
25 A. Absolutely certainly, yes.

249

1 and Brief summary of incident" on the SAI report. Do
2 you see that:
3 "The inquest into the death of ..."
4 And so on?
5 A. Yes.
6 Q. The bit I want to take you to is where it says -- it is
7 the tail end of the first line in the second paragraph:
8 "... Claire Roberts' parents contacted the hospital
9 and a review of the notes -- and after a review of the
10 notes it was considered in retrospect that the known
11 hyponatraemia which was treated may have had a part to
12 play in the medical condition ..."
13 Leaving that aside, you can see that is -- also
14 appears under the "Date and Brief summary of incidents".
15 You can see that:
16 "It was considered in retrospect that the known
17 hyponatraemia which was treated may have had a part to
18 play in the medical condition leading to death."
19 Okay?
20 THE CHAIRMAN: It's in box 2. Working up from the bottom,
21 the last three lines.
22 MS ANYADIKE-DANES: Thank you very much indeed. So this is
23 an e-mail that comes in or goes off, I should say, first
24 thing in the morning of 28th March and this incident
25 report is being sent off on 28th March as well.

251

1 Q. Thank you very much.
2 A. Certainly it would be now.
3 Q. Thank you. Mr Chairman, I have nothing further.
4 THE CHAIRMAN: Okay. Are there any more questions for
5 Dr McBride?
6 MR MCCREA: I think so. We are just taking some
7 instructions.
8 THE CHAIRMAN: Okay. If you can wait for five minutes,
9 doctor, we will tidy up any questioning and get it
10 finished this evening, if you don't mind. Thank you.
11 (5.15 pm)
12 (Short break)
13 (5.20 pm)
14 MS ANYADIKE-DANES: Dr McBride, there is only one question
15 or one issue that I have for you. I wonder if we can
16 pull up 139-046-001 and have next to it 002. Right.
17 The only reason I pulled up the 001 is so that you can
18 see the date of that e-mail. So the date is 28th March
19 2006 and you are Ccd into it. Do you see that?
20 A. Yes.
21 Q. Okay. Now can we pull off that 001 and put up
22 302-164-003? There we are.
23 A. Okay.
24 Q. The information that you are being CCed into, which is
25 from Peter Walby, that's the information under the "Date

250

1 The question for you is: did you understand that
2 what had happened was that there was known hyponatraemia
3 in relation to Claire, which had been treated? Was that
4 your understanding of her clinical path, if I can put it
5 that way?
6 A. Again it's difficult to think back. I mean, my --
7 I can't recall -- I mean, I accept that point you were
8 going to ask me, and then I forwarded this on to the
9 Department. Obviously my responsibility is to make sure
10 that I was forwarding accurate information on to the
11 Department.
12 Q. Exactly.
13 A. My understanding that -- I think it's my recollection of
14 the information coming out the case note review was that
15 Claire had hyponatraemia.
16 Q. Yes.
17 A. I certainly -- I'm not certain if I'm aware of this now
18 from reading the following transcripts.
19 Q. I understand the difficulty.
20 A. I find it very difficult. So I'm not clear in my own
21 mind at this juncture whether or not the -- I think the
22 crucial phrase here was "treated".
23 Q. There is two actually. "The known hyponatraemia", which
24 sounds as if that was something that was known at the
25 time as opposed to something that was discovered when

252

1 you looked at it eight years later for your case review.
2 That's one, and the second is that it was treated.
3 A. Yes. I mean, I think obviously it's a matter for the
4 inquiry to determine whether or not it was treated or
5 not. I have heard a range of views. My
6 understanding -- well, I am not sure honestly what my
7 understanding and recollection was at that time.
8 I didn't note anything unusual about that, I have to
9 say, but then again I wouldn't have been expert in the
10 -- in IV fluid management.
11 Q. Then whose job is it -- this is being presented --
12 A. No, I appreciate that.
13 Q. No, no, I understand that.
14 A. I accept that point.
15 Q. This is being presented to the Department.
16 A. No, I accept that point.
17 Q. So somebody presumably has the job and the
18 responsibility of making sure the Department is getting
19 accurate information --
20 A. Yes, absolutely.
21 Q. -- particularly on the key issue, which is this whole
22 hyponatraemia question. So one way of reading that is
23 that they knew about the hyponatraemia at the outset, if
24 I can put it that way, and it was treated. If that is
25 a way of reading that, then that might be an issue that

253

1 Q. Exactly. So where does the information come from? Who
2 is responsible for getting the information to put on
3 that form, make sure it's accurate and submit it to the
4 Department?
5 A. I mean, ultimately -- sorry. This isn't a trite answer,
6 but ultimately it's the responsibility of the trust.
7 It's ultimately --
8 THE CHAIRMAN: You are accepting the information provided to
9 you by Mr Walby, who you know had been involved in --
10 A. Yes.
11 Q. -- liaising and preparing the trust representation for
12 the inquest. On foot of the inquest he comes back to
13 you, provides that information, which you then report to
14 the Department?
15 A. And, as you ask it in that way, I see the point that you
16 are making.
17 Q. Yes.
18 A. I mean, I had no reason to believe and still don't have
19 any reason to believe that that information would have
20 been anything other than factual, as indeed we
21 understood it to be. Whether or not it actually is
22 factual, as you say, is a matter.
23 Q. Yes.
24 A. I certainly -- I certainly would have read it.
25 I certainly wouldn't have forwarded it without thinking.

255

1 would be disputed, the extent to which all that was
2 done, and I know you say, well, it is for this invest...
3 -- this inquiry to establish --
4 A. Yes.
5 Q. -- whether it was known and it was treated, but I'm not
6 really at that stage.
7 A. No, I appreciate that.
8 Q. This is being presented to the Department. So somebody
9 has satisfied themselves that that is an accurate
10 account of what happened.
11 A. Sure.
12 Q. I'm trying to find out who had that responsibility and
13 how was that done?
14 A. In terms of -- you know, again you can interpret that in
15 another way. I mean, in terms of hyponatraemia there is
16 a -- well, in the loosest sense there's a low serum
17 sodium. I'm not an expert in biochemical markers, but
18 certainly, you know, Claire had a low sodium. It's
19 I suppose debatable, and again it genuinely will be
20 a matter for this inquiry, and I have heard some of the
21 expert witness evidence in relation to whether there was
22 a reduction in fluids, or wasn't a reduction in fluids,
23 or whether there was a planned proposed production. I
24 think that's open to interpretation I think is all
25 really I can say.

254

1 I certainly --
2 Q. That's fine.
3 A. -- didn't spot any inconsistencies, but I accept the
4 point that you're making, and indeed I did forward. So
5 therefore I have a responsibility in that respect.
6 Q. Yes.
7 MS ANYADIKE-DANES: Thank you very much. I have nothing
8 further.
9 THE CHAIRMAN: Okay. Thank you very much.
10 Mr McAlinden, have you anything for Dr McBride
11 before he finishes?
12 Okay. Doctor, that brings your evidence to an end.
13 Thank you very much for a long day, and you are now free
14 to leave if you want unless there's anything else.
15 A. If I could add on a personal note obviously I'm not the
16 Medical Director in the Royal any longer, but I am
17 certainly very mindful of the fact that, you know, it's
18 been sixteen years, as we have mentioned already today,
19 since Claire's death, certainly eight years since I was
20 made aware of Mr and Mrs Roberts' concerns, and it is
21 actually eight years to the day that I referred Claire's
22 death to the coroner. So I am very conscious of that.
23 I certainly didn't anticipate at that time that the
24 -- they would still be seeking answers to very
25 straightforward and reasonable questions, and obviously

256

1 this inquiry has highlighted that there are a range of
2 complex factors and, as is so often the case, there were
3 things that should have happened that didn't, things
4 that happened that shouldn't against the context of some
5 underlying causes and environmental issues, which
6 obviously are properly a matter for this inquiry and for
7 you, Chair, in due course.

8 I mean, certainly all that I would want to add is
9 that certainly if any decisions that made at any point
10 in time delayed the Roberts getting those answers, I am
11 sorry for that.

12 THE CHAIRMAN: Thank you very much indeed. Thank you,
13 doctor.

14 (Witness withdrew)

15 DISCUSSION OF HOUSEKEEPING ISSUES

16 THE CHAIRMAN: Gentleman, I won't keep you much longer than
17 another minute or two, because I anticipate there might
18 be a few problems on the roads tonight.

19 We're starting tomorrow morning at 10 o'clock with
20 Dr Steen I think. Is that right?

21 MR FORTUNE: Yes, sir.

22 THE CHAIRMAN: Okay. Thank you.

23 I have received two papers in the last half hour.
24 There is a paper, Mr Green, that you've provided, which
25 is by way of a submission about what I should do in

1 THE CHAIRMAN: I am reluctant to go back over this again
2 tomorrow, but I will consider it tonight. Dr Sands is
3 coming back tomorrow to deal with this specific
4 allegation. I am interpreting this for the moment as
5 points which you want to be picked up and developed and
6 tested by Ms Anyadike-Danes in her questioning.

7 MR QUINN: They are points that will appear in our
8 submissions.

9 THE CHAIRMAN: Yes.

10 MR QUINN: They are points that were developed by Mr and
11 Mrs Roberts after hearing Dr Steen on various issues.
12 So therefore we couldn't have been prepared for the
13 points -- most of the points. They are points that
14 perhaps in fairness should be put before they are put in
15 the submissions. That's the only reason why we sent
16 them. We don't think that there will be much developing
17 of them. Dr Steen has already put her case very, very
18 straightforwardly. So there's not much more can be
19 developed out of that, but those are the issues that we
20 see may need some touching upon tomorrow.

21 THE CHAIRMAN: Right. Well, I don't see this -- I see this
22 as slightly different from Mr Sands' -- Mr Green's
23 submission on behalf of Dr Sands, which really for those
24 who haven't seen it is an invitation to me to consider
25 the allegation made against Dr Sands and then

1 relation to Dr Sands.

2 MR GREEN: Yes. I don't want to say anything about that
3 now. It's -- I just thought sooner rather than later so
4 that you had ample time to think about it. I have
5 copied Mr Quinn in and asked Mrs Conlon to copy all the
6 interested parties whose e-mail addresses I don't have
7 in. Miss Danes and my learned friend Mr Quinn have been
8 copied in. It is perhaps appropriate they have
9 an opportunity to read it and think about it overnight
10 before anything else is said about it.

11 THE CHAIRMAN: Right. Well, I think that the other
12 interested parties should see this submission this
13 evening. It is copied and it can be handed out in the
14 next couple of minutes. Okay?

15 MR GREEN: Thank you very much.

16 THE CHAIRMAN: Mr Quinn, then from your instructing
17 solicitor I have received a three -- two and a half
18 page letter which is along the lines of effectively
19 supporting -- setting out issues which you want to be
20 developed with tomorrow's witnesses, and I presume
21 that's a reference to Dr Steen?

22 MR QUINN: Yes, mostly Dr Steen.

23 THE CHAIRMAN: We'll consider this overnight. Dr Steen gave
24 some evidence about this this morning.

25 MR QUINN: She did.

1 effectively make a ruling on it before Christmas. Now
2 that I interpret effectively as a submission on how
3 I should reach a conclusion and when I should announce
4 that conclusion on that issue. So in a sense -- in a
5 sense that's procedural. Right?

6 MR QUINN: It is.

7 THE CHAIRMAN: Your submission is in a sense factual, that
8 these are the points which you want Dr Steen and
9 Dr Sands to be tested on.

10 MR QUINN: Yes.

11 THE CHAIRMAN: So in a way it is directly lines of questions
12 which you would like Ms Danes to ask. Isn't that right?

13 MR QUINN: Exactly. That's why we produced it.

14 THE CHAIRMAN: Okay. Well, that being so, I think that --
15 is it -- would you agree it's appropriate for these
16 lines to be shown to the representatives of Dr Sands,
17 Dr Steen and the trust?

18 MR QUINN: Yes. No objection to that.

19 THE CHAIRMAN: We will also arrange that in the next
20 few minutes. Mr Fortune?

21 MR FORTUNE: Sir, I was about to ask for sight of the
22 document.

23 THE CHAIRMAN: You're getting it.

24 MR FORTUNE: Can I just say this, having heard my learned
25 friend? I was not aware that Dr Sands had a case to

1 put. Dr Sands is here to assist you, sir, to answer
2 questions. As far as I know this is not supposed to be
3 an adversarial contest, although at times it may seem
4 a bit like that.

5 THE CHAIRMAN: Well, I am arranging for Mr Green's paper to
6 be circulated tonight, because it is a suggestion about
7 how I should deal with this element of the inquiry by
8 effectively virtually an immediate report, and that --
9 we can consider that tomorrow.

10 Mr Sephton, just one point for you. There was
11 an issue which came up last week in a document which we
12 have asked for Dr Webb's response on. Can you help us
13 with that? Are we going to get a response and when?

14 MR SEPHTON: I don't know when, sir. The letter has been
15 sent to Dr Webb for his comments. There was a delay
16 because the documents were not picked up until Friday
17 I think, but it's on its way.

18 THE CHAIRMAN: Well, I would be -- since Dr Webb has made
19 a wonderful degree of recovery, which I am very, very,
20 pleased about obviously, I would be very grateful if you
21 could find out if you could -- see if you could find out
22 if we have some word back tomorrow from Dr Webb, because
23 it's a -- in the scheme of things it is not
24 an irrelevant point. Okay?

25 Thank you very much. Tomorrow morning, 10 o'clock,

1 ladies and gentlemen. Thank you.
2 (5.40 pm)
3 (The hearing adjourned until 10 o'clock tomorrow morning)
4 --ooOoo--
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1
2 I N D E X

3 DR HEATHER STEEN (called)1
4 Questions from MS ANYADIKE-DANES1

5 DR MICHAEL McBRIDE (called)64
6 Questions from MISS ANYADIKE-DANES64

7 DISCUSSION OF HOUSEKEEPING ISSUES257

8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25