

1  
2 (10.00 am)  
3 (Delay in proceedings)  
4 (10.22 am)  
5 Housekeeping and timetabling discussion  
6 THE CHAIRMAN: Okay. I am sorry we started a little bit  
7 late today, ladies and gentlemen. There was some  
8 business to sort out from the papers that came in last  
9 night.  
10 I think the order today is we are going to start  
11 with Dr Steen. At some point, Mr Fortune, if and when  
12 Dr Steen needs a break, we will move on to  
13 Professor Lucas. Then we will come back to Dr Steen and  
14 finish with Dr Sands: is that okay? Right.  
15 MR FORTUNE: It depends how long Professor Lucas is going to  
16 take --  
17 THE CHAIRMAN: Yes.  
18 MR FORTUNE: -- because I am not sure that Dr Steen will be  
19 up to sitting in the afternoon.  
20 THE CHAIRMAN: Well, let's see. Professor Lucas is  
21 available into the afternoon, so let's see how the  
22 morning develops. Okay?  
23 Before we do that I said yesterday or I gave  
24 a message yesterday that I would confirm what the  
25 schedule is between Christmas and Easter. What I will

1 Beyond that, we have to vary the running order. As  
2 you know, our intention has always been to move on from  
3 Claire's case to the aftermath of the death of  
4 Lucy Crawford as the way into the case of  
5 Raychel Ferguson. While we are about 90 per cent of the  
6 way through the preparation of the Lucy aftermath  
7 segment of the inquiry, there is an issue which has  
8 emerged in the last two weeks, which we have to resolve  
9 first. It is unlikely that we will be in a position to  
10 resolve that before 20 January. Accordingly, I am going  
11 to switch the two segments of the aftermath of Lucy's  
12 death and Raychel clinical. The effect of that will be  
13 that from Monday, 20 January, for four weeks, I will  
14 hear the evidence in Raychel clinical.  
15 MR QUINN: Is that the 28th, sir?  
16 THE CHAIRMAN: From Monday, 28 January for four weeks.  
17 There will then be a one-week break, which will be the  
18 week of 25 February. Then from 4 March, for four weeks,  
19 we will deal with the aftermath of Lucy's death.  
20 I should say now before you all start lining up  
21 those diaries, those four weeks for Lucy will take us up  
22 to Thursday, 28 March, which is three days short of  
23 Easter Sunday because it is an early Easter in 2013. So  
24 it is four weeks from 20 January for Raychel clinical,  
25 a one-week break and then four weeks from 4 March for

1 do is I will do that now and then we can go into  
2 Dr Steen's evidence. If anybody has anything to say  
3 afterwards about what I am about to say, they can pick  
4 that up either later on today or tomorrow, but I don't  
5 want to delay today's evidence any longer than it is  
6 already delayed.

7 I have already announced that we will sit in the  
8 week beginning 14 January to complete some outstanding  
9 evidence which primarily relates Adam's case, but in the  
10 cases of Dr Carson, and particularly Mr McKee, it runs  
11 into Claire's case. So in that week of Monday,  
12 14 February --

13 MR FORTUNE: February?

14 THE CHAIRMAN: Sorry. January. Thank you. 14 January, we  
15 will hear from Professor Rating and Professor Kirkham.  
16 We are trying to arrange Professor Kirkham to give  
17 evidence which would then be followed by  
18 Professor Rating. At the moment, that's a bit  
19 difficult. So I cannot yet confirm which days they will  
20 be sitting -- they will be appearing in that week, but  
21 we will try to do them in that sequence. That week, we  
22 will also then do Mr McKee and Dr Carson and then  
23 Professor Mullan, who you may remember from some months  
24 ago was the governance expert for the inquiry in Adam's  
25 case. So that will be the week of 14 January.

1 the aftermath of Lucy.

2 As you will realise, what is left after that are  
3 three areas which have a thread running through them:  
4 One is any governance issues in Raychel's case; the  
5 second is the role of the department; and the third is  
6 Conor Mitchell's case to the limited extent that we are  
7 looking at Conor's case from the aspect of the  
8 implementation of the hyponatraemia guidelines.

9 As you will see from the tight schedule through  
10 January, February, March, we will need some time after  
11 Easter to finish the preparations for those three  
12 elements, which will be taken -- which will run  
13 together. It is therefore most likely -- this will have  
14 to be confirmed -- that they will be taken together from  
15 Tuesday, 28 May. The Monday, 27 May, is a Bank Holiday.  
16 So we will start on Tuesday, 28 May and run through to  
17 Thursday, 4 July. So I will leave that with you for  
18 now.

19 I should say that in Raychel's case the clinical  
20 papers will be distributed this week. Interested  
21 parties were identified and notified on 8 November,  
22 that's six weeks ago, and we have not heard anything  
23 other than to say they are all still represented by DLS.  
24 The papers will go to DLS this week. It is then up to  
25 the doctors and nurses who have been identified to

1 advise if they have separate representation. Okay.  
2 MR LAVERY: Yes.  
3 THE CHAIRMAN: If we need to come back on anything about  
4 that later, we will do so. In the meantime, let's push  
5 on with Dr Steen.  
6 MR GREEN: Just one matter. Dr Sands is here. He is in  
7 a side room gathering his thoughts. He is finding the  
8 whole process very trying and would like to be called  
9 sooner rather than later. So I wonder, if it wouldn't  
10 inconvenience anybody else, if he could be called  
11 perhaps as soon as Dr Steen finishes her evidence. I am  
12 conscious that we have Professor Lucas at the back, but  
13 ... Dr Sands is, as I say, find it trying and a shorter  
14 rather than longer period on the starting blocks would  
15 be much appreciated by him.  
16 THE CHAIRMAN: There is a certain logic to that in the flow  
17 of the evidence. We will start with Dr Steen, we will  
18 go for maybe an hour and a quarter until 11.45. Then we  
19 will take a break for the stenographer. If there is  
20 an agreement about the order of witnesses, I will take  
21 that agreement, and if there isn't, I will deal with it  
22 after the break; okay?  
23 MR GREEN: That's very helpful. Thank you very much.  
24 THE CHAIRMAN: Dr Steen.  
25

5

1 you there?  
2 A. No.  
3 Q. Ah. Well, I am sure that can be furnished. We saw your  
4 CV previously, but we perhaps weren't looking at it  
5 entirely from the point of view of governance issues, if  
6 I can put it that way. The reference for your CV is  
7 311-017-001. I am not going to go through the clinical  
8 aspects of that because you have already helped us with  
9 that during the clinical phase of the hearing, but just  
10 to ask you about certain matters. You did become  
11 clinical director at some point; can you help us with  
12 the date of it?  
13 A. Can I -- is there anything else on any of the pages?  
14 Q. About clinical director?  
15 A. Yes, medical management posts. No. I think it was when  
16 Dr Hicks stood down, there was a period where there  
17 wasn't a clinical director for a few months and then  
18 I took it up. I think that was approximately 2001.  
19 Q. I can -- the best we can do on this is this first  
20 page --  
21 A. Yes.  
22 Q. -- where you say that:  
23 "Between 1999 and 2010, I took several medical  
24 management roles, including clinical director for  
25 paediatrics."

7

1 DR HEATHER STEEN (continued)  
2 Questions from MS ANYADIKE-DANES (continued)  
3 MS ANYADIKE-DANES: Good morning, Dr Steen.  
4 A. Good morning.  
5 Q. Dr Steen, yesterday formed a slightly different order of  
6 dealing with matters in the sense that you were rather  
7 helping us with things that you were prepared to concede  
8 were deficient in the care or the arrangements for the  
9 care of Claire or fell below the standard that you would  
10 have expected.  
11 A. Yes.  
12 Q. And I think you ran through a number of points, which  
13 I don't need to recap this morning, but just formally  
14 speaking, if I can deal firstly with this: you have  
15 provided a witness statement on governance aspects. The  
16 reference for it is 224/3. It is dated 6 November 2012.  
17 It is not as full a statement as perhaps we had invited  
18 from you, but it was doing the best you could in your  
19 circumstances to get us something in writing to be  
20 shared amongst the other interested parties. So  
21 recognising it is perhaps not as full as it might be, do  
22 you nonetheless adopt that as your evidence, subject to  
23 anything else that you might say in this oral hearing?  
24 A. I do.  
25 Q. Thank you. You also have a CV; do you have that with

6

1 A. Yes.  
2 Q. So that gave us the spread. We wanted something  
3 a little more particular than that.  
4 A. In 1999, I took on the role of sub-director for  
5 ambulatory services. So I supported the clinical  
6 director for out-patient services, A&E and acute medical  
7 paediatrics. Dr Hicks then stood down, I think, in  
8 2001. The clinical director post was a very onerous  
9 post. Nobody particularly wished to take it on and  
10 there were some discussions. I agreed to take it on  
11 with the understanding that additional support would be  
12 put in and the Chief Executive then undertook  
13 a reorganisation, not purely because of what I had said,  
14 but I think he recognised there needed to be  
15 reorganisation within the service, and he introduced  
16 divisionalisation. He divided the Trust into divisions.  
17 Now, from a medical management perspective, what really  
18 helped with that was he identified additional support.  
19 MR FORTUNE: Can we slow Dr Steen down? I anticipate the  
20 stenographer is having some difficulty.  
21 MS ANYADIKE-DANES: Sorry.  
22 THE CHAIRMAN: I think what you had said was:  
23 "From a medical management perspective, what really  
24 helped with that was the Chief Executive identified  
25 additional support."

8

1 Okay. Right. So those are the circumstances in  
2 which you took the job on. Let's leave it at the moment  
3 from some time --  
4 A. No, we will take it further. So the additional support  
5 was that he developed divisional directors who had  
6 50% -- five sessions -- divisional medical management  
7 and also some performance management, and that helped  
8 support the entire medical management structure within  
9 the Trust. And I took up the divisional director's  
10 post -- I think it was 2002. Others can correct this --  
11 for women's and children's services and then  
12 Dr Paul Jackson became clinical director in children's.  
13 Then under revision of the trusts in 2007, again there  
14 was a restructuring, and the roles were changed again.  
15 A lot of the direct management issues went out of the  
16 medical managers' posts and they became much more what  
17 we called associate medical directors and, for a period  
18 of three years, I was associate medical director for  
19 women's and children's services.  
20 MS ANYADIKE-DANES: What you said, about how others might be  
21 able to help, actually Dr Hicks herself has tried to  
22 help. In her transcript of 11 December -- we don't need  
23 to pull it up -- at page 16, lines 4 to 14, she thinks  
24 you took up your position -- at that time she was  
25 referring to it as "clinical director" -- in March 2002.

9

1 A. That's correct.  
2 Q. Do you actually remember that happening?  
3 A. I just remember two little bits out of the whole thing.  
4 There had been -- there had been a lot of discussion  
5 around hyponatraemia, a lot of discussion about what was  
6 happening. There was awareness that there was -- the  
7 department were developing the guidelines and I think  
8 some Trust staff may have been involved in those early  
9 guidelines, and they came out on a page, an A4 page,  
10 that would be put up in every notes.  
11 I actually remember Bob Taylor coming down to Allen  
12 Ward and putting it up in the treatment room in Allen  
13 Ward.  
14 Q. He was part of that group. Did you know that at the  
15 time?  
16 A. I probably did at the time. He actually put it up in  
17 Allen Ward and drew everyone's attention to it. We also  
18 incorporated -- the junior doctors at that stage had  
19 an induction programme.  
20 Q. Uh-huh.  
21 A. So when they came and started with us in August, there  
22 were two to three half-days where we took them through  
23 some processes, et cetera, so that they had an induction  
24 into working in the Children's Hospital. That went  
25 into -- that page went into their induction process and

11

1 A. Uh-huh.  
2 Q. Would that sort of fit with what you are thinking?  
3 A. Yes.  
4 Q. Thank you. Irrespective of whether it was clinical  
5 director -- sorry. Maybe I should just clarify that  
6 with you. The slight reorganisation that gave rise to  
7 the divisional director post, did that happen around  
8 that time or some time shortly after 2002?  
9 A. I think I was in post about a year before it happened.  
10 Q. So 2003 roughly then?  
11 A. I mean others -- this is --  
12 Q. I understand.  
13 A. -- Royal Trust business and it should be clearly  
14 documented, the process and the dates somewhere --  
15 sorry. I am sure I shouldn't have asked for more  
16 documentation.  
17 Q. Anyway, so you were there with the particular, if I can  
18 put it that way, managerial role that a clinical  
19 director has from 2002 onwards --  
20 A. Yes.  
21 Q. -- would that be fair to say?  
22 A. Yes.  
23 Q. Thank you. Just so we have it, that means that you were  
24 in post round about the time that the hyponatraemia  
25 guidelines were being introduced.

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1 IV fluids were then part of the induction process.  
2 Q. Would it have fallen to you to ensure that a degree of  
3 prominence was given to those guidelines, that there was  
4 some system in place for monitoring and evaluating their  
5 compliance with them? Would that have been part of what  
6 you would have done?  
7 A. Part of my role and the manager's role and the nurse  
8 manager's role.  
9 Q. And if it was part of your role together with the other  
10 two that you mentioned, what actually did you do to set  
11 up a system to ensure that?  
12 A. I can't remember. I am sorry.  
13 Q. Was there a system established?  
14 A. I can't remember. I am sorry.  
15 Q. And the reason I am asking you this is, apart from the  
16 fact it was part of your role -- I don't know if you  
17 were here when Nurse McRandal gave her evidence. Her  
18 evidence was that then in Allen Ward the nurses were not  
19 measuring urine output.  
20 THE CHAIRMAN: Sorry. Now.  
21 MS ANYADIKE-DANES: I mean at the time when she was giving  
22 her evidence, you know. Why I was asking you that is  
23 because that would indicate that the guidelines -- the  
24 1992 guidelines -- forget about the fact they were  
25 revised in -- the 2002 guidelines -- forget about the

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1 fact they were revised in 2007 -- were not being  
2 monitored, measured appropriately.  
3 If we pull up the guideline itself, it is not a very  
4 good depiction of it, but it is 069A-088-358. Okay.  
5 THE CHAIRMAN: Do you want to refer to it to show that the  
6 guidelines say specifically that output is to be  
7 measured?  
8 MS ANYADIKE-DANES: Yes.  
9 THE CHAIRMAN: I don't think there is any dispute about  
10 that, doctor. Part of the guidelines is that urine  
11 output is to be measured; is that right?  
12 MS ANYADIKE-DANES: Just in case you can't remember --  
13  
14 A. I can't remember, but if it is there, it is there.  
15 MS ANYADIKE-DANES: What it says it:  
16 "Fluid balance must be assessed at least every 12  
17 hours by an experienced member of clinical staff."  
18 Then it has "intake", which we are not concerned  
19 about.  
20 A. Yes.  
21 Q. Then it has output:  
22 "Measure and record all losses (urine, vomiting,  
23 diarrhoea, et cetera) as accurately as possible."  
24 And what Nurse McRandal was saying was that even now  
25 in Allen Ward, they were putting "PU", passed urine.

13

1 Q. So associate medical director until 2010. So should you  
2 not have known whether or not the guidelines are being  
3 complied?  
4 A. And my understanding was, from aspects of any audits  
5 that were carried out -- and including the RQIA  
6 inspections -- that people were satisfied with the  
7 guidelines. So it was a surprise to me to hear Nurse  
8 McRandal saying that that aspect has not been carried  
9 out because we have been inspected. The Trust has been  
10 inspected by RQIA and I am not sure that that was raised  
11 as an issue.  
12 Q. Well, we can go back and look at what the RQIA found in  
13 terms of the validation in relation to these guidelines  
14 in 2008 and 2010, but in any event, any process that you  
15 put in place for auditing the implementation and  
16 recording that should, if that was what was happening,  
17 should have identified that.  
18 A. Yes.  
19 Q. Thank you. Can you help with this? So far as you are  
20 concerned were there meetings, were there plans for how  
21 to implement, educate and monitor the guidelines?  
22 A. There may have been meeting and plans, but I can't give  
23 you details. There certainly were meetings and plans.  
24 The governance structures were being developed much more  
25 strongly, and I remember one small bit of work that

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1 They were not measuring -- whether by weighing nappies  
2 or some other sort -- the urine output.  
3 If you were there when the guidelines were published  
4 and issued by the Chief Medical Officer and would have  
5 been part of the team responsible for ensuring that they  
6 were being implemented, and then questioning how it can  
7 be that in 2012 in Allen Ward they are not following  
8 a particular aspect of it.  
9 A. I'm unsure why Allen Ward haven't followed the process  
10 completely correctly. My understanding was that the  
11 nursing staff had been recording the fluid output.  
12 I can only suggest that the make-up of Allen Ward's  
13 patients were such that there's very few patients on  
14 total fluid replacements. I don't know. The nurse  
15 managers perhaps can answer that better.  
16 Q. Well, I appreciate you may not be able to remember,  
17 because I know you have some difficulties with that,  
18 what exactly you did in 2002, but you were still with  
19 that managerial role as divisional director with  
20 responsibility for women and children up until as  
21 recently as 2010.  
22 A. No. Divisional director until 2007.  
23 Q. And then --  
24 A. Associate medical director for women's and children's  
25 services.

14

1 I was doing with one of the chief pharmacists where we  
2 wanted to do small workshops on drug prescribing as well  
3 as IV fluid prescribing, child protection. We wanted to  
4 do more of that, so certainly I know there was ongoing  
5 work being done. At the same time, there was a lot of  
6 work being done in trying to develop our IV fluid  
7 guidance, our IV fluid input/output chart, and there  
8 were contributions being made regionally towards that to  
9 try to improve the documentation, because our IV fluid  
10 charts were not adequate to allow us to document  
11 accurately all that was happening.  
12 Q. Yes. How involved would you be in your -- this is  
13 taking some time away from Claire, I understand that,  
14 but now we have -- this is what your position is. How  
15 involved would you have been in any decisions that the  
16 Children's Hospital would have made as to how they used  
17 Solution No. 18?  
18 A. Certainly as clinical director I would have been quite  
19 closely involved with that and Solution No. 18, in  
20 2002/2003, was being restricted right down. Again  
21 somebody else can give you more detail than I can, where  
22 we used it -- we restricted it right down to PICU, the  
23 renal unit and I think oncology because of their  
24 specific concerns and some of the complications of their  
25 drugs and there was a -- over a period of time, the

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1 whole provision, the type of IV fluids we had in the  
2 ward were all changed so that the -- the fluids come in  
3 a bag and there is lots of different types. You have it  
4 with extra sugar, extra sodium, extra potassium. So you  
5 can have different combinations. So there was a lot of  
6 work going on identifying what times of fluid bags we  
7 needed, how we were going to get them into the wards,  
8 keep them clearly needed, make sure the fifth-normal  
9 solution was being monitored closely and only available  
10 in certain circumstances.  
11 Q. I see that. Did the Children's Hospital, and clearly  
12 the premiere children's hospital in Northern Ireland and  
13 a teaching hospital at that -- did it share that  
14 knowledge with other hospitals: this is what we are  
15 doing?  
16 A. People were sitting on the working party, so there was  
17 information being shared across the working party about  
18 processes, and I think I attended about two meetings of  
19 that, but other people attended --  
20 Q. I don't mean about developing the guidelines. I mean  
21 about in the response to that, attitudes to what you  
22 would do about controlling the use of Solution No. 18.  
23 Was the position that the Royal was taking in relation  
24 to that being communicated to other hospitals and  
25 trusts?

17

1 Q. Were there clinicians from other hospitals?  
2 A. Yes, there was anaesthetists and a paediatrician,  
3 I think, from every hospital and maybe a couple of A&E  
4 consultants from across the Province. I mean, the  
5 membership of that group will be documented somewhere.  
6 Q. Was there any intention to get it representative, so  
7 you'd have people from Altnagelvin and so forth?  
8 A. Yes, I think there was -- I can remember some faces  
9 around the table. The membership of that will be well  
10 documented somewhere.  
11 Q. Thank you. Sorry. I took you out of the way, really,  
12 because I had not appreciated that you had quite that  
13 role and for quite that long, if I can put it that way.  
14 If I can now move to things specific to Claire and  
15 try and move roughly in chronological order, but taking  
16 it from the point where we had more or less left off, if  
17 I can put it that way, when you were giving your  
18 evidence in the clinical phase. I want to ask you about  
19 the cause of death --  
20 A. Yes.  
21 Q. -- as a first point. Dr Webb expressed the view that  
22 the cause of death was, and it is as he recorded it in  
23 the notes:  
24 "SIADH, hyponatraemia, hyposmolality, cerebral  
25 oedema and coning following prolonged epileptic

19

1 A. I will think it probably was through the working group.  
2 I don't know. I'm not sure.  
3 Q. Okay. Then --  
4 MR FORTUNE: Perhaps we could find out from Dr Steen whether  
5 members or clinicians of other hospitals sat on the  
6 working group because, in that way, we may get a better  
7 picture.  
8 MS ANYADIKE-DANES: Thank you. You said you attended two.  
9 A. I think when the working group was first set up,  
10 Jarlath McAloon took it over. There was only one  
11 anaesthetist from the regional centre on it, which had  
12 caused some concerns because the district general  
13 hospital fluid needs are not as complex as when you come  
14 to a regional centre, where you may have total  
15 parenteral nutrition, two different types. It just  
16 wasn't. So I asked for further representation. I can  
17 remember attending I think two meetings in  
18 Dundonald House and then I think Peter Crean took a role  
19 and various other members took a role. I think  
20 Bill McCallion, I don't know, may have taken a role in  
21 surgery, but there was much more sub-specialty input to  
22 that working group.  
23 Q. Do you actually recall attending -- I think you said you  
24 attended two. Do you recall that?  
25 A. I think I attended two.

18

1 seizures."  
2 When you came to write the death certificate, how  
3 did you go about determining what was the cause of death  
4 to complete that death certificate?  
5 A. I have no recollection. I can only assume it was  
6 following discussion with Dr Webb. Dr McKaigue can  
7 remember some discussions that took place around the  
8 time. It was what we thought was the process. The  
9 encephalitis hadn't been proven, which is why we had  
10 been seeking a limited post-mortem. You can say the  
11 status epilepticus hadn't been proven, but Dr Webb was  
12 convinced that had a role in it.  
13 Q. Yes.  
14 A. I think when you look back, the hyponatraemia was seen  
15 as a consequence of the other underlying processes and  
16 they have was not put in. It obviously would be put in  
17 now just --  
18 Q. Was there any reason why you didn't frame it -- if you  
19 were to a large extent dependent on Dr Webb's  
20 characterisation of what had happened, because you  
21 hadn't really been involved with treating Claire or had  
22 actually seen her to examine her, if you were dependent  
23 on him, is there any reason why you didn't characterise  
24 in just the way that he had in the notes and records?  
25 A. I have no recollection. We had a discussion. I am sure

20

1 we had a discussion and that's where we moved forward.  
2 Q. Well, did you form an independent view from looking at  
3 the medical notes and records or was your view really  
4 from the discussions of those who had actually treated  
5 her?  
6 A. I have no recollection.  
7 Q. You don't know?  
8 A. I would -- in reconstructing it, I strongly feel that  
9 there was discussion with Dr Webb about the way forward,  
10 not only around post-mortem, but also cause of death,  
11 and the conversation, discussion with the parents.  
12 Q. Well, maybe I can put it in this way: I think you said  
13 that you didn't know about the encephalitis point  
14 because that was one of the things that you believed you  
15 might learn after the brain-only autopsy.  
16 A. Yes.  
17 Q. You weren't going to learn anything more about the  
18 status epilepticus.  
19 A. No, not unless there had been hippocampal changes,  
20 I believe.  
21 Q. On the back of the certificate of cause of death --  
22 I think you refer to it as "a wee box".  
23 A. Yes.  
24 Q. There is a box that indicates, that if you receive  
25 further information, you may revise.

21

1 classification of the cause of death in the light of the  
2 post-mortem evidence --  
3 A. Yes.  
4 Q. -- or information, I should say.  
5 A. Yes.  
6 Q. Did you? Did you revisit it in the light of the  
7 post-mortem report?  
8 A. Revisit the registration of death?  
9 Q. Yes.  
10  
11 A. I don't think we did. I can't find any documents -- I  
12 have no recollection. I can't find any documentation to  
13 say whether it was fed back to the register of deaths or  
14 not.  
15 Q. Is there any reason why having ticked that you didn't do  
16 it?  
17  
18 A. Not particularly, no. I obviously didn't think about it  
19 at the time and neither did Dr Webb.  
20 Q. Is it possible that that completely passed you by, that  
21 you were going to look at that again?  
22  
23 A. Yes. I remember on one occasion the registrar actually  
24 came back to us and asked for information. When  
25 I ticked that, the register of deaths had actually come

23

1  
2 A. Yes.  
3 Q. It is a very blurred copy, but we can see a sample like  
4 that. 269/1 at page -- if we pull up pages 113 and 114.  
5 Take those two together. Well, let's look at that.  
6 That's the --  
7 A. Front.  
8 Q. -- front of it. You can see how it is framed. There is  
9 the (a), which in this case would have been the cerebral  
10 oedema and then there is the (b), which in this case was  
11 the status epilepticus.  
12 A. Yes.  
13 Q. Then if we pull up the 114 and flip that around, you see  
14 it is quite blurred, but that's the sort of thing you  
15 are talking about; is that right? (a), if we just see  
16 that.  
17 A. Yes.  
18 Q. That's on the back:  
19 "(a) Will you be in a position to give further  
20 information for a more precise statistical  
21 classification, eg as a result of post-mortem or other  
22 reasons? Yes/no."  
23 I think you indicated "yes".  
24 A. Yes.  
25 Q. So you were prepared, effectively, to look again at the

22

1 back to me, but I am -- I don't know what happened in  
2 this case.  
3 MS ANYADIKE-DANES: Sorry, Mr Chairman.  
4 MR SEPHTON: I wonder if we can find out who "us" is,  
5 please.  
6 MS ANYADIKE-DANES: I was going to go there.  
7 THE CHAIRMAN: Well, go there, please. Who do you mean the  
8 registrar came back -- you mean in another case, not  
9 Claire's case?  
10 A. In another case, the register had come back to me when  
11 I had done that asking for further information.  
12 Q. So this is not something that happened in Claire's case  
13 so far as you can recall?  
14 A. No, not that I'm aware of.  
15 Q. Thank you. Can you then help with exactly what you  
16 thought, on the evidence, was the cause of Claire's  
17 death in 1996, what you thought then?  
18 A. I think looking back on what happened, I believed that  
19 she had a viral infection which had triggered seizures,  
20 that may have caused encephalitis, that it resulted in  
21 SIADH, which in turn had resulted in hyponatraemia,  
22 which had exacerbated the cerebral oedema, which had  
23 exacerbated the SIADH, which got us into a vicious  
24 cycle.  
25 Q. Did you appreciate at the time that Dr Webb himself

24

1 didn't regard the viral infection as a very strong  
2 possibility, if I can put it that way?  
3 A. I've no recollection. Dr Webb was aware of what was  
4 happening and was also aware when we fed back to the  
5 parents what was happening and I'm not aware that he  
6 strongly felt the virus was not a problem.  
7 Q. Not he "strongly felt"; he didn't regard it as a very  
8 strong possibility.  
9 A. I can't remember.  
10 Q. Well, let me ask you this then: where did you get your  
11 view that what had triggered all of this was a viral  
12 infection? Where did that come from?  
13 A. The raised white cell count, the low-grade pyrexia --  
14 temperature -- at the time that she came in, the history  
15 of vomiting illness.  
16 Q. And you formed the view that that would be enough to  
17 indicate that she'd got some sort of viral infection of  
18 a sufficient degree to set off that chain of events?  
19 A. Yes.  
20 Q. Well, if that's the case, were you surprised that that  
21 wasn't actually being treated until 5 o'clock?  
22 A. I think the only treatment you can do for viruses is  
23 herpes simplex. Herpes simplex encephalitis, my  
24 understanding is it is a flitting -- her picture would  
25 not have been typical of a herpes simplex encephalitis.

25

1 had any particular in-depth discussion about her, as  
2 I understand it, until that moment in time. So do you  
3 not try to do all you can to bottom out what these  
4 differential diagnoses are so you can be certain in your  
5 mind so not only can you write the death certificate,  
6 but you can advise that this is not a case for the  
7 coroner?  
8 A. I have no doubt that Dr Webb and I did discuss it and  
9 that my view was that this was an explainable -- sudden,  
10 but explainable -- death as a result of viral -- viral  
11 illness triggering status epilepticus, with or without  
12 viral encephalitis, SIADH and cerebral oedema.  
13 Q. I understand that. I am just trying to take you, piece  
14 by piece, to see where you got that information from.  
15 So if you had discussed it with him, as you think  
16 you must have done, then are you saying that you would  
17 have -- you are likely to have asked him how he treated  
18 her, in which case, if you did, that should have  
19 disclosed, "The reason why I was prescribing acyclovir  
20 at 5 o'clock was because I had formed the view that the  
21 kind of viral infection she had was herpes simplex"?  
22 A. He wouldn't have had to say that. I would have known it  
23 from looking at the notes. Acyclovir he -- in the  
24 notes -- I mean, he writes:  
25 "Query encephalitis. Unlikely. Acyclovir."

27

1 There is a huge number of viruses that can cause  
2 encephalitis, but when it was considered, then the  
3 acyclovir should have been considered.  
4 Q. Sorry?  
5 A. When it was considered.  
6 Q. When what was considered?  
7 A. Herpes simplex encephalitis as an option. So once  
8 Dr Webb felt the herpes simplex, although most unlikely,  
9 was an option, then the acyclovir should have been  
10 given.  
11 Q. Have you seen any evidence in the notes that he thought  
12 herpes simplex was an option?  
13 A. He had asked for acyclovir to be given -- it is only  
14 functional against herpes simplex.  
15 Q. But it is not actually diagnosed as herpes simplex in  
16 the notes.  
17 A. No. Acyclovir works across a very narrow spectrum of  
18 viruses.  
19 Q. Did you ask him how he had got to herpes simplex?  
20 A. No, I have no recollection.  
21 Q. Wouldn't you want to know? You are the person who is  
22 now going to take responsibility for formulating the  
23 death certificate. You have to form a view as to what  
24 caused this child's death at a slight disadvantage  
25 because you have not actually examined her, nor have you

26

1 That's the one virus that we can treat. We can't  
2 treat all the other viruses. So he is covering his  
3 options. He has considered that as the one virus he  
4 could treat and he has covered his options and advised  
5 the child be treated.  
6 Q. So it is not he has formed the view it is herpes  
7 simplex?  
8 A. No.  
9 Q. Since you can't treat any other virus, let's administer  
10 that and, if it is that, at least it is being addressed?  
11 A. It is being treated. I think that was his approach.  
12 Q. If that's the logic, then you would be doing that  
13 shortly after 11 o'clock because that's when the notes  
14 indicate that Dr Sands, following his conversation with  
15 Dr Webb, thought it was encephalitis/encephalopathy?  
16 A. Yes, and I think Dr Webb --  
17 THE CHAIRMAN: The timing depends on when Dr Sands and  
18 Dr Webb spoke.  
19 MS ANYADIKE-DANES: Some time after that.  
20 A. And I think Dr Webb maybe gives some evidence on this.  
21 Q. No, I am asking: did you -- you are looking at these  
22 notes. You are trying to formulate what happened --  
23  
24 A. Yes.  
25 Q. -- and reach a view as to why the child died. So to

28

1 a certain extent you are checking against what you are  
2 thinking is happening with what the notes say and  
3 whether these things are consistent.  
4  
5 A. Yes.  
6 Q. That's the point. So what I am asking you about is: if  
7 you are thinking that the trigger to all this is viral,  
8 and you are thinking that, and you see that there is --  
9 by the time you read the notes, at which point we don't  
10 know when they were -- an addition was made to them, but  
11 in any event, it is put there under the ward round. So  
12 you are looking.  
13  
14 A. Yes.  
15 Q. And you are seeing "encephalitis" is there. If somebody  
16 is going to take the view, "Well, let's at least treat  
17 it with acyclovir because that's all we can treat it  
18 from", are you not trying to find out why didn't you  
19 start the one treatment you can apply for encephalitis  
20 shortly thereafter? Is that not a query you would be  
21 making?  
22 A. That would be a query I would be making.  
23 Q. And if you had got an answer to that, that would have --  
24 would you have factored that into your consideration as  
25 to how strong is the view that it is viral?

29

1 Dr Steen at an earlier stage, frankly, is wrong.  
2 THE CHAIRMAN: I am not sure it is as black and white as  
3 that. I think it depends in part what the discussion is  
4 between Dr Webb and Dr Sands. Let's move on.  
5 MS ANYADIKE-DANES: Thank you, Mr Chairman.  
6 What I am trying to find out is, when you read the  
7 notes, what you were taking from the notes in  
8 combination with the discussions that you could have  
9 with the treating clinicians who were available to you?  
10 If you read the notes, then that  
11 encephalitis/encephalopathy entry appears at about  
12 11 o'clock in the ward round note. Sorry. It did not  
13 appear about 11 o'clock; it appears in the ward round  
14 note.  
15 A. Yes.  
16 Q. Thank you. When you read the notes then, do you notice  
17 that the registrar, experienced registrar, Dr O'Hare,  
18 has thought about encephalitis and has struck it  
19 through?  
20 A. I can't tell you what I thought. I have no  
21 recollection. We are now saying what would be the  
22 normal process when I was reviewing notes and the answer  
23 is, yes, I would have reviewed Dr O'Hare's notes and  
24 I would have realised the encephalitis had been stroked  
25 out. I would have realised that somebody had written

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1 A. No. How strong is the view that it was herpes virus,  
2 because acyclovir is herpes.  
3 Q. Okay.  
4 MR FORTUNE: I am troubled by this line of questioning  
5 because the ward round takes place some time around  
6 11 o'clock. Dr Sands has a real concern and decides  
7 that he needs an opinion from Dr Webb. That opinion is  
8 sought some time around midday. Dr Sands leaves it to  
9 Dr Webb to attend, examine Claire and to make an entry  
10 in the notes. Is it effectively fair --  
11 THE CHAIRMAN: Sorry. Just be clear. When you say "leaves  
12 him to make an entry in the notes" --  
13 MR FORTUNE: Well, in the sense that --  
14 THE CHAIRMAN: -- leaves Dr Webb to make his own entry in  
15 the notes.  
16 MR FORTUNE: Yes.  
17 THE CHAIRMAN: Sorry. That's fine.  
18 MR FORTUNE: If Dr Webb is going to come and examine Claire,  
19 then Dr Sands would have a reasonable expectation that  
20 Dr Webb would make an entry in the notes.  
21 THE CHAIRMAN: There was a bit of an issue about entries.  
22 I was just clarifying which one you are referring to.  
23 MR FORTUNE: It is at that point more appropriately that any  
24 question of herpes simplex or acyclovir might begin to  
25 arise. By inference, to criticise Dr Sands or, indeed,

30

1 in, after the ward round, "encephalitis/encephalopathy"  
2 and I would have realised Dr Webb's input during the  
3 afternoon of the Tuesday.  
4 Q. But is it not relevant to what you are trying -- what  
5 you are trying to work out at the moment, because you  
6 have got the virus in your mind as a starting point. Is  
7 it not relevant to know that the very symptoms you are  
8 talking about like the slightly raised white cell count  
9 and also whether she were apyrexia or not, that was  
10 information that was available to Dr O'Hare, who had  
11 examined Claire, and yet had discounted encephalitis at  
12 that stage? Is that not relevant to you forming the  
13 view that what is at the seat of all of this is a viral  
14 encephalitis?  
15 A. I think it's a journey during the disease process. When  
16 Dr O'Hare saw the child, she had certain thoughts. When  
17 she reviewed the child, she had certain thoughts. When  
18 the ward round saw the child, there were certain  
19 thoughts. When Dr Webb saw the child, there were  
20 certain thoughts. Diseases progress and sometimes as the  
21 disease progresses the underlying cause becomes more  
22 obvious or, indeed, less obvious.  
23 Q. Yes, and if one looks at the note that Dr Webb would  
24 have made after that -- let's just pull these two things  
25 up -- it is 090-022-053 -- and then pull up 054

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1 alongside it, please. Yes. Sorry. Thank you very  
2 much. That's the entirety of Dr Webb's note when he  
3 goes to the ward and examines Claire; okay? As you  
4 would have been reading that, do you see anything in  
5 that note he makes that relates to viral encephalitis?  
6 A. No. At that stage he says he didn't have a clear  
7 picture of the prodrome and yesterday's episodes and the  
8 main findings are probably longstanding, but need to be  
9 checked, and he felt that she was most likely  
10 post-seizure -- acute encephalopathy, post seizure.  
11 Q. So there is no encephalitis there?  
12 A. No.  
13 Q. So, in fact, that doesn't turn up again, if I can put it  
14 that way, until the note that's timed at 5 o'clock --  
15 1700 hours it is timed.  
16 A. Yes.  
17 Q. So that's why I am really asking you where you got your  
18 certainty, if I can put it that way, that what has  
19 started all of this is a virus and viral encephalitis.  
20 A. She had a temperature and raised white cell count of --  
21 I think it was 16.2, 16.5. Something triggered her  
22 illness. She had vomiting. The most likely thing is  
23 a viral illness triggering the entire thing. Why else  
24 did she get a raised white cell count? Why else did she  
25 have a low-grade temperature? Why else did she start to

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1 does that do to her cause of death in your view?  
2 A. Well, then there is the discussion with Dr Webb again.  
3 Is he content that the entire picture is due to  
4 seizures?  
5 Q. And that is a discussion that you would have to be  
6 having with him once you got the autopsy report?  
7 A. Yes.  
8 Q. And was there a discussion with him like that?  
9 A. I have no recollection, but would I assume that there  
10 was, especially before we met the parents.  
11 Q. And would a discussion like that -- well, it could have  
12 had a bearing on the death certification, could it not?  
13 A. Yes.  
14 Q. So that's quite an important discussion.  
15 A. It is.  
16 Q. Should that not have been recorded somewhere?  
17 A. Yes, it should have been.  
18 Q. Because effectively -- what I think you're saying is  
19 that you would have had a discussion like that with him,  
20 and the fact that you haven't changed the death  
21 certificate means that, notwithstanding the fact that  
22 the autopsy doesn't appear to give you much evidence for  
23 the viral encephalitis element of it, that must mean  
24 that the seizures are actually the trigger for what  
25 ultimately led to the cerebral oedema, because that's

35

1 vomit at home?  
2 Q. I appreciate those questions and those are, presumably,  
3 things Dr O'Hare turned her mind to and discounted.  
4 A. Sorry. I need the note. Can we go back, because  
5 I don't ...  
6 Q. Of course.  
7 MR FORTUNE: 090-022-052. If you want the whole note it,  
8 starts on 050.  
9 MS ANYADIKE-DANES: So she has the viral illness.  
10 A. Yes, she has a viral illness.  
11 Q. But she's taken out the encephalitis.  
12 A. Yes. So she thought, when she saw the child and looked  
13 at those issues, there was an underlying viral illness.  
14 I am not sure many of the experts don't agree there was  
15 an underlying viral illness.  
16 Q. But when you classify it, do you have it as just a viral  
17 illness or do you have it as viral encephalitis?  
18 A. Well, that was the final -- that was the question that  
19 needed the post-mortem to finalise it. I think that's  
20 where I was looking. I think, looking back, because I  
21 have no recollection, but looking back, I think that was  
22 one of the questions I wanted the limited post-mortem to  
23 confirm: had the virus itself spread to her brain or was  
24 it all secondary to seizures?  
25 Q. And if the virus hadn't spread to her brain, then what

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1 the only other thing you have got left.  
2 A. Yes.  
3 Q. That would therefore mean that "I don't need to change  
4 the death certificate because I have got 'cerebral  
5 oedema secondary to status epilepticus'".  
6 A. Yes.  
7 Q. So the very thing that you would wanted to have  
8 clarified has what I think is a viral infection. Does  
9 stay just as that -- a tummy bug, for example -- or did  
10 it develop into something more and become viral  
11 encephalitis. You have got your answer to that,  
12 effectively.  
13 A. Yes.  
14 Q. In terms of the encephalitis element of that it, and if  
15 that's so, and you have had your discussion with  
16 Dr Webb, it must mean that you were satisfied that he  
17 had the seizures as producing that chain of events.  
18 A. Sorry. I have got lost a bit in that.  
19 Q. No. Think about it. Cerebral oedema, that's your  
20 primary cause, secondary to status epilepticus.  
21 A. Yes.  
22 Q. Yes.  
23 A. My reconstruction of the post-mortem or understanding of  
24 the post-mortem results was there was inflammatory  
25 change and that there was a viral encephalitis. I know

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1 the experts have now discussed this and looked at it.  
2 I know there may be slightly different views, but my  
3 understanding going back and looking at what we did and  
4 how we acted was that we had felt there was inflammatory  
5 change in keeping with a viral encephalitis and, as  
6 such, I should have notified the register of deaths of  
7 a change in death certification.  
8 Q. Yes, it is one or the other, isn't it?  
9 A. Yes.  
10 Q. If you think that how you interpreted that report was  
11 that that virus -- that change, sub-acute inflammation,  
12 that that was sufficient to tell you that there was  
13 a presence of encephalitis, then the death certificate  
14 isn't quite right, is it?  
15 A. No.  
16 Q. So then why didn't you change it?  
17 A. I don't remember. I don't think there was any specific  
18 reason why not. It just got missed in what needed to be  
19 done.  
20 Q. But that was the very thing that you had wanted the  
21 autopsy to deal with.  
22 A. Well, it was also the very thing I wanted to be able to  
23 talk to the parents about.  
24 Q. Yes. So it was therefore in your mind. So if it is in  
25 your mind and you are going now to explain to the

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1 are not there, if I can put it that way, with your  
2 original classification of the death certification.  
3 A. Yes.  
4 Q. Because you have the cerebral oedema which nobody  
5 disputes following the CT scan.  
6 A. Yes.  
7 Q. Then you have the seizure activity, which you refer to  
8 as status epilepticus, but it is seizure activity and he  
9 has that in there actually as part of the trigger.  
10 A. Yes.  
11 Q. If when now you see the report from autopsy, you  
12 certainly should have had a discussion with him about  
13 that, because that introduces a new factor, in fact,  
14 something that you thought, although you haven't  
15 characterised it in that way, might have been the  
16 original trigger, and that introduces, doesn't it,  
17 something that he hasn't got in his note? So you should  
18 have had a discussion about that because -- "Maybe we  
19 really should be changing this death certification.  
20 Certainly it will affect how we explain matters to the  
21 family".  
22 A. Yes.  
23 Q. So, as I say again, that was an important discussion.  
24 Either way it is an important discussion.  
25 A. Yes, and it should have been documented.

39

1 parents, "Actually we have now got some confirmation",  
2 why aren't you changing the death certificate?  
3 A. I don't know. I have never changed a death certificate.  
4 I have provided information once when asked by the  
5 register, but I have never actually been in the process  
6 of changing the content of a death certificate.  
7 Q. But it was one of the things you had held open the  
8 possibility to do --  
9 A. Yes.  
10 Q. -- because you could just have ignored that box.  
11 A. Yes, that's right.  
12 MS ANYADIKE-DANES: Okay. Just pardon me one moment.  
13 Sorry. (Pause).  
14 If one just puts up, so I am clear about what you  
15 are saying now, 090-022-057 -- there we are. See that  
16 on that -- the actual bottom. That's Dr Webb's  
17 classification or characterisation of the cause of death  
18 at that time --  
19 A. Yes.  
20 Q. -- 4.40. Okay? He starts with SIADH, not anything  
21 viral. He starts with SIADH and then he goes in to:  
22 "Hyponatraemia, hyposmolality, cerebral oedema and  
23 coning after prolonged epileptic seizures."  
24 A. Yes.  
25 Q. So that actually fits closer, although some of the steps

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1 Q. And if it's not documented, what is his explanation then  
2 for how he now regards matters if you have introduced  
3 a potentially different trigger?  
4 A. I --  
5 Q. To you. I mean --  
6 A. I can't say what Dr Webb thought. I have no  
7 recollection. I do know that the two of us were in  
8 agreement on the way forward and agreement in speaking  
9 to the parents and providing the information the parents  
10 requested.  
11 Q. Thank you.  
12 MR SEPHTON: I am sorry to interrupt. Perhaps Dr Steen  
13 ought to be asked to deal with the proposition that  
14 Dr Webb said he didn't see the parents again and the  
15 strong probability -- it certainly wasn't put to him to  
16 the contrary -- was that he didn't talk to Dr Steen  
17 after the autopsy report came back.  
18 MS ANYADIKE-DANES: Dr Steen?  
19 A. Dr Webb, as far as I'm concerned, did see me with the  
20 parents and I think the two letters that were sent in  
21 March give some confirmation to that in that I write to  
22 the GP, which was done at the time -- I write to the GP  
23 to say that Dr Webb and I had met with the parents.  
24 I then gave a brief summary to the GP and said that  
25 Dr Webb was going to provide I think -- can we get it

40

1 up? No? Do you not want to put it up?  
2 THE CHAIRMAN: Let's put up the two letters together  
3 actually. It's 090-001-001 and then 090-002-002. Yes.  
4 Thank you: one is your letter, Dr Steen, to Dr McMillin,  
5 the GP --  
6 A. Yes.  
7 THE CHAIRMAN: -- and the other is Dr Webb's letter to  
8 Mr and Mrs Roberts.  
9 A. Yes.  
10 "Dr Webb and myself have since seen Claire's parents  
11 and discussed the post-mortem findings with them."  
12 So that was dictated on 5th March 1997. So at time  
13 it was very clear in my mind that Dr Webb and I had both  
14 met with the parents and that the action Dr Webb had to  
15 do following that meeting was that Mr Roberts wanted  
16 a short summary of the post-mortem report, which Dr Webb  
17 would send him. Then there's Dr Webb's letter also  
18 showing the short summary.  
19 MS ANYADIKE-DANES: Thank you. The short summary that  
20 Dr Webb provides reflects the finding of a low-grade  
21 infection, meningoencephalitis.  
22 A. Yes.  
23 Q. And the implications of that are something you would  
24 have discussed with him.  
25 A. Yes.

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1 a transverse myelitis. It is like an enterovirus, it is  
2 like a polio virus. She had come out with a bit of  
3 a temperature and she had just wiped out, her spinal  
4 cord, that affected breathing and she stopped breathing.  
5 So it is not unknown for young children to come in and  
6 rapidly deteriorate. They compensate -- their bodies  
7 are strong and they compensate and then they rapidly  
8 deteriorate.  
9 Q. And -- well, I will go into it later on. Can I just ask  
10 you briefly something about the brainstem death tests?  
11 A. Yes.  
12 Q. I only want to pick up on some points you were not able  
13 to deal with because they were not put to you in your  
14 own evidence. Since you gave your evidence, we have had  
15 expert evidence to deal with the brainstem death tests,  
16 in particular both Dr Aronson and Dr MacFaul were of the  
17 view that Dr Webb really ought not, in the circumstances  
18 of the anticonvulsants that had been prescribed to  
19 Claire, ought not to have inserted into her notes or  
20 written in her notes that she was -- didn't have any  
21 medication of a sedating or paralysing effect. I think  
22 that is the expression that's used. I will just get the  
23 right one. It is at 6 o'clock just before he is going  
24 to do the first brainstem test. Yes.  
25 Under "No sedating/paralysing medication" -- we

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1 Q. Claire is admitted to hospital around about 8 o'clock or  
2 so on to the ward on the Monday, the Monday evening.  
3 She suffers her respiratory collapse in the early hours  
4 of the Wednesday morning. It is quite a sudden turn of  
5 events; would you not agree?  
6 A. Yes.  
7 Q. Was that something also that troubled you as to how what  
8 doesn't appear to be a very serious set of symptoms,  
9 whether viral or otherwise, doesn't appear very serious  
10 when she is first admitted, but led to her collapse and  
11 death so relatively quickly? Did that trouble you  
12 trying to work out how this child died?  
13 A. I am sure it did.  
14 Q. And if it does trouble you, were you able to consider  
15 that you had a sufficiently robust explanation for what  
16 you thought was the cause of her death and how that  
17 could have actually taken hold and happened that  
18 quickly?  
19 A. Yes, otherwise I would not have issued a death  
20 certificate, and I have seen it since. It was one of my  
21 children who I had been looking after for many years who  
22 happened to be admitted for a totally separate thing  
23 when I wasn't -- when I was on holiday. I got a phone  
24 call on holiday to say that she had suddenly arrested  
25 and died in the ward. She had what is called

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1 don't need to put it up. I will just give the  
2 reference. 090-022-058. So you had heard their view  
3 that they didn't consider that you could write that,  
4 that she did have medication in her system that had  
5 sedating effects, if I put it that way. Were you  
6 concerned about that? Did you discuss that with  
7 Dr Webb?  
8 A. I think we touched on this yesterday.  
9 Q. I am not sure we entirely did. Did you discuss that  
10 with Dr Webb?  
11 A. Dr Webb and I would have been very careful about  
12 ensuring the criteria to fill in the brainstem deaths.  
13 Looking back, her same phenytoin --  
14 Q. You did touch on.  
15 A. Yes, we did.  
16 Q. So what I am trying to ask you is: to what extent you  
17 relied on Dr Webb to tell you the likelihood of those  
18 dosages remaining present in her system as something  
19 that could have a sedating effect?  
20 A. I would have relied, I think, to a certain extent on  
21 the midazolam. The phenytoin -- I would have been more  
22 aware that the blood level was within the upper limit of  
23 normal, but was in the therapeutic range. Therefore,  
24 I wouldn't have relied so much on the phenytoin. Also  
25 I know phenytoin used to be used a lot for epilepsy, but

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1 it has so many side effects it is not particularly used  
2 now; it is just used for the acute episodes. I would  
3 have been comfortable with the idea that phenytoin --  
4 actually, when it gets into a high dose, it starts to  
5 make you a bit wobbly on your feet before it starts to  
6 make you very sleepy. The phenytoin I would have been  
7 comfortable with myself.  
8 Q. Would you have been equally comfortable to express  
9 a view on the likely sedating effect of the phenytoin  
10 and midazolam?  
11 A. I would have relied on him to reassure me -- this is  
12 reconstruction -- that the midazolam would have been out  
13 of the system.  
14 Q. Either out of the system or if in the system, not, in  
15 combination with phenytoin, having a sedating effect --  
16 A. Yes.  
17 Q. -- so you would have needed his guidance about that?  
18 A. Yes.  
19 Q. Is that something you would have wanted to be confident  
20 about?  
21 A. Of course.  
22 Q. If I can then just -- I am conscious of the time. Can  
23 we have a few more minutes?  
24 A. Or one more session and finish it today? I can't keep,  
25 from my health perspective --

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1 one issue.  
2 A. Yes.  
3 Q. Then you said her temperature was raised.  
4 A. Yes.  
5 Q. Then you said she was vomiting.  
6 A. Yes.  
7 Q. If I can just address that with you. Let's take the  
8 white cell count first. That was raised -- 16.5 when it  
9 was first noted.  
10 A. Yes.  
11 Q. But in your note -- you make your note at 4.00 am,  
12 090-022-057. There we are. You can see it just  
13 a little bit in the corner there. Can you see it is  
14 "WCC = 9.4"? It is down by the time you note it.  
15 A. Yes.  
16 Q. So whatever has happened during the day, it has actually  
17 come down.  
18 A. Yes, and I think some of the experts have addressed  
19 that, the way in which the white cell count can change  
20 during an illness.  
21 Q. No, I am talking from your point of view.  
22 A. Yes.  
23 Q. From your point of view, one of the criteria or one of  
24 the reasons why you thought there was an underlying  
25 viral condition was to do with her raised white cell

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1 THE CHAIRMAN: Doctor, the only question now is whether --  
2 we will finish you today.  
3 A. Thank you.  
4 THE CHAIRMAN: The only question is whether you take a break  
5 now and come back either immediately after the break or  
6 at 2 o'clock or whether -- do you want to think about  
7 that?  
8 A. No. I would prefer that we take a break and get it  
9 finished, because a longer break over lunch and all  
10 won't necessarily revive me particularly.  
11 THE CHAIRMAN: So if we take a break now for  
12 fifteen minutes --  
13 A. Yes. Thank you very much.  
14 THE CHAIRMAN: -- and resume your evidence at 11.40?  
15 A. Yes.  
16 THE CHAIRMAN: Thank you very much.  
17 (11.25am)  
18 (Short break)  
19 (11.40am)  
20 (Delay in proceedings)  
21 (11.52 am)  
22 MS ANYADIKE-DANES: Dr Steen, can I just revisit with you  
23 the bases on which you formed the view there was  
24 an underlying viral condition? I think, when I asked  
25 you about it, you said her raised white cell count was

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1 count. What I am saying is that it had been slightly  
2 raised, but it was certainly down by the time you are  
3 looking at it at 4 o'clock.  
4 A. Yes, and that's what can happen with illnesses. The  
5 white cell count varies.  
6 Q. If you are using that as a basis, how do you know  
7 whether the white cell count is going down because  
8 that's just a normal fluctuation of disease or it is  
9 going down because actually the child is recovering?  
10 A. An expert --  
11 Q. No, I mean from your point of view when you are reaching  
12 your view.  
13 A. From my perspective, I needed to know what was causing  
14 the trigger. If we go right back to her admission  
15 details, we can see the white well count was elevated.  
16 The fact her white cell count is not elevated further  
17 makes it unlikely she had an overriding bacterial  
18 infection which pushes white cells up. Viral infections  
19 can push white cells down really low, as can bacterial  
20 infections.  
21 Q. So it is not a very reliable base though because it can  
22 go up and down.  
23 A. It is. If it is elevated it is elevated. If it is  
24 elevated, it is elevated for a reason. You then have to  
25 watch the fluctuations, but use it with other symptoms,

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1 signs and tests to determine if the infection is  
2 developing further.  
3 Q. Does that mean it should have been tested more often to  
4 see if there were fluctuations?  
5 A. No, because I think it was felt to be viral. I think  
6 one of the questions raised earlier was why wasn't there  
7 a differential done at the time of admission and that  
8 differential would have allowed us to determine it was  
9 lymphocytic, which is the white cell most involved with  
10 viruses. A fluctuating white cell count will not  
11 necessarily affect the progress or the treatment.  
12 Q. Okay. Let's go to the other one, which is temperature.  
13 We can see that on the central nervous system  
14 observation chart, 090-039-137. Okay. The temperature  
15 you can see where it is on the far right-hand side. Do  
16 you see the temperature there?  
17 A. Yes.  
18 Q. Those are the values for temperature. The actual record  
19 of it you can see it almost opposite that or adjacent to  
20 it in the middle where you can see those two raised  
21 parts; okay?  
22 A. Yes.  
23 Q. So there is two raised parts and then it comes down  
24 again. We know from having looked at her medication  
25 that she was actually prescribed paracetamol. So it

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1 Q. Yes. That's the recordings of it since 1 o'clock on the  
2 Tuesday, the 22nd.  
3  
4 A. But there's a previous obs chart.  
5 Q. Yes. Let's have a look at that then.  
6 A. Hold on. I had that just a minute ago, actually.  
7 Sorry.  
8 THE CHAIRMAN: 090-025-072.  
9 MR FORTUNE: [Inaudible: no microphone] that was a previous  
10 admission.  
11 THE CHAIRMAN: Sorry.  
12 A. The issue was had she a low-grade temperature. I think  
13 the obs you have shown show she had a low-grade  
14 temperature on the evening. Viral infections can be  
15 high temperatures, low -- she had a low-grade  
16 temperature.  
17 MS ANYADIKE-DANES: She had a low-grade temperature which  
18 was addressed by paracetamol and then she didn't have  
19 a temperature and according -- if we just pull that back  
20 up --  
21 A. The paracetamol would have reduced her temperature.  
22 Q. Just bear with me. Let's pull up 090-039-137 and if we  
23 pull up next to it the temperature chart, which is  
24 090-044-147. Right. Do you see evidence of  
25 a temperature there?

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1 really only goes up on two occasions. Then it is pretty  
2 normal on admission. It goes up on two occasions, comes  
3 down --  
4 A. Sorry. Can we go back to the A&E notes?  
5 Q. Yes, we can. The A&E note is to be found at  
6 090-012-014.  
7 A. There is another page that her obs are on.  
8  
9 Q. Well, it is the referral. Can we pull that up alongside  
10 090-011-013?  
11 A. No. There is another page that gives her clerk-in  
12 details, her obs, temperature, pulse, respiration.  
13 Q. Then that's 090-010-012.  
14 A. Her temperature is normal there. I can only do this by  
15 going back through her notes bit by bit.  
16 Q. That's fine. It is normal there on admission.  
17 A. It is normal there. Then we need to go to ...  
18 Q. Then it is normal -- apyrexia. That's normal, isn't it?  
19 A. Yes.  
20 Q. It is recorded on 090-012-014 as apyrexia, which is in  
21 the middle of that line there if you can see that.  
22 Then, if you look at the admission Dr O'Hare takes,  
23 I don't think one can find any reference to her having  
24 a temperature there.  
25 A. Then the temperature, pulse and respiration chart.

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1  
2 A. It was 37.3 at time of admission and went to normal and  
3 then at -- on her -- if you go to her CNS obs chart.  
4 Q. Yes.  
5 A. It was elevated at -- really it was normal --  
6 Q. It was elevated at 8.00 pm?  
7 A. No, I think it was also elevated at 6 and 7, but then  
8 spiked further at 8.  
9 Q. Yes.  
10 A. It is normal. I am assuming the -- if we use the other  
11 scale, the 170, the first noted temperatures were  
12 normal, and it shows it elevated at 6pm. It improved  
13 with paracetamol, but never came down to 37 again.  
14 Q. Yes, but essentially apart from those two slight  
15 elevations, which were addressed, essentially her  
16 temperature is normal.  
17 A. It's a low grade pyrexia. Normal temperature is 37.  
18 Q. Well, what --  
19 A. And there's a raised white cell count and she had  
20 vomiting.  
21 THE CHAIRMAN: What about the vomiting, doctor? The  
22 vomiting was overnight from Monday into Tuesday.  
23 MS ANYADIKE-DANES: Yes, we can see it at -- I am sorry. I  
24 beg your pardon.  
25 A. Prior to admission?

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1 THE CHAIRMAN: Prior to admission, then overnight Monday  
2 into Tuesday, and by the time you see her -- you see  
3 Claire at 3 or 4 in the morning on the Wednesday -- what  
4 was her vomiting within the previous 24 hours?  
5 A. The vomiting it stopped I think that morning, and I am  
6 sure most people who know when they get a tummy bug, you  
7 may have profuse vomiting for a period of time. You may  
8 or may not have diarrhoea and then feel grotty for a few  
9 days.  
10 MS ANYADIKE-DANES: 310-001-001. If we just expand that.  
11 Thank you:  
12 "She had vomited in the afternoon prior to  
13 admission."  
14 Then you see her recorded vomits along there. They  
15 are all indicated by the red diamonds.  
16 A. Yes.  
17 Q. So the last time she is recorded as having a vomit is at  
18 6 o'clock on the Tuesday morning.  
19 A. Yes.  
20 Q. And those are all strong enough indications for you?  
21 A. Those are very common symptoms, as I am sure many people  
22 in the room have had, of a tummy bug, a vomiting illness  
23 with or without diarrhoea.  
24 Q. And no diarrhoea?  
25 A. Without diarrhoea, yes. A gastritis rather than

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1 done, you would be very surprised indeed if Dr Webb was  
2 not somehow at least aware of that discussion, but more  
3 probably part that have discussion?  
4 A. Well, I think Dr McKaigue suggested he was part of the  
5 discussion.  
6 THE CHAIRMAN: Yes. Okay.  
7 MS ANYADIKE-DANES: I think one needs to be a bit careful  
8 about what Dr McKaigue says. It is 12 December,  
9 page 26, lines 2 to 18. I am not sure he says it in  
10 quite those terms. Perhaps the discussion starts  
11 earlier. I am not entirely sure that Dr Webb is saying  
12 he was part of a general discussion with you and Dr Webb  
13 as to whether the case was properly a coroner's case.  
14 We can address that later on. In any event, it is  
15 a matter of surmising because you have no recollection.  
16 A. No. But Dr Webb was part of the process right through  
17 until the post-mortem results were received and the  
18 discussion with the parents. So just as any other  
19 doctor can raise concerns, if there were concerns raised  
20 that he was uncomfortable with, they could have been  
21 referred to the coroner at any stage as he was part of  
22 the process.  
23 Q. Just for completeness what Dr Webb says:  
24 "I was not involved in this discussion and do not  
25 know why Claire's case was not referred to the coroner."

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1 an enteritis.  
2  
3 Q. So can I just ask you this quickly? When you formed the  
4 view that this was not a case to be referred to the  
5 coroner, is that something that you discussed with  
6 Dr Webb?  
7 A. I think we have covered this already, and I've said that  
8 very clearly. This discussion -- Dr McKaigue has  
9 a clear recollection of the discussion at one  
10 section during the morning -- the Wednesday morning, and  
11 Dr Webb, as far as I'm concerned, would have been part  
12 of the discussions right through.  
13 Q. I don't believe he thinks he was part of that  
14 discussion.  
15 A. Well, I know and I'm very surprised by that. He maybe  
16 doesn't recall.  
17 Q. But you don't recall.  
18 A. I don't recall --  
19 Q. No.  
20 A. -- but he did the second set of brainstem death tests.  
21 He would have seen --  
22 THE CHAIRMAN: Let me see if I can summarise it. Your point  
23 is if Dr McKaigue -- you don't recall, this but if  
24 Dr McKaigue remembers a discussion on the Wednesday  
25 morning about why Claire had died and what is now to be

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1 That was his witness statement. For reference, it  
2 is 138/1, page 53.  
3 A. I am aware of that. I am also aware of what Dr McKaigue  
4 has said. I am also aware of due process and our  
5 accountability as clinicians to report anything we have  
6 concerns about. Dr Webb was also part of the process  
7 right through to meeting the parents in end of  
8 February/March 1997 and would have been aware. It was  
9 in the notes what had happened.  
10 Q. Yes. Dr Hicks, when she gave her evidence, was in the  
11 circumstances, so on the totality of things as were  
12 presented to her, was surprised that Claire's death was  
13 not reported to her. She was then your clinical lead.  
14 A. Yes.  
15 Q. And she was surprised that it wasn't reported to her and  
16 that it wasn't reported to the coroner. Just for  
17 reference's sake, that's at 11 December, page 53,  
18 lines 16 to 23, although we don't need to pull it up.  
19 Did you hear that evidence from Dr Hicks?  
20 A. Yes.  
21 Q. Are you aware of it?  
22 A. Yes.  
23 Q. And your comment?  
24 A. I have said, clearly in retrospect, this should have  
25 been referred to the coroner at the time, but at the

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1 time I believed we could explain her death and it was  
2 due to natural causes.  
3 THE CHAIRMAN: That means that you were sufficiently  
4 confident about the cause of Claire's death that you  
5 took the view that it was natural causes, that it didn't  
6 need to be referred to the coroner and, by the same  
7 reasoning, you did not need to speak to Dr Hicks.  
8 A. Well, I don't think there was a process in place that  
9 all coroner's cases were reported to the clinical  
10 director.  
11 THE CHAIRMAN: No, but if you were referring a case to the  
12 coroner because of a concern, for instance, that there  
13 was some level of --  
14 A. Medical mismanagement, yes.  
15 THE CHAIRMAN: -- medical mismanagement or fluid  
16 mismanagement, then that is an issue you would have had  
17 to report immediately to Dr Hicks, isn't it?  
18 A. Yes.  
19 THE CHAIRMAN: Thank you.  
20 MS ANYADIKE-DANES: Was there any other issue in relation to  
21 Claire that might take you to discuss her case with  
22 Dr Hicks?  
23 A. Dr Webb was a neurologist. Dr Hicks was a neurologist.  
24 Dr Webb was there giving advice. I don't know -- we  
25 didn't discuss it with Dr Hicks, so we must have been

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1 with Dr Steen and Dr Webb in the early hours of  
2 Wednesday morning, if there was any further discussion  
3 between Dr Steen and any consultant in PICU about  
4 a decision not to refer Claire's death to the coroner,  
5 it wasn't with you?  
6 "Answer: No."  
7 MS ANYADIKE-DANES: Now you are on that page, can we pull up  
8 the immediately preceding page, but keep this one?  
9 Thank you. So this is the issue about -- if we start at  
10 line 10:  
11 "Question: Did you interest yourself at that stage  
12 in what she had entered [she being yourself] on the  
13 medical certificate of cause of death?  
14 "Answer: Yes, I did.  
15 "Question: Given that you believed that  
16 meningoencephalitis was part of the clinical picture,  
17 that SIADH and hyponatraemia were part of the picture,  
18 were you surprised it that she [that's Dr Steen] did not  
19 put those on the death certificate?  
20 "Answer: I was surprised that encephalitis wasn't  
21 on the death certificate."  
22 Then that leads into the discussion that he had ad  
23 which enabled him to take the view you were the  
24 clinicians and if you had --  
25 MR FORTUNE: In fairness to Dr Steen, read the whole of the

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1 reassured by what we were doing.  
2 Q. I meant from the point of view that she was your  
3 clinical lead. It is convenient that she also happens  
4 to be a paediatric neurologist. That was also helpful.  
5 A. Yes, so not as a clinical lead. It was not routine to  
6 report deaths to the clinical director. There was no  
7 process for doing so. The deaths were collated through  
8 the audit secretary for presentation at the mortality  
9 meeting.  
10 Q. Okay. So in any event, you formed that view that you  
11 know you are sufficiently confident in your view that  
12 you don't need to report it to the coroner. Then comes  
13 the issue as to what kind of autopsy you are going to  
14 have.  
15 MR FORTUNE: Before we go on, can I just go back to this  
16 discussion involving Dr McKaigue? My learned friend  
17 referred to page 26.  
18 MS ANYADIKE-DANES: It is the wrong page, I think.  
19 MR FORTUNE: I was going to say page 25 might be more  
20 appropriate.  
21 MS ANYADIKE-DANES: Thank you very much for that.  
22 MR FORTUNE: Because the witness deals with the conversation  
23 and then, at line 17, the chairman becomes involved:  
24 "Question: Just to clear up this point, Dr McKaigue:  
25 when you were saying earlier that you had the discussion

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1 answer.  
2 MS ANYADIKE-DANES: I beg your pardon:  
3 "... but on the other hand, Dr Webb had again,  
4 I think, in his written note talked about SIADH being  
5 related to status epilepticus."  
6 "Question: Given that you were surprised that the  
7 medical certificate issued didn't accord with your  
8 understanding, what did you do in consequence?"  
9 Which leads on could the discussion, which  
10 ultimately has him, as I was summarising -- I hope not  
11 unfairly -- he formed the view that if the treating  
12 clinicians had seen enough evidence to enable them to  
13 form that view, then he was really seeing Claire when  
14 she was really at the end of her life, as it were.  
15 A. Yes.  
16 Q. But the point I was going to take you to was: whatever  
17 was the discussion, he was initially surprised  
18 encephalitis was not on the death certificate. So if  
19 you were having a discussion with him -- well, you can't  
20 remember.  
21 A. I can't remember, and if that's his evidence, I don't  
22 think he can remember further.  
23 Q. Okay. Thank you.  
24 THE CHAIRMAN: It is also relevant for Dr Sands that it is  
25 Dr McKaigue's recollection that encephalitis was part of

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1 the picture, and this is part of the picture on the  
2 morning of 23 October.  
3 MS ANYADIKE-DANES: If we then go on to the point that I was  
4 going to ask you about, the brain-only autopsy. Dr Webb  
5 says that he's quite clear that it wasn't discussed,  
6 that it is between you and he as to whether it would be  
7 brain-only, and that's to be found on 3 December at  
8 page 226 at line 1. He literally says:  
9 "And I'm quite clear that we did not discuss it."  
10 I know you don't independently remember any of these  
11 things, but is your evidence you wouldn't have made such  
12 a decision without discussing it with him?  
13 A. Yes, and he would have been aware of the process that  
14 was being undertaken when the results came back, the  
15 information that was in the post-mortem and how that was  
16 shared with the parents.  
17 Q. You've heard the evidence from the other clinicians and  
18 the experts as to, if there's no impediment or  
19 restriction being put on it from the family, why don't  
20 you just have a full autopsy.  
21 A. I can't remember how the conversation went. I can't  
22 understand, you know, where we got -- where our process  
23 was. I don't find parents coming back and saying that  
24 the process of autopsy is not difficult for them and  
25 I can't reconstruct what was going on. I just know that

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1 A. Yes.  
2 Q. You have the benefit of looking at her medical notes and  
3 records and speaking to the other clinicians involved.  
4 They don't. We can see what Mr Roberts says about that  
5 time. It is the transcript of 13 December, page 94,  
6 lines 7 to 17. He says:  
7 "Yes, I do recall, after Claire's life support was  
8 discontinued, that my wife, myself and Dr Steen went  
9 into an office just off PICU and we discussed the  
10 post-mortem."  
11 I think that means you are there and not Dr Webb, on  
12 his recollection of it.  
13 A. Yes.  
14 Q. "It would be a brain-only post-mortem. We were being  
15 guided by Dr Steen down that road. We'd never asked --  
16 we never questioned about the scope of the post-mortem.  
17 We didn't ask really what had to be done. We were being  
18 guided by Dr Steen. We were asking, 'What do we do  
19 now?'. This is the process. And Dr Steen then took us  
20 through that process that we needed to try and identify  
21 the virus."  
22 And they go on in a similar vein in their witness  
23 statement for the inquiry, but the issue is they are  
24 dependent on you to tell them whether a full autopsy is  
25 appropriate or some more restricted sort. So from their

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1 the conversation would have been had with the parents.  
2 They can remember bits of it. Some of them, they  
3 remember only too clearly. I believe I would have  
4 discussed all the options with them.  
5 Q. Well, that sounds like you would have discussed with  
6 them the possibility of having a full autopsy.  
7 A. Well, yes. I think I've covered that before in my  
8 evidence as well, about the process that you would  
9 cover, about whether you can -- you are happy with the  
10 cause of death, whether you have any queries, whether  
11 those queries could be answered in a following way, and  
12 that's a limited post-mortem, a full post-mortem or  
13 whether, in fact, you are unhappy and you actually need  
14 to involve the coroner.  
15 Q. Well, the parents being unhappy is not really the  
16 trigger for involving the coroner.  
17 A. Well, it is actually. Anyone can report a death to  
18 a coroner. I think if a family are deeply unhappy about  
19 what the process is, there needs to be a discussion  
20 around that. It would not be the first time the coroner  
21 has been phoned because there are family concerns.  
22 Q. I appreciate that, but the reality is that the extent to  
23 which Claire's parents can engage with you in  
24 a discussion like that is dependent on the information  
25 they receive?

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1 point of view, it is not a matter of you laying out the  
2 options to say, "You can have this or you can have  
3 that". They are depending on you to say what is the  
4 appropriate thing to do in these circumstances. They  
5 have never, obviously, been in that situation before.  
6 A. No, and I would have already discussed that with Dr Webb  
7 and we would have formed a view before I went in to  
8 speak to the parents. I think there was probably  
9 a nurse there as well. I am not sure if Dr Webb was  
10 there at that stage. He was probably still in PICU.  
11 Q. The question I asked you was simply: why didn't you, in  
12 the absence of any form of opposition or restriction  
13 from the family -- which is quite often what happens in  
14 these cases -- why didn't you just allow a full  
15 post-mortem?  
16 A. I have -- obviously Dr Webb and I felt that enough  
17 information could be gleaned a brain-only post-mortem.  
18 Q. Yes. Do you think now that it would have been better to  
19 have had a full post-mortem?  
20 A. I think probably it would, though I am unsure -- I think  
21 the outstanding diagnosis that Dr MacFaul has raised is  
22 Reye's syndrome, which would have shown some fatty  
23 change in the liver, which I think is very unlikely with  
24 her normal sugars and whatever. I think it would have  
25 been much easier if we had just gone to the coroner,

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1 never mind a full post-mortem.  
2 THE CHAIRMAN: It is also fair to say that Professor Lucas,  
3 who we will hear from later on today, has said in his  
4 report that the decision to limit the examination to  
5 Claire's head was not unreasonable and he has done so in  
6 many similar cases himself.  
7 MS ANYADIKE-DANES: If I now ask you very quickly about the  
8 issue of the death certificate. The point I want to ask  
9 you very quickly about that is: is that something that  
10 you discussed with Dr Webb, Dr McKaigue and/or  
11 Dr Taylor?  
12 A. I don't know if Dr McKaigue and Dr Taylor -- Dr Taylor  
13 I think was there on the Tuesday morning, so he wouldn't  
14 have been in PICU on, sorry, the Wednesday morning.  
15 Q. Wednesday morning, yes.  
16 A. He wouldn't have been in PICU on the Wednesday evening.  
17 I think Dr McKaigue must have actually come back. He  
18 wouldn't have been on. Dr McKaigue must have actually  
19 come back to do the second set of brainstem tests with  
20 us and to see Claire to the end. I have no doubt  
21 I discussed it with Dr Webb. Dr McKaigue says he is  
22 aware of what I wrote in the chart. I don't know how  
23 much conversation I had with Dr McKaigue that evening.  
24 Q. I understand.  
25 Can I now deal with the period immediately after the

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1 a multidisciplinary way, discussing Claire's death.  
2 A. Yes.  
3 Q. Dr McKaigue has said he thought you did present at  
4 a mortality conference; you can't actually remember it.  
5 A. No.  
6 Q. If you had presented, would you have wanted Dr Sands  
7 there I presume?  
8 A. If he had -- I don't know where Dr Sands --  
9 Q. No, would you have wanted him there?  
10 A. Yes. I don't know where he was.  
11 Q. And you would have invited Dr Webb presumably.  
12 A. Well, the whole medical staff, except for those dealing  
13 with emergencies, would be expected to attend.  
14 Q. And Doctors Herron and Mirakhur have said, from time to  
15 time, they have been invited to those sorts of meetings,  
16 particularly if they have presented a report that's  
17 likely to form part of the general discussion.  
18 A. Yes. The timing of a case being discussed will depend  
19 on being able to get as many of the relevant people  
20 there as possible, including pathology.  
21 Q. Yes. Just so that we know, so far as you are concerned,  
22 what happens at a meeting like that?  
23 A. I thought we'd talked through this yesterday.  
24 THE CHAIRMAN: Let me try to bring this to a head, because  
25 we have to get on to your 2004 evidence. If there had

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1 receipt of the autopsy report? When -- if you had been  
2 there when -- I don't know. Were you there when Doctors  
3 Mirakhur and Herron were giving their evidence?  
4 A. Some of it.  
5 Q. I took them through some of the benefits about having  
6 discussions between the pathologists and the clinicians,  
7 which can happen in a number of cases. It can happen  
8 before you even refer it to them and they can be  
9 instrumental in the kind of autopsy that's going to  
10 happen. It can happen when they first get it and they  
11 want to make sure that they understand what it is you  
12 are wanting them to look at. After they complete, it  
13 can happen, and before they issue their final report and  
14 then following their final report. So there's any  
15 number of opportunities for discussion, depending on the  
16 nature of the case. You would accept that, I presume.  
17 A. Yes.  
18 Q. Professor Lucas in his report at 239-002-012 says:  
19 "Perhaps, had there been a mortality conference  
20 after the autopsy, a bright clinician might have asked,  
21 'But is that inflammation/encephalitis to account for  
22 what happened?'. Then the initial story would have  
23 unravelled and a focus on other causes such as  
24 hyponatraemia might have emerged."  
25 So what he is pointing to is the benefits of, in

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1 been a mortality conference, and I have to say I am  
2 entirely unsure whether Dr McKaigue is right about this,  
3 he seems to have a recollection that you may have  
4 presented Claire's death to a mortality conference.  
5 A. Uh-huh.  
6 THE CHAIRMAN: If that had been done, then that should have  
7 involved you, Dr Sands, Dr Webb, Dr Herron and  
8 Dr Mirakhur.  
9 A. Usually only one neuropathologist will come.  
10 THE CHAIRMAN: One of them?  
11 A. Yes.  
12 THE CHAIRMAN: That in itself would have prompted  
13 a discussion that, to the extent you were taking  
14 encephalitis out of the autopsy report, Dr Herron would  
15 have said, "No, no, no. That's such a low-grade  
16 encephalitis that that is not actually a cause of  
17 Claire's death"; isn't that right?  
18 A. Yes.  
19 THE CHAIRMAN: So in all probability there have appears to  
20 have been no such discussion and that leads me away from  
21 believing that Dr McKaigue is right. I am not  
22 suggesting for a moment that he has been deliberately  
23 dishonest; there's just no record of these conferences  
24 and, if there had been a conference which had flagged up  
25 that encephalitis did not actually feature, that would

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1 have led to a reconsideration of what happened to  
2 Claire; isn't that correct?  
3 A. Yes, and there is no record, and at least now there's  
4 a record that the case has been discussed and if there  
5 were any key issues. I don't know when the  
6 neuropathologists determined that encephalitis was not  
7 part of it. I don't know if in 1997 that would have  
8 come across. The process should have been that it was  
9 presented twice --  
10 MS ANYADIKE-DANES: That's the chairman's point.  
11 A. Yes.  
12 Q. In their view, when they wrote that under the commentary  
13 of the clinicopathological reconciliation, what that  
14 meant was that that was not sufficient to have  
15 contributed to Claire's death. That's what they meant  
16 by that.  
17 A. Yes.  
18 Q. And when they gave their evidence, they scored it on  
19 zero to ten. Dr Herron had it at one to two, possibly  
20 closer to one. Dr Mirakur thought more like two, but  
21 in any event apparently five, according to Dr Mirakur,  
22 is the level at which you begin to think that  
23 inflammation of that sort contributes to death in some  
24 way from their evidence. It wasn't a feature from their  
25 point of view.

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1 A. And, as you suggested yesterday, if there was  
2 a discussion, then it was totally ineffectual. So  
3 either the discussion didn't happen, or if it happened,  
4 it didn't actually go into enough depth or interrogate  
5 the case to such an extent.  
6 THE CHAIRMAN: So either it didn't happen or, if it did  
7 happen, it wasn't worth it because it did nothing --  
8 nothing was learned despite the fact that there are  
9 clearly some things that could have emerged from it.  
10 A. I think you summarised that yesterday.  
11 MS ANYADIKE-DANES: And the person to present that and  
12 ensure that those threads are tied is you.  
13 A. Myself and Dr Webb.  
14 Q. Thank you. Then just one quick point, because  
15 Professor Lucas has referred to it in his report.  
16 Remember when we had those two letters? You are writing  
17 to the GP; Dr Webb is writing to Claire's parents.  
18 A. Uh-huh.  
19 Q. Both the inquiry's expert pathologists were asked about  
20 the interpretation of the autopsy report so as to  
21 present -- provide those letters. Professor Lucas' view  
22 was Doctors Steen and Webb have over-interpreted the  
23 infection pathogenesis compared with the original  
24 autopsy report comment. In other words, you have seen  
25 too much into it, that's his view.

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1 MR FORTUNE: From Dr Scott-Jupp's point of view, you don't  
2 score.  
3 THE CHAIRMAN: That doesn't take us anywhere. If you don't  
4 score, it is either there or it is not. If you don't  
5 score -- I know Dr Scott-Jupp said you don't score it  
6 and Dr Harding said something similar. Dr Harding said  
7 "it is either there or it is not". The evidence  
8 effectively is it is not there. If you take a different  
9 approach, and you do score it, it is there at such a low  
10 level it did not contribute to Claire's death. That's  
11 the evidence. The only point I am trying to get to with  
12 Dr Steen is that the -- we are trying to get through  
13 this point as quickly as we can to move on to 2004 --  
14 had there been a discussion along the lines you have  
15 talked about, Dr McKaigue has talked about,  
16 Professor Lucas has talked about, it is most likely it  
17 would have emerged at this conference or discussion  
18 that, in fact, encephalitis is not part of Claire's  
19 cause of death. Therefore we have to -- we have to  
20 discuss between ourselves what did actually cause her  
21 death. We have to reconsider referral to the coroner.  
22 We have to reconsider perhaps the death certificate.  
23 All of that can only be done if there's a discussion.  
24 A. Yes, and we've no evidence of the discussion.  
25 THE CHAIRMAN: Yes.

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1 A. Yes.  
2 Q. Would you accept that now?  
3 A. Well, yes, because we felt that it did indicate  
4 encephalitis, and then, of course, there is the CSF  
5 findings.  
6 Q. Yes. So if I move on, although just on that, if you had  
7 had -- this is another matter you must have felt quite  
8 comfortable about, otherwise you would have had some  
9 conversation to satisfy yourself about it.  
10 A. Which part?  
11 Q. You must have felt quite confident you could write the  
12 GP in those terms, otherwise you would have clarified  
13 the point with the pathologists.  
14 A. Yes, yes.  
15 Q. So then if we can go to the meeting with the -- with Mr  
16 and Mrs Roberts. Firstly, you are aware of the UTV --  
17 THE CHAIRMAN: Are we now in 2004?  
18 MS ANYADIKE-DANES: We are now in 2004, sir. Sorry.  
19 You are now aware of the UTV documentary because you  
20 are CCed into that e-mail that's says it going to happen  
21 at 9 o'clock the next evening. Did you watch then?  
22 A. I can't remember if I watched it then or taped it and  
23 watched it later.  
24 Q. But you were being CCed because of your position as  
25 clinical lead, effectively.

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1 A. But it doesn't mean I was actually available at that  
2 time. I certainly watched it within 24 or 48 hours.  
3 Q. You did? What did you take from it?  
4 A. I can't remember beyond being very concerned, very  
5 worried about the content, how it would affect  
6 clinicians and parents of children. I felt it was  
7 a very worrying programme. I can't remember the detail.  
8 Q. I understand that, but maybe you can remember the drift.  
9 Was the Trust formulating some sort of group to analyse  
10 and assess the implications of that --  
11 A. I can't remember.  
12 Q. -- so that the Trust could respond?  
13 A. You would have to look -- I can't remember.  
14 Q. If it had, would you expect to be part of it?  
15 A. This was 2004? Yes, I would have been. I would have  
16 expected that either me or another representative from  
17 children's services would have been part it have.  
18 Q. So a response to that is, of course, that Mr Roberts  
19 contacts the hospital.  
20 A. Yes.  
21 Q. And the result of that is there's going to be a meeting  
22 with them, but prior to that, do you not get contacted  
23 by Dr McBride to carry out a case note review, or if it  
24 is not Dr McBride, it is Dr Rooney?  
25 A. Yes. Again I can't remember the detail and can't

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1 A. I can't remember at this stage what the process was and  
2 what the medical director had asked us to do.  
3 Q. No, I am asking you if you would have wanted to talk to  
4 the person who was then registrar and who had most  
5 direct contact with Claire during her admission on  
6 your -- in your paediatric team.  
7 A. I am not sure at that stage I would have wanted to do  
8 anything other than review the medical notes and then  
9 determine whether further --  
10 Q. Yes.  
11 A. -- steps needed to be taken.  
12 Q. How thoroughly would you have wanted to look at those  
13 medical notes?  
14 A. As thoroughly as I could within a given time frame with  
15 other challenging issues.  
16 Q. Were you given a time frame?  
17 A. I can't remember.  
18 Q. Thank you.  
19 Did you know if there were going to be other  
20 clinicians looking at those notes?  
21 A. I can't remember.  
22 Q. So you produce a patient journey.  
23 A. I think that was in response to -- Dr Rooney, is it?  
24 I don't ...  
25 Q. Yes, I think Dr Rooney asks you. Just so that we have

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1 remember the e-mail trail, but yes, I was asked to carry  
2 out a patient journey -- I think is the way it was  
3 phrased.  
4 Q. Before you could carry out the patient journey, you  
5 would have to do a review of her patient notes and  
6 records.  
7 A. Yes.  
8 Q. Leaving aside you can't remember what happened in this  
9 particular case, but if you are going to perform  
10 an exercise like that, what do you do to inform yourself  
11 other than just read the medical notes and records?  
12 A. Well, you get the medical notes and records and you try  
13 to go through them in as much detail as you can. It  
14 would also -- your focus maybe is drifted slightly by  
15 what the query has been.  
16 Q. Yes.  
17 A. So -- I mean, you just go through the records and you  
18 identify key issues that you think are relevant.  
19 Q. Would you seek, for example, to talk to Dr Sands?  
20 A. At that stage, not necessarily.  
21 Q. Wouldn't that be part of putting it in context for you,  
22 since those medical notes, with the exception of the  
23 notes made at 4 o'clock on the Wednesday morning, none  
24 of those records are yours and you were not there to see  
25 the context in which they were being record?

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1 it, the patient's journey is at 177/1, page 34.  
2 MR QUINN: Mr Chairman, could we confirm whether or not it  
3 was Professor Rooney or Professor Young who encouraged  
4 the patient timeline -- whatever you want to call it.  
5 MS ANYADIKE-DANES: Patient journey.  
6 MR QUINN: Patient journey. I had assumed it was  
7 Professor Young had --  
8 MS ANYADIKE-DANES: I think it is actually Dr Rooney.  
9 THE CHAIRMAN: Yes, because I think Professor Young's -- his  
10 involvement was specifically being asked if fluid was  
11 an issue. As I understand his evidence, that's what he  
12 specifically said he was confined to.  
13 MS ANYADIKE-DANES: That's correct, Mr Chairman.  
14 THE CHAIRMAN: Once he said that, it meant Claire's case was  
15 going to the coroner. I know there is a bit of tipping  
16 around the edges about the consultation with the family,  
17 but that's effectively what his comment meant.  
18 MS ANYADIKE-DANES: So this is yours?  
19 A. Yes, I think so.  
20 Q. So then -- how comprehensive are you intending this to  
21 be?  
22 A. As detailed as I could do it. I was wanting the salient  
23 facts -- obviously, I would have wanted the salient  
24 facts to be there to be able to talk the parents through  
25 what had happened with Claire.

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1  
2 Q. Okay. Well, do you see that "loose motions for two  
3 days"? Can you help with where that comes from?  
4 A. Right. We would have to -- we have been through the  
5 loose motions when I have given evidence before. That  
6 needs to have been done either from history-- that's  
7 a summation from the notes and we have discussed this  
8 before about whether there was a loose motion on the  
9 Friday. Dr Webb has written "loose motions for a couple  
10 of days", has he? I mean, that -- Dr Webb's note.  
11 Q. Dr Webb's note?  
12 A. Timed at 2.00 pm --  
13 Q. At 2.00 pm?  
14 A. -- on the Tuesday.  
15 Q. I'm just going to that. That's at 090-022-053. Can we  
16 pull up the other part of it, 054?  
17 A. And the next bit, his discussion with Mrs Roberts.  
18 Q. Uh-huh. I am not sure that I see "loose motions for two  
19 days" there.  
20 A. No, we haven't got to Mrs Roberts' bit.  
21 Q. Sorry. That's at 5 o'clock then. 090-022-055:  
22 "Claire had loose motion on Sunday."  
23 I think that's what that says:  
24 "Background from mum."  
25 A. Yes.

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1 have it in the next page at 23.30.  
2 MS ANYADIKE-DANES: If we go to page 36, you don't seem to  
3 have summarised Dr Webb's note there. Do you see it at  
4 4.00 am in the morning? It is literally the last  
5 line in that box.  
6 A. Yes.  
7 Q. You haven't summarised his note. This is where he says  
8 SIADH and so forth that we have already seen.  
9 A. Yes.  
10 Q. That would have been a relevant entry to summarise,  
11 wouldn't it?  
12 A. It depends how far I was taking the timeline to. Was  
13 I taking it until she was admitted to ICU.  
14 Q. I can answer that. You take it up until 8 o'clock in  
15 the morning, which we see on page 37. So is there  
16 a reason why you don't include his analysis?  
17 A. No.  
18 Q. But that would have been appropriate, wouldn't it?  
19 A. It depends how detailed I was able to do it within the  
20 time frame. It could have been included, yes.  
21 Q. I asked you if it would have been appropriate. Else --  
22 THE CHAIRMAN: I am sorry. We can leave that point because  
23 this could lead into a fairly unhelpful debate about  
24 whether you include everything and, if you don't include  
25 everything, what bits do you leave out and what bits

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1 Q. "And vomiting Monday."  
2 MR FORTUNE: We also have a picture based on Dr O'Hare's  
3 note on the Monday evening, 090-022-050, of "loose  
4 motion three days ago". So if you combine the two, it  
5 is not an unreasonable summary.  
6 MS ANYADIKE-DANES: If you combine the two:  
7 "Loose motions for two days."  
8 That's a matter entirely for others to comment on.  
9 THE CHAIRMAN: I have got the point.  
10 MS ANYADIKE-DANES: Anyway, if we then go to the next  
11 page -- sorry -- I beg your pardon -- 35, you have got  
12 the Glasgow Coma Scale entry at 7 at 14.30, but you  
13 don't seem to enter that it goes down to 6 at 4.00 and  
14 5.00.  
15 A. No, this was not a minute-by-minute account of Claire's  
16 admission.  
17 Q. But 6 is the lowest she goes to.  
18 A. Yes. At 21.30, I have got that it is 6 again.  
19 Q. That's your explanation, that you don't have -- you are  
20 not seeking to put everything in it?  
21 A. I am not seeking to put everything in it. It is  
22 an overview of what had happened to Claire with salient  
23 facts in it. Her coma scale went between -- I think it  
24 was 9 and 6 over a period of time.  
25 THE CHAIRMAN: Sorry. You have got it in twice. You also

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1 stay in? So let's move on.  
2 MS ANYADIKE-DANES: Would you have put the second brainstem  
3 death test in there?  
4 A. I mean, I stopped at 0800. I don't know why I stopped  
5 at 0800, but that's what I did.  
6 Q. Okay.  
7 A. I could have put in the high sodium. I could have put  
8 in the DDAVP. I could have -- that's where I stopped.  
9 Q. I understand. When you actually meet the parents on  
10 7 December, you have this with you. At least the  
11 evidence was that there were three documents that were  
12 available.  
13 A. Yes.  
14 Q. There was her medical notes and records, there was the  
15 autopsy report and there was the patient journey.  
16 A. Yes, and this would have been the patient journey.  
17 Q. And that you were, as part of your role -- which is  
18 actually to explain to the parents the treatment that  
19 she had received throughout her admission -- that was  
20 what you were going to contribute and then  
21 Professor Young was going deal with the issue of  
22 hyponatraemia; is that right?  
23 A. Yes.  
24 Q. Is there any reason why you couldn't have provided the  
25 family with a copy of your patient's journey.

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1 A. No. If they had asked for it, they could have received  
2 it.  
3 Q. You could have offered it.  
4 A. Yes.  
5 Q. Okay. Professor Young sends an e-mail, which I'm sure  
6 you heard if you had heard any part of Dr McBride's  
7 evidence yesterday.  
8 A. I didn't, unfortunately.  
9 Q. Ah, sorry. I beg your pardon. Professor Young sends  
10 an e-mail to Dr McBride, who was then the medical  
11 director, as you know --  
12 A. Uh-huh.  
13 Q. -- indicating to him that you and he had differences  
14 about the role of the fluids; do you remember that?  
15 A. No, I don't remember that, but I've heard Dr --  
16 Professor Young's evidence, and he talks about the three  
17 slices in a pie and which proportion is attributable to  
18 what and I think that any difference we had at that  
19 stage was how much was contributed to by epilepsy, SIADH  
20 and fluids. You know it was just where the pie was  
21 sliced, that there were other issues going on purely  
22 than the normal saline and hyponatraemia.  
23 Q. Okay. Did you think when -- because by the time you get  
24 to 2004, you are the director -- you are a director  
25 yourself.

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1 Q. Yes.  
2 A. That may have been helpful.  
3 Q. That was the point I was getting to.  
4 A. Yes.  
5 Q. It might have been helpful if there had been  
6 a governance person there who could be viewing it from  
7 a governance perspective --  
8 A. Yes.  
9 Q. -- as opposed to you who was helping as a clinician.  
10 A. Yes.  
11 Q. When the parents were being taken through by you how  
12 Claire had been treated and why she had been treated in  
13 the way she had been and so on, the view that they  
14 got -- and I will stand to be corrected -- was very much  
15 that the viral encephalitis or the viral cause was still  
16 very much a feature of how you were explaining matters  
17 to them, whereas, in fact, at that time you would have  
18 known, however strongly you thought the virus was  
19 present, the evidence didn't really support a very  
20 strong presence of virus.  
21 A. Well, the post-mortem -- our interpretation of the  
22 post-mortem had not changed at that time. Dr Webb  
23 wasn't there, but I was there and the interpretation of  
24 the post-mortem had not been brought into question. So  
25 that was one slice of the pie.

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1 A. Yes.  
2 Q. Did you think that it might be appropriate to have, if  
3 he could be there, Dr Webb?  
4 A. Yes. In fact, I asked that Dr Webb be kept informed  
5 because I felt it was quite important that his opinion  
6 was taken on board.  
7 Q. No, I mean have him at the meeting with the family.  
8  
9 A. Well, he was in Dublin. It would have been helpful to  
10 have him there, yes.  
11 Q. Thank you. Did you think that given that you were  
12 involved as Claire's consultant, that it might have been  
13 appropriate to have another independent person, maybe  
14 Dr Hicks perhaps? Do you think that would have been  
15 appropriate?  
16 A. Well, at this stage, I very much was back to being  
17 a clinician.  
18 Q. Yes.  
19 A. And I think the way Dr McBride managed this was me, as  
20 any other paediatrician or clinician --  
21 Q. Exactly.  
22 A. -- as was Dr Sands. So I suppose if you were going --  
23 it was up to him to determine who else was to be there,  
24 but the clinical director would have been someone who  
25 had an overview and a governance role there.

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1 Q. Ah.  
2 THE CHAIRMAN: Doctor, if I ask you to pause there, there  
3 seems to have been a missed opportunity in 1997 to  
4 discuss the autopsy report with Dr Herron and/or  
5 Dr Mirakhur; okay?  
6 A. Yes.  
7 THE CHAIRMAN: Mr and Mrs Roberts contact the hospital in  
8 October 2004 after the broadcast of the documentary.  
9 A meeting is arranged, at which they are going to be  
10 given more information.  
11 A. Yes.  
12 Q. Is this not a second opportunity to speak to Dr Herron  
13 and/or Dr Mirakhur, especially if there is some degree  
14 of difference, at least in emphasis, between you and  
15 Professor Young?  
16 A. That is an opportunity. I don't know if Dr McBride  
17 considered it or not.  
18 THE CHAIRMAN: But if you were being asked, as you were now  
19 being asked, and Professor Young -- sorry. You knew  
20 before this there was a degree of difference between you  
21 and Professor Young, maybe not fundamental, but at least  
22 one of emphasis --  
23 A. Yes.  
24 THE CHAIRMAN: -- or slices of pie, however you describe  
25 it --

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1 A. Uh-huh.  
2 THE CHAIRMAN: -- that's a point at which either or both of  
3 you can speak to Dr Herron and Dr Mirakhur and just  
4 tease out with them some of this information.  
5 A. I, at this stage, did not want to go beyond what the  
6 medical director had asked me to do because I did not  
7 want to be seen to be influencing a process that was  
8 starting and I wanted to keep very much to do what I was  
9 asked to do, which was the clinical journey, the  
10 chronology.  
11 THE CHAIRMAN: After the meeting when Mr Roberts immediately  
12 followed up with a list of detailed questions, did you  
13 think of going at that point to Dr Herron or Dr Mirakhur  
14 for their input?  
15 A. No. I was being directed by Dr McBride on the way  
16 forward and what he wished me to do.  
17 THE CHAIRMAN: That would not prevent you, I suggest,  
18 saying: this might be the time, Dr McBride, when we  
19 speak a bit more to Dr Herron or Dr Mirakhur to find out  
20 what their view was and just make sure we are on the  
21 right lines from 1996/1997.  
22 A. Yes. I know when we went -- I can't remember all the  
23 details of the coroner's case, but I am not sure  
24 Dr Herron at that stage was contradicting the fact that  
25 there may have been a degree of viral encephalitis.

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1 the time. In 2004, a process was started. There was  
2 a first meeting with the parents to try to identify  
3 issues, what other issues were ongoing. I think at the  
4 time that meeting had been in place, it was obvious the  
5 case was going to the coroner, and I was being directed  
6 by others on the way forward with investigating or  
7 managing the case. I brought the clinical information  
8 I had on the day to that meeting and I tried to follow  
9 up any questions. I actually suggested that the parents  
10 write everything down and decide what they want to do  
11 about each point because there is so much information  
12 that goes round and you start to think, "Have they asked  
13 that or have they not?". I always tell parents to write  
14 down questions when they come into their heads and then  
15 we will go through each one and go through it.  
16 So I believe I came, on that day in 2004, with the  
17 clinical journey to talk the parents through it and  
18 then, as a result of that, answer any questions that  
19 they raised to the best of my ability and then taking it  
20 forward into the coroner's case.  
21 Q. If that was your obligation, did you not have to look  
22 very carefully at your medical notes and records to  
23 ensure that you have properly got from them anything  
24 that might explain the reasons for and the circumstances  
25 of her death?

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1 THE CHAIRMAN: Okay. Thank you.  
2 MS ANYADIKE-DANES: I understand what you are saying, that  
3 you were being guided very much by what Dr McBride was  
4 asking you to do.  
5 A. Uh-huh.  
6 Q. But nonetheless, irrespective of that -- and this may be  
7 what the chairman was aiming at really -- you have your  
8 own independent obligations as a clinician under the GMC  
9 and, in fact, one that would have governed your conduct  
10 at that meeting in 2004 was this one that I am going to  
11 pull up now. It is 314-014-002. That's the one that  
12 was in operation in May 2001, carrying on, and in  
13 operation in 2004. If we go to 23, which is at  
14 314-014-012, that's paragraph 23:  
15 "If a child under your care has died, you must  
16 explain, to the best of your knowledge, the reasons for  
17 and the circumstances of the death to those with  
18 parental responsibility."  
19 So would you not accept that that does require you  
20 to be absolutely sure that you are providing all the  
21 reasons that you can and describing all the  
22 circumstances that you can that relate to the death of  
23 Claire to her parents?  
24 A. Yes, and in 1997 I think I did provide those with the  
25 information and my understanding of the information at

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1 Previously you were under some pressure, I think,  
2 when you were dealing with matters at 4 o'clock in the  
3 morning. You were going to have to see the parents, so  
4 you had to get a view as best you could of what was  
5 happening so you could go and explain as best you could  
6 to the parents. One might see there is a bit of time  
7 pressure. You don't necessarily have everybody you  
8 might want to speak to to get a full picture. Maybe you  
9 had an opportunity to do that again when the autopsy  
10 report came in, but leaving that aside, you now know  
11 that the only reason you are looking at this is because  
12 a suspicion that something that should have happened in  
13 1997 did not happen, which is that Claire's case wasn't  
14 maybe properly considered in ways that it might have  
15 been, and that's the whole reason the parents who have  
16 that concern have come to the hospital and the medical  
17 director has thought that sufficiently worthy of  
18 attention that he has set up what you call the beginning  
19 of a process and the next step of that, for you, is,  
20 having found the information, to do your patient's  
21 journey and so on and to meet with the parents.  
22 If you are providing that kind of information, is it  
23 really explicable that you should have missed the  
24 dosage, for example, of the drugs?  
25 A. The dosage of the drugs, they are not drugs I would

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1 normally prescribe. I assume I didn't check the drug  
2 kardex, which would have given the 120 of midazolam,  
3 fully, but I missed them. Dr Webb missed them. The  
4 coroner's experts missed them. It was only this  
5 inquiry.

6 MR FORTUNE: And also the experts instructed by the police  
7 service.

8 THE CHAIRMAN: In fairness I think the criticism about  
9 missing the overdose of drugs is a stronger one to make  
10 of other people than Dr Steen. Specifically it is  
11 a stronger one to make of Dr Webb.

12 MS ANYADIKE-DANES: Mr Chairman, I make no criticism about  
13 it. I am simply asking if that's not the sort of thing  
14 you should be scrutinising through the documentation. I  
15 am talking about process. It's not for me to criticise  
16 at all.

17 A. Yes, it should be, but there would be information there  
18 that I would not be fully aware of, and the relevance of  
19 it I would not have been fully aware of. I think from  
20 the phenytoin perspective I missed the calculation, but  
21 I had the serum levels, and the serum levels are what  
22 reassured me that her phenytoin was reasonable.

23 Q. Yes. Can I ask: did you see the letter from Mr and  
24 Mrs Roberts of 8th of December?

25 A. Yes, I've seen that.

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1 through these issues one by one, but that meeting didn't  
2 take place.

3 Q. Well, I give you this, so that you can comment on it if  
4 you can for us. One of the -- well, I don't know it's  
5 a reason the meeting didn't take place, but the evidence  
6 that Mr Roberts and Mrs Roberts has given is that when  
7 they met with you, although they were seeing something  
8 or hearing something new from Professor Young that  
9 appeared to be giving them answers to questions that  
10 they had had and issues that had not been resolved for  
11 them, they essentially heard nothing from you that was  
12 any different from what you had told them in 1997. They  
13 didn't -- and I expand a little bit to try to get the  
14 sense of what they were saying -- they didn't seem to  
15 get the impression from you that you were now addressing  
16 that and sort of reinterpreting things and understanding  
17 and helping them understand in the light of that what  
18 had happened in 1996. Effectively they got the  
19 impression that you were wedded to your original view.

20 A. No. Once Professor Young reviewed the situation --  
21 I think you used the term "fluid mismanagement", which  
22 I think is a very good term to use for Claire's case,  
23 because we had been very sure we had given her  
24 maintenance fluids, what would be given normally to  
25 a child in this way, but, in fact, a lot of what this

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1 Q. So you would then be part of a process of trying to  
2 provide answers to that letter, because the whole point  
3 at the conclusion of that meeting is that if they had  
4 any queries, the trust was open to try to address those  
5 queries?

6 A. Yes.

7 Q. And indeed they did have queries, and one sees them at  
8 089-003-006 and the next page, 007. Those are their  
9 queries. When you see those, do you not feel that you  
10 ought to perhaps have another look at the medical notes  
11 and records in order to see if you can assist in  
12 addressing some of these queries?

13 A. If I remember correctly, at that time Nicky Rooney was  
14 trying to do minutes of the meeting, addressing some of  
15 the issues that the parents had raised at the meeting,  
16 and then this came in as well. I think there was  
17 various information flying around as people tried to  
18 answer the questions both from -- that had arisen in the  
19 meeting, but also in this as much as possible, and we  
20 would have focused in on trying answer questions  
21 relevant to ourselves.

22 Q. Is that appropriate in your view?

23 A. I think we were doing the best we could to try to answer  
24 all this information. I know the plan had been to meet  
25 with the parents quite quickly again to actually go

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1 inquiry and the coroner's case have been about is how  
2 her fluids should have been managed because of her  
3 condition, how her U&E should have been repeated  
4 earlier. So the fifth-normal saline per se as the key  
5 issue, I don't think I put that top of the issue. What  
6 I put top of the issue was we didn't check her U&E. We  
7 didn't monitor her condition. We didn't repeat the  
8 levels and we didn't take actions early enough to make  
9 a difference.

10 Q. Thank you for that. Can I ask you this? Were you able  
11 to get that from the view that Professor Young had  
12 formed? When he came to the conclusion that the  
13 hyponatraemia could well have contributed to her death  
14 and explained his reasons for that, and you would have  
15 been a part of meetings and understood his explanation,  
16 what you have just characterised then is a sequence of  
17 things.

18 A. Uh-huh.

19 Q. Did you understand that as being -- as the implication  
20 from what he was saying?

21 A. I can't remember exactly where we got it from, but  
22 I know we clearly felt -- we looked and we saw where the  
23 U&E had been done. It had been done 27 hours I think  
24 after she had been admitted. Routine would have been  
25 24 hours, but, in fact, because of her condition, it

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1 should have been done earlier. I don't think there was  
2 ever, once Professor Young had reviewed her notes from  
3 a fluid management perspective, there was any query that  
4 her fluids had been mismanaged. The proportion of how  
5 the fluid mismanagement had contributed to her overall  
6 condition, the slices of the pie, were where I think the  
7 discussion lay.

8 Q. Did you tell the parents --

9 THE CHAIRMAN: Sorry. In your eyes this was a new factor  
10 which had not previously been considered?

11 A. No, we hadn't -- I have raised this in my evidence  
12 before. We just hadn't put it together.

13 MS ANYADIKE-DANES: Did you at that meeting or even when  
14 there was a response to the parent, which I think  
15 ultimately Nicky Rooney signed off on --

16 A. Uh-huh.

17 Q. -- but I think it had gone round those who were involved  
18 to make sure it was accurate, did you feel that, what  
19 you have just said now, that her fluids had been  
20 mismanaged, was something that could have been  
21 disclosed -- communicated to the family?

22 A. I thought it had been communicated. I think  
23 Professor Young very clearly -- I mean, I took -- when  
24 it came to the fluid bit, the decision had been made  
25 Professor Young would do that bit, so that that was his

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1 a clinician would understand that as amounting to  
2 a mismanagement of fluids, but it doesn't say that in  
3 terms, does it?

4 A. No.

5 Q. But you -- that's what you have just explained to the  
6 Chairman that you understood, and that's why I asked  
7 you, given that you are dealing with lay people here,  
8 and people who are likely still to be rather emotional  
9 about the whole thing, would that not have been  
10 appropriate, simply to say, "We think in your case very  
11 regrettably that your daughter's fluids were  
12 mismanaged"?

13 A. I think that we were trying to give more detail than  
14 perhaps was -- well, the parents actually -- Mr Roberts'  
15 knowledge base really was quite high. He did ask  
16 everything. We tried to get into the impact of the low  
17 sodium and the effect low sodium would have on swelling,  
18 etc. So perhaps we went about it the wrong way.  
19 Perhaps we should have made it -- we should have phrased  
20 it differently.

21 THE CHAIRMAN: There is one specific point which is not  
22 included in that note, which is that her -- her bloods  
23 should have been checked earlier than they were.

24 A. Yes.

25 Q. That is absent from the note, is it not?

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1 clear opinion as agreed with the Medical Director, and  
2 I thought Professor Young had indicated that.

3 Q. That the fluid had been mismanaged?

4 A. Yes. You would have to show me the documents. I can't  
5 remember.

6 THE CHAIRMAN: I think the pages which are relevant are  
7 WS177-1, pages 59 and 60, which are Professor Young's  
8 contribution to the meeting. If you pick it up --  
9 sorry. Can you give me page 59 and 60? Thank you.  
10 This is the minute of the meeting, Dr Steen. If you  
11 look on the left-hand side of the screen, page 59,  
12 halfway down the page it says:

"Professor Young joined in at this point."

14 A. Uh-huh.

15 Q. He then made a series of points, which were noted. It  
16 goes on to the next page, where he says in the third  
17 paragraph down:

"Professor Young advised Mr and Mrs Roberts that the  
19 trust wants to be completely open ... and therefore will  
20 have to approach the coroner for advice on the best  
21 course of action."

22 Now he is -- if you look -- I won't read it all out,  
23 but if you look at what he says in that page or so, that  
24 seems to be the extent of what he is recorded as saying.

25 MS ANYADIKE-DANES: It is possible, Dr Steen, that you as

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1 A. Yes, and I don't know if it is part of the answers to  
2 all the questions. I don't know.

3 MS ANYADIKE-DANES: If one --

4 THE CHAIRMAN: Okay. Sorry, Mr Fortune. What's your point?

5 MR FORTUNE: Sir, if you look at page 61 and the second part  
6 of the second paragraph, here is Professor Young adding  
7 that:

"... with the viral infection, seizures and fluids  
9 administered, it is difficult to say what their relative  
10 contribution would have been."

11 THE CHAIRMAN: Sorry. That point doesn't help this  
12 discussion. That is a point where Professor Young is  
13 saying there are three issues and it cannot be said with  
14 precision the extent to which each of those three issues  
15 contributed to Claire's death.

16 MR FORTUNE: Yes, but if you --

17 THE CHAIRMAN: The point I am on is a different one, that in  
18 terms of what Dr Steen has just advised us that she  
19 realised as a result of this issue being opened up that  
20 the blood test should have been repeated. 24 hours  
21 would have been standard, but in Claire's case the test  
22 should have been repeated earlier, because she had  
23 a slightly low level on Monday night. That was not  
24 advised to the parents at the meeting on 7th December  
25 2004.

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1 MR FORTUNE: I accept that point, but the previous point was  
2 about fluid mismanagement.  
3 THE CHAIRMAN: Right.  
4 MS ANYADIKE-DANES: The issue -- well, that was your  
5 expression, that you thought there was fluid  
6 mismanagement. If one says that to lay people, that  
7 connotes to them that "In some way we were responsible  
8 for the death of your child".  
9 A. Yes.  
10 Q. In fact, when you gave your evidence to the coroner, you  
11 advanced things along the lines of the omission that the  
12 Chairman has just pointed out, and you said:  
13 "Her blood tests results at 11.30 should have lead  
14 to a clinical reassessment and the test should have been  
15 repeated. Simultaneously there should have been  
16 a reduction in fluids", and so on.  
17 You also at that stage were putting things that you  
18 were prepared to concede should have happened and didn't  
19 happen, and the only point that I'm really dealing with  
20 is if you are obligated to explain things as fully as  
21 possible in language that families can understand,  
22 should these things not have been said to the families  
23 expressly -- to the family when you met them? That's  
24 all.  
25 A. I can only say we tried to inform and respond to the

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1 with the medical director and how the meeting progressed  
2 was dependent on me providing the clinical journey with  
3 support from Dr Sands where appropriate and then  
4 Professor Young talking about the IV fluids. I think we  
5 did try to raise with the parents the issue that the  
6 fluids had changed. We were doing things differently,  
7 that things had been done wrongly at the time. If it  
8 was not conveyed by that, I apologise.  
9 THE CHAIRMAN: Doctor, you certainly conveyed the fact that  
10 things had changed.  
11 A. Yes.  
12 THE CHAIRMAN: What was not stated was that things been done  
13 wrongly at the time.  
14 A. Yes.  
15 THE CHAIRMAN: Because that paragraph, the one that  
16 Mr Fortune wanted us to highlight, makes the very point:  
17 "There are no accurate records of the amount of  
18 fluid lost, as this would not have been done routinely  
19 at that time."  
20 So that's making a point some things have changed so  
21 that the Roberts get the impression: well, with the  
22 benefit of hindsight, if we did things in 1996 the way  
23 we do them 2004, we would have picked up more. But what  
24 is missing from this is the point which you have said  
25 that you realised, when this meeting was taking place,

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1 parents' questions as much as possible, that there was  
2 a process that was in place with questions coming -- the  
3 first meeting, questions coming in from the parents, and  
4 there to be a second meeting. In the meantime documents  
5 were going round to try to complete the questions.  
6 Perhaps we could have made it clearer to them at the  
7 time.  
8 Q. No. My point is: Should you have done it?  
9 I appreciate you were responding to their questions,  
10 but, with respect, that is laypeople asking you out of  
11 their knowledge base something. You are the clinicians.  
12 You have formed views about these things. They don't  
13 know the standard of care that's required for these  
14 matters. You form views of deficiencies and  
15 inadequacies and you have culminated some of those in  
16 the expression "fluid mismanagement". So all I am  
17 saying is: Should you not have been offering that to  
18 the parents, who have waited so long to understand what  
19 happened to their daughter? At the very least, if you  
20 formed views of how things went wrong instead of just  
21 waiting for their questions and answering their  
22 questions, should you not have led off with: here are  
23 some things we know we failed you on and failed your  
24 daughter on and we are very sorry?  
25 A. The process at the meeting was to take place as arranged

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1 that the second blood test on Claire which should have  
2 been made in light of the reading of 132 on admission  
3 was not made until the following evening. That's the  
4 point. Anyway I've got that. That's fine.  
5 A. Thank you.  
6 MS ANYADIKE-DANES: Mr Chairman, I actually don't have any  
7 other points, but I suspect there might be a few.  
8 THE CHAIRMAN: Well, if there are, they will have to be very  
9 few, because Dr Steen I think is legitimately exhausted.  
10 She has been very unwell and whatever criticisms I may  
11 make in the report, I acknowledge the fact that Dr Steen  
12 has come back from serious illness. This is the fifth  
13 occasion on which she has given evidence. I will arise  
14 for a short time for a few questions, Mr Quinn. That  
15 will be it. I hope that's understood. Okay?  
16 (1.05 pm)  
17 (A short break)  
18 (1.10 pm)  
19 (Delay in proceedings)  
20 (1.20 pm)  
21 MS ANYADIKE-DANES: Thank you very much, Mr Chairman. There  
22 is an issue which may have a supplemental to it.  
23 It follows on, Dr Steen, from the points that you  
24 were making that you were trying to be open and to give  
25 the family proper information and there was an issue as

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1 to whether, if not concessions, at least admissions of  
2 things were properly conveyed to the family in the way  
3 that they could understand, the things that you are  
4 prepared to accept constituted deficiencies or were  
5 below the standard of care that they would have wanted  
6 their child to have had. So that the area we are in.

7 You said you were in a process, but also Dr McBride  
8 has given the view that the questions that the family  
9 raised, he wanted to have addressed.

10 A. Yes.

11 Q. And after that meeting, the family wrote on 8 December  
12 to identify a series of things that were still concerns  
13 and queries for them. Ultimately, that letter is  
14 answered by a letter which is signed by Dr Rooney, but  
15 in fairness to, her she relies very much on the clinical  
16 information that you and others provide for her to  
17 satisfy --

18 A. Yes.

19 Q. -- the requirements of it being accurate. The letter is  
20 dated 1 January 2005, not to be pulled up, but the  
21 reference is 089-006-012. The letter travels around as  
22 she seeks to ensure that it's accurate, and there are  
23 changes which are suggested, at least on one occasion,  
24 by Mr Walby, and you would have been aware that the  
25 letter is receiving revision, if I can put it that way.

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1 to you."

2 That "6" is a query that the family have, so it is  
3 an attempt to answer that query; okay?

4 "While the clinical notes reflect the level of  
5 medical concern, there is no note summarising the  
6 content of conversations between medical staff and  
7 relatives. However, Dr Webb has noted that he spoke to  
8 Mrs Roberts at 5.00 pm on 22 October. It is difficult  
9 to give an opinion on why Claire was not moved to PICU."

10 It then goes on to talk about her hourly  
11 observations. So that presumably is the position as it  
12 comes from Dr Rooney, informed as she has been by the  
13 views of you and others; okay?

14 A. Yes.

15 Q. Just so you have it, because I don't want you to be  
16 confused, I just want to give you the actual question  
17 that was formed by the Roberts:

18 "Why was Claire not admitted to intensive care if  
19 her condition was so serious?"

20 That is a question and that is what 6 is seeking to  
21 answer.

22 A. Yes.

23 Q. So as it comes to Mr Walby, it has effectively, "we  
24 don't know why she wasn't moved to PICU", which has the  
25 suggestion maybe she should have been and we can't

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1 A. Yes.

2 Q. If I just pull up, by way of example, 177/1, page 90.

3 I should say this is a three-page letter. So 89 is the  
4 first page.

5 A. I'm sorry, whose --

6 Q. This is a draft of the letter that is ultimately going  
7 to be in final form, the 12 January letter that goes  
8 out, signed by Dr Rooney to Claire's parents; okay?

9 A. Yes.

10 Q. So just to orient you -- I am sorry -- perhaps let's  
11 have page 89. That will orient you.

12 A. Who has this document gone to?

13 THE CHAIRMAN: These are handwritten changes by Mr Walby.

14 A. Sent to myself?

15 MS ANYADIKE-DANES: The draft goes around. At this stage,  
16 this letter has been informed, if I can put it that way,  
17 by you and others. This is it now landing on Mr Walby's  
18 desk and he makes some of these comments on it; okay?

19 A. Yes.

20 Q. So the comment that I wanted to take you to in  
21 particular is the one at paragraph 6. I only brought up  
22 the first page to try to orient you a little bit as to  
23 where it was going; do you see paragraph 6? It says:

24 "It is not possible to say how information regarding  
25 Claire's serious condition was not adequately conveyed

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1 adequately answer that for you and that was unfortunate.

2 A. Yes.

3 Q. In fact, that is something that is reflected in  
4 Dr Webb's own statement that he signed to go to the  
5 coroner. I will just read it out to you so we don't  
6 have so many things on the screen. The reference of it  
7 is 139-098-021. He says in the final paragraph of that  
8 page:

9 "I made the mistake of not seeking an intensive care  
10 placement for Claire before I left the hospital on the  
11 evening of October 22nd. However, I am not sure whether  
12 she would have met the criteria for admission to PICU,  
13 as there was to problem with her airway or breathing at  
14 that point."

15 He goes on, but that's essentially what he is  
16 saying. So he thought that maybe there was  
17 a deficiency, that she could and should have been moved  
18 earlier. This letter is chiming or this proposed answer  
19 is chiming with that.

20 Then when we see what it actually turns into, which  
21 is to be found --

22 THE CHAIRMAN: Page 40.

23 MS ANYADIKE-DANES: 089 --

24 MR FORTUNE: 006-014.

25 MS ANYADIKE-DANES: Yes. Thank you. There. So it's at

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1 6(b). Do you see that:  
2 "With regard to why Claire was not moved to PICU,  
3 her hourly CNS observations had remained stable for  
4 a period of time and no clinical signs of further  
5 deterioration were noted."  
6 That is, in fact, a formulation of words that  
7 results from Mr Walby's comments. It is quite difficult  
8 to see on the manuscript:  
9 "This suggests we are critical of our failure --"  
10 MR FORTUNE: "To move her."  
11 MS ANYADIKE-DANES: "-- to move her. Maybe we are?"  
12 So the point I am getting at is: if the intention  
13 was to be open and transparent with the parents, there  
14 seems to be a suggestion in relation to their query  
15 about PICU, just one aspect of her care, that maybe  
16 there was a failure there and maybe she ought to have  
17 been moved earlier to PICU, but when it comes back as  
18 their answer to them, in fact, there is a justification  
19 for why she wasn't moved to PICU. There is no  
20 suggestion that maybe it would maybe have been better to  
21 have moved her earlier on reflection. It simply says  
22 the reasons why she wasn't.  
23 A. And who was Dr Walby asking to change this?  
24 Q. Sorry?  
25 A. Was Dr Walby asking me to change this?

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1 because she told us she took the lead in drafting it and  
2 then sent this to you and Professor Young.  
3 A. Yes.  
4 THE CHAIRMAN: So paragraph 6 is an initial draft from her.  
5 If you look at the right-hand side of the screen,  
6 page 90, 6(a) and 6(b). This is unlikely to be an area  
7 that Professor Young is involved in.  
8 A. Yes.  
9 THE CHAIRMAN: He was engaged for a limited purpose.  
10 Therefore it is more likely you provided that draft.  
11 A. 6(b)?  
12 THE CHAIRMAN: Yes, 6(b). It then appears that, at  
13 Mr Walby's instigation, the opening line in 6(b) was  
14 removed. So what you had included was:  
15 "It is difficult to give an opinion on why Claire  
16 was not moved to PICU."  
17 Then it continues. Mr Walby, on my interpretation,  
18 has then effectively removed the first sentence and  
19 replaced it with:  
20 "As to why Claire was no moved to PICU ... her  
21 hourly observations had remained stable."  
22 Does that seem to fit?  
23 A. Yes.  
24 THE CHAIRMAN: Right.  
25 MS ANYADIKE-DANES: Did you at any point come to know that

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1 Q. No. Dr Walby was proposing that a change was made.  
2 THE CHAIRMAN: What is the question for Dr Steen?  
3 MS ANYADIKE-DANES: The question for Dr Steen is: if the  
4 clinicians were clear about the concessions that they  
5 felt ought to be made, do you think this was  
6 a concession that ought to have been made, that some  
7 consideration should have been given to taking her to  
8 PICU earlier? Is that a view that you might share?  
9  
10 A. Yes. I am not sure Dr -- Dr Webb's statement would not  
11 have been available at this time.  
12 Q. I understand that, yes.  
13 A. But yes, she was -- she was a sick child. I do agree  
14 that she probably would not have met the criteria to get  
15 into ICU as they were in those days, but she was a sick  
16 child.  
17 Q. And do you think that, therefore, some active  
18 consideration ought to have been made to perhaps getting  
19 her there?  
20 A. Yes, and I don't know who drafted which draft.  
21 THE CHAIRMAN: I am pretty sure I do know, actually. Let's  
22 go to 177/1, please. Sorry. If you keep up page 90 and  
23 would you put up with it, please, page 80 for the  
24 moment? Okay. If you look at page 80, paragraph 6, I  
25 am pretty sure that is Professor Rooney's initial draft

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1 that had happened?  
2 A. I have no recollection of coming to know that this had  
3 happened. I choose my words carefully because my memory  
4 is too poor --  
5 Q. I understand.  
6 A. -- but I'm not aware that happened.  
7 Q. Would you have been happy with that change if it had  
8 been brought to you?  
9 A. I think we would have had to sit down and discuss it as  
10 to why it was important to -- to re-word it in that way,  
11 because there were levels of debates and there remain  
12 levels of debates about how Claire's case should have  
13 been managed and processed. Admission to PICU was one,  
14 and I don't -- I personally don't have a concern saying,  
15 even at this stage, to parents: you know, perhaps she  
16 should been moved to PICU and we should reflect on that  
17 and look back on that. These are possible reasons why  
18 she was not moved but is it fair to ask why was she not  
19 moved? That's a fair question.  
20 Q. Would you have preferred that to be the version that  
21 goes to the parents?  
22 A. I would have because I think that allows the debate and  
23 thoughts in the parents' mind to proceed. I mean, it  
24 allows parents to think, "Right well, why did they not  
25 do it? Okay. These are the reasons. Do we accept

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1 that? Do we not?".

2 MR FORTUNE: Sir, I am not aware of any e-mail that

3 indicates, certainly to Dr Steen, "These are the

4 amendments I have suggested. Signed Peter Walby. What

5 do you think? Are we now agreed?"

6 THE CHAIRMAN: I don't think we have that in the e-mail

7 trail. Maybe that didn't happen.

8 MR FORTUNE: Well, there is no evidence, but ...

9 MR QUINN: Mr Chairman, I am very mindful of the time.

10 There is one particular question arising out of this

11 letter and it will take 30 seconds.

12 I wonder if 089-006-0013 could be brought up, which

13 is the final letter that went out to the Roberts in

14 January 2005. I just want to ask through yourself, sir:

15 given the doctor's earlier concession in relation to

16 fluid mismanagement, can she comment on paragraph 5(a),

17 the last sentence:

18 "It is not possible to say whether a change in the

19 amount and type of fluids would have made any different

20 in Claire's case as she was very ill for other reasons."

21 Given the concession that was made, that does seem

22 rather unusual.

23 A. I think at that stage we had not been to the coroner's

24 court. We had not got the expert witnesses. We had

25 Professor Young's preliminary view of the fluid

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1 A. And I don't have a problem with that.

2 MS ANYADIKE-DANES: Dr Steen said she was unclear about the

3 e-mail traffic or maybe Mr Fortune said that, it is at

4 177/1, page 71. If you pull up next to it page 70, you

5 can see this is -- right down at the bottom, that's

6 dated 8 December. This is the query I think --

7 Mr Chairman, you have already had this in evidence about

8 trying to find out when the blood test was taken for the

9 result that appeared at 11.30, but on the right-hand

10 side you can --

11 THE CHAIRMAN: I think it is page 70, in the middle of the

12 page, where Professor Rooney says:

13 "This is the final version. I will send it out

14 today."

15 MS ANYADIKE-DANES: Sorry. It is to Heather Steen.

16 A. Sorry. Could you show me where --

17 THE CHAIRMAN: Dr Steen, if you look on the screen, the

18 left-hand side is page 70. The middle of that page is

19 from Nichola Rooney, dated 9 December, just after

20 9.30 am.

21 A. Yes.

22 THE CHAIRMAN: It is to you and it is indicating that you

23 are getting the final version of the letter.

24 A. But it doesn't say that Peter Walby has seen it.

25 MS ANYADIKE-DANES: No. This is the final version --

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1 management. I don't think we were in a position at that

2 time and at that part of the process to be able to say

3 which bit of the pie was giving what. It was different

4 by the time we'd got the experts' reports in. We were

5 in a different situation. We also have heard although

6 her likelihood of death if her sodium had been managed

7 would probably have been less, I'm not quite sure if it

8 would have made a difference. I am not sure if it would

9 have made a total difference. It would have made a

10 difference.

11 THE CHAIRMAN: Let me say I take the evidence as being that

12 had Claire's fluid and sodium been controlled better and

13 properly it, would have removed that element of her

14 illness from the equation.

15 A. It certainly would. It certainly would.

16 THE CHAIRMAN: That leaves an issue as to exactly what else

17 was wrong with her. Mr Roberts has expressed his

18 opinion on that last week.

19 A. Yes.

20 THE CHAIRMAN: I fear I am not as -- sorry. Mr Roberts

21 expressed an opinion last week. I am not sure that

22 anybody has said it's absolutely certain that Claire

23 would have lived, but there is no doubt that her

24 prospects of surviving would have been greatly increased

25 had the fluid issue not been part of the equation.

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1 A. Yes. I am not sure --

2 Q. -- with the change.

3 A. Yes.

4 Q. That's the point.

5

6 A. Yes. Well, if that's the way it is, that's the way it

7 is. I'm not aware of what the final letter at that

8 stage was. I don't know if there were further changes.

9 I don't know when Peter Walby made that note.

10 THE CHAIRMAN: No, that's the wrong letter. The meeting had

11 only taken place on 7 December. So that isn't -- okay.

12 If we need to pick that trail, we can. That's

13 incorrect. Okay? So you are right that cannot be the

14 final version of the letter. If anything, that's

15 referring to minutes of meeting on 7th.

16 A. 7 January?

17 THE CHAIRMAN: That's right.

18 MS ANYADIKE-DANES: I accept that, Mr Chairman. I think

19 that's probably the minutes. I apologise for that. If

20 we need to find out exactly what happened, we will look

21 for it.

22 THE CHAIRMAN: But I don't think we need recall Dr Steen on

23 it.

24 MS ANYADIKE-DANES: Not on that point, certainly not.

25 A. Can I just say something?

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1 THE CHAIRMAN: Of course, doctor.  
2 A. Firstly, thank you for your consideration, because I  
3 have tried to help the inquiry, but I know my personal  
4 circumstances has made it difficult.  
5 Secondly, I am so sorry to the Roberts. I think the  
6 death of a child is tragic and I think living with it  
7 and with grief is really, really difficult. I apologise  
8 for any part I had in it. It was never deliberate, but  
9 I understand your grief and your heartache and your  
10 pain. I'm not -- I don't -- I haven't experienced  
11 personally -- I am sure lots of people in the room know  
12 what it is like -- but I apologise to you.  
13 Finally, it is the inquiry, Mr O'Hara. This is  
14 labelled hyponatraemia and I know, because I was on the  
15 ground when fifth-normal was banned from the wards,  
16 there was sort of "oh, fifth-normal is gone, the problem  
17 has gone". I think Claire's condition has started to  
18 make people understand that fluid mismanagement -- and  
19 I thank you for that term -- is really, really  
20 important. We need to get our fluid management right,  
21 which is not just the salt content, but it is  
22 monitoring, it is what we put in, it is looking at what  
23 we get out. I am just very keen that people realise  
24 fifth-normal was not the sole problem and getting rid of  
25 it have has not got rid of fluid mismanagement as a risk

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1 to anger and incredulity at what they have uncovered and  
2 what they have had revealed to them as the last number  
3 of weeks have progressed.  
4 I also accept entirely that they have previously  
5 raised a concern about the specific entry made by way of  
6 addition in Dr Sands' handwriting in the medical  
7 records. That is the entry which added  
8 "encephalitis/encephalopathy" as a possible or  
9 differential diagnosis.  
10 Dr Sands was questioned about this on 19 October.  
11 He was questioned about when and why he made the entry  
12 and why he didn't time it and sign it. Mr and  
13 Mrs Roberts then gave evidence on Wednesday, 31 October,  
14 in the course of which they had the chance to and they  
15 did raise these issues.  
16 It was not until 13 December that Mr Roberts alleged  
17 that this entry was fabricated in that it was made in  
18 2004 or 2005, but only after Claire's case had been  
19 raised again by the family on foot of the Ulster  
20 Television programme.  
21 It is this allegation that I am recalling Dr Sands  
22 to respond to.  
23 Dr Sands, please.  
24 DR ANDREW SANDS (recalled)  
25

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1 for any patient.  
2 THE CHAIRMAN: I don't know if you read Professor Gross'  
3 evidence in Adam's case. He says hyponatraemia is still  
4 misunderstood, so there is a lot more to it than one  
5 solution.  
6 A. Yes, thank you.  
7 (The witness withdrew)  
8 THE CHAIRMAN: Ladies and gentlemen, we need to take a  
9 break. We will start at 2.30 with Dr Sands; okay?  
10 (1.40 pm)  
11 (The short adjournment)  
12 (2.30 pm)  
13 (Delay in proceedings)  
14 (2.46 pm)  
15 THE CHAIRMAN: Just before Dr Sands returns to the witness  
16 box, let me say something about his return to the  
17 witness box: I entirely understand, as best anyone can  
18 or any of us can, the depth of frustration which must be  
19 felt by Mr and Mrs Roberts, in particular as they have  
20 listened to the evidence from October onwards about  
21 Claire. That evidence has revealed a series of  
22 mistakes, missed opportunities, especially on  
23 22 October, which might well have avoided Claire's death  
24 had they not been committed.  
25 I also recognise that this frustration may well turn

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1 Questions from MISS ANYADIKE-DANES  
2 MS ANYADIKE-DANES: Good afternoon, Dr Sands.  
3 A. Good afternoon.  
4 Q. I wonder if you could first pull up the transcript of  
5 Mr and Mrs Roberts' evidence on 13 December. If we go  
6 to page 127. If we can pull up page 128 alongside of  
7 that, please. Thank you. So if we go to line 7, this  
8 is the chairman summarising points -- in fact, I think  
9 this is Mr Roberts:  
10 "I think that raises another issue around -- and  
11 I don't want to go back to it too much, but when the  
12 actual note, the 'encephalitis/encephalopathy', was  
13 added because I do feel that when we did go back in 2004  
14 and we were heading -- we had our meeting and we were  
15 heading for a coroner's inquest, that Dr Steen was asked  
16 by Dr McBride in the first instance to review the  
17 medical notes."  
18 It goes on:  
19 "I find that very difficult to accept, that a doctor  
20 who potentially is going to be asked a question about  
21 the treatment of a child is given in the first instance  
22 the opportunity to look at the medical notes."  
23 Mr Roberts addresses that. Then we go over the  
24 page, 128. The chairman says:  
25 "If I understand it rightly, in effect what you're

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1 querying is whether, when Dr Steen saw the notes, and  
2 the issue had been raised on the back of the  
3 documentary, she then saw that there wasn't a reference  
4 to encephalitis, so she got Dr Sands to write it in?  
5 Bluntly, is that what you're saying?

6 Mr Roberts:

7 "That's my belief."

8 Part of what goes on thereafter is something you  
9 have seen already, which is along the lines of a letter  
10 from Mr and Mrs Roberts' solicitors dated, I believe,  
11 17 December, where they are really setting out why it is  
12 that they think that including that reference to  
13 "encephalitis/encephalopathy" by way of an amendment or  
14 addition, if I can put it that way, to the ward round  
15 notes, why that doesn't fit with what actually happened  
16 thereafter and what is recorded thereafter.

17 I understand that you would, in the course of  
18 addressing that point that is quite crisply put by the  
19 chairman and where Mr Roberts says "I believe", like not  
20 only to deal with that but also to address these matters  
21 that are being said as supportive of why it is they have  
22 that belief; would I be right in putting it that way?

23 A. That's correct.

24 Q. Thank you. If we can go to that then.

25 MR QUINN: Mr Chairman, there is one fundamental piece of

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1 then the form is that those are then re-directed by the  
2 inquiry, who is the body that receives them, to the  
3 target of the criticism.

4 There was -- excuse me -- no misunderstanding in  
5 relation to the inquiry that that is the procedure.

6 I incorrectly informed you when you came to speak to me,  
7 because it is some time since I looked at the protocols.

8 MR GREEN: Sorry. I didn't mean to sound as if I was  
9 falling out with Ms Danes about it.

10 THE CHAIRMAN: Sorry. I don't accept these are Salmon  
11 letters. That is why they were not set out by the  
12 inquiry. There is a letter about Dr Sands which raises  
13 31 questions and it ends:

14 "We would be grateful if you would put these  
15 questions to Dr Sands and revert to us at your earliest  
16 convenience."

17 That's not a Salmon letter, Mr Quinn. I am sorry,  
18 it is just not a Salmon letter. Even if we are supposed  
19 to interpret that as a Salmon letter, that letter does  
20 not contain an allegation that Dr Sands fabricated  
21 a note eight years later.

22 MR QUINN: Well, you will see why we were somewhat confused  
23 by that response, because on 27 September 2012 we got  
24 a letter with a postscript at the back stating:

25 "We note the Roberts' concern as outlined in this

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1 this jigsaw missing. We wrote Salmon letters on  
2 13 December. In the first and second Salmon letters,  
3 these issues were raised. There may be an issue as to  
4 whether or not the Salmon letters were received.

5 MR GREEN: Forgive me. They were not received by those  
6 representing Andrew Sands. That may have been due to  
7 an understandable misunderstanding by Miss Danes as to  
8 what the inquiry protocol mandated, because until  
9 moments before you came in, sir, it was her  
10 understanding that the inquiry protocol mandated that  
11 those third party Salmon letters were not sent to the  
12 parties whom they affected. Mr Quinn and I looked at  
13 the protocol and took her hands from the wrong end of  
14 the stick.

15 MS ANYADIKE-DANES: Sorry. Can I just interrupt there? My  
16 learned friend is quite right. We had a meeting and  
17 I had expressed that view, but I did not at any earlier  
18 time misunderstand the way the protocols worked. It is  
19 a long time since I had looked at those particular  
20 protocols. We had been over them in detail as to how  
21 these matters should be addressed and I am quite sure  
22 that people in the inquiry knew the process of Salmon  
23 letters going out. In fact, the letters from the third  
24 parties are not Salmon letters; they are third party  
25 letters which, if they indicate a potential criticism,

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1 letter and the matters raised will be put to Dr Sands  
2 during the course of the oral hearings."

3 THE CHAIRMAN: That's right. Sorry. That's because --  
4 those were understood to be you raising questions,  
5 factual questions to ask Dr Sands at the hearing, and in  
6 essence they were asked of him at the hearing. When he  
7 gave evidence in October, in essence those questions  
8 were put to him.

9 MR QUINN: Yes.

10 THE CHAIRMAN: Not one of those letters includes the  
11 allegation -- sorry. Let me put it this way -- it's  
12 what I said a few minutes ago. I see a fundamental  
13 distinction between querying Dr Sands as to when and why  
14 he made an entry in the notes in 1996 on the one hand  
15 and, on the other hand, making an allegation that he  
16 only made that entry in the note eight years later after  
17 the UTV documentary. Am I right in saying that the  
18 letter which you've referred to does not raise  
19 an allegation that the entry was made eight years later?

20 MR QUINN: You are correct.

21 THE CHAIRMAN: Am I not right in saying when Dr Sands gave  
22 evidence in October and he was questioned, as Ms Danes  
23 did, with input from you and others, that it was not  
24 requested that that allegation about fabrication be put  
25 to him?

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1 MR QUINN: I accept that.  
2 THE CHAIRMAN: Am I not right in saying that when Mr and  
3 Mrs Roberts gave their evidence late her October that  
4 that allegation was not made by them at that point?  
5 MR QUINN: I accept that.  
6 THE CHAIRMAN: So the first time that the allegation was  
7 made in the history of the inquiry was last week.  
8 MR QUINN: Yes, I accept that also.  
9 THE CHAIRMAN: If that is the case, why was it not made  
10 earlier?  
11 MR QUINN: Can I ask: if these are not Salmon letters, then  
12 if we had written in the letter that there was  
13 an allegation that we suspect that something happened in  
14 2004, it wouldn't have gone out either.  
15 THE CHAIRMAN: No, but you would have alerted the inquiry to  
16 the allegation, and that would then have been followed  
17 up in whatever way we thought was appropriate, but the  
18 issues which were raised in -- the issues which are  
19 raised in this letter, in effect, found their way into  
20 the questioning of Dr Sands when he gave his evidence in  
21 October.  
22 MR QUINN: Yes.  
23 THE CHAIRMAN: So they were raised in October. So when he  
24 was giving his evidence in October, the allegation -- if  
25 it was accepted by the inquiry as an appropriate

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1 why the questions are phrased as they are because  
2 I understand that Mr and Mrs Roberts are concerned about  
3 the way that Claire 's treatment was provided and the  
4 way that there were exchanges between various doctors on  
5 the Tuesday.  
6 MR QUINN: Yes.  
7 THE CHAIRMAN: I have got no difficulty with that. I think  
8 you were going on then to say -- in essence, does it  
9 then come to this: that having heard all of this  
10 evidence unfold, they have moved from thinking, "This is  
11 hard to explain, it doesn't make much sense to us", to  
12 form a view that the only coherent explanation is that  
13 it was fabricated eight years later?  
14 MR QUINN: I took specific instructions at lunchtime and  
15 that's what the parents will say.  
16 THE CHAIRMAN: I think they have said what they have to say.  
17 Is the point that, having listened to the evidence over  
18 October, November and into December --  
19 MR QUINN: Yes.  
20 THE CHAIRMAN: -- having had these concerns before, they  
21 think the only conclusion anybody could draw is not just  
22 that there were question marks about the notes, but that  
23 the notes were fabricated eight years later.  
24 MR QUINN: May I add to that: I think it was the day before  
25 I opened the governance issues on behalf of the family,

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1 question -- would have been raised with him.  
2 MR QUINN: Yes, Mr Chairman. Let me put this in the context  
3 of the Roberts. They fully accept they didn't raise  
4 these issues, but they sit here as parents and they  
5 listened to the evidence and they put together what they  
6 feel is their opinion in this case and, at your own  
7 invitation, Mr Chairman, Mr Roberts tells the room, the  
8 chamber what he thinks. I have no control over that.  
9 Mr Chairman, you have probably no control over it. You  
10 are trying to get at the truth. You are trying to get  
11 at what the Roberts think. What they think is the truth  
12 they should say and put it in proper context.  
13 Mr Chairman, you have the difficult task of balancing  
14 between those two opinions, those two sets of evidence  
15 and coming to a conclusion.  
16 THE CHAIRMAN: Yes.  
17 MR QUINN: One thing I respectfully submit is certain, and  
18 that is, between questions 12 and 20, we raise a number  
19 of issues in relation to the medical notes, and not only  
20 do we raise issues as to when the entry was made, we  
21 raise issues in relation to the reasoning behind why the  
22 entries were made. When one looks at our second,  
23 shorter letter of 1 September --  
24 THE CHAIRMAN: I have no difficulty with that at all.  
25 I understand why the queries are raised and I understand

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1 we were served file 139 and, in file 139, there were  
2 numerous e-mails, letters, et cetera, that were  
3 purporting to change statements, that were undermining  
4 the independence of Professor Young, that clearly showed  
5 Professor Young was in contact with various clinicians.  
6 If one looks at that as an outside observer and one  
7 opens file 139, which we have also written a lengthy  
8 letter about, and one looks at that as a neutral  
9 observer, one has to say, "Well, what's happening?". So  
10 on the basis of the evidence that is being served during  
11 the course of this tribunal, this inquiry, the Roberts  
12 formed an opinion and when we are invited to say what  
13 that opinion was, Mr Roberts did so.  
14 THE CHAIRMAN: Okay. Then I understand the position more  
15 clearly. It is not that this was a view -- while they  
16 had concerns about the notes before the hearing  
17 started --  
18 MR QUINN: Yes.  
19 THE CHAIRMAN: -- those notes are now hardened into a view  
20 that the only credible explanation for the entry that we  
21 are going to come to on 22 October is that it was added  
22 eight years later.  
23 MR QUINN: Yes. And may I just say, just to clarify things,  
24 this was not done out of any malice whatsoever. The  
25 other issue that they want to raise also is that other

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1 documents were then identified. For example, the  
2 patient journey by Dr Steen. We didn't know who had  
3 made that, but on any neutral reading of that document,  
4 it is clear Dr Steen and Dr Sands consulted about it or  
5 wrote it together. It is clear that it is a joint  
6 document, because the timings -- we have written about  
7 this and I am not going to go on about it any longer --  
8 the timings in the side columns where the timings are is  
9 not the same timings as in the medical records.

10 Therefore there has been some conversation between  
11 the clinicians, including Dr Webb, because he comes in  
12 at a different timing altogether at 12.35. It therefore  
13 seems apparent to the parents there has been discussion  
14 between the doctors, discussion with Professor Young,  
15 discussion with Professor Rooney -- who we think is not  
16 in any way involved in anything underhand whatsoever,  
17 may I add. When one looks at this as a neutral observer  
18 and one sees the weight of the documentation that is  
19 being served and the implications of those documents  
20 without the proper explanation that has been given in  
21 evidence now, one can see how the Roberts have arrived  
22 at that conclusion.

23 THE CHAIRMAN: Okay. I think what we have reached is some  
24 clarification that this is a -- so in the circumstances  
25 I am not critical of the fact that this issue was not

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1 THE CHAIRMAN: Yes. In essence, it's almost in the form of  
2 a submission.

3 MR QUINN: Yes.

4 THE CHAIRMAN: That because of these gaps, errors, failings,  
5 however they are described in the record, the conclusion  
6 which I should reach is that this entry was not made at  
7 the time.

8 MR QUINN: You actually asked me that, Mr Chairman, when  
9 this letter was presented. I made a concession this may  
10 be better argued in submissions.

11 MR GREEN: Sir, the allegation goes slightly further than

12 you have quite pithily encapsulated it because what

13 Mr Roberts said at page 127 of the transcript for --

14 THE CHAIRMAN: It is on the screen at the moment, I think.

15 MR GREEN: You are absolutely right. Sorry, sir.

16 That it was "as we were heading for a coroner's  
17 inquest". So the allegation seems to be that it was not  
18 just a forged entry as a back-covering exercise in  
19 a general sense, but it was a deliberate conspiracy  
20 intended to send the coroner down the wrong track. So  
21 in other words an act intending and intended to pervert  
22 the course of justice.

23 THE CHAIRMAN: Or knowing that the medical records would be  
24 referred to at the coroner's inquest, the records from  
25 1996 needed to have something extra in them.

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1 raised in the September/October period --

2 MR QUINN: I am obliged, sir.

3 THE CHAIRMAN: -- because at that stage they were not your  
4 instructions.

5 MR QUINN: Exactly.

6 THE CHAIRMAN: Your instructions were concerns rather than  
7 a belief.

8 MR QUINN: Yes.

9 THE CHAIRMAN: Right. In that case, I will take what Mr and  
10 Mrs Roberts have said as maybe an indication that their  
11 frustration is turning into even more, even deeper  
12 scepticism and possibly anger than it was before.

13 We will let Dr Sands respond to what is, in effect,  
14 a belief which Mr and Mrs Roberts have formed on the  
15 back of the evidence that they have heard to date; okay?

16 MR QUINN: My junior just wants ...

17 THE CHAIRMAN: Just one second. (Pause).

18 MR QUINN: Finally, we did submit a letter of 17 December,  
19 which clearly was not prompted by Mr Green's very ably  
20 managed submission.

21 THE CHAIRMAN: Yes.

22 MR QUINN: The two crossed in correspondence. The purpose  
23 of the 17 December letter was, in fact, to alert the  
24 inquiry to the problems that the Roberts have with the  
25 records and the evidence as it now stands.

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1 MR GREEN: Absolutely. I just want to make it absolutely  
2 plain why this is being taken so seriously: it is  
3 an allegation which involves several criminal offences,  
4 if true, that one could think of immediately.

5 THE CHAIRMAN: Thank you very much.

6 Mr Fortune?

7 MR FORTUNE: Sir, I rise at this stage, because, of course,  
8 Dr Steen is caught by this allegation of conspiracy.

9 THE CHAIRMAN: That's why she was asked about it yesterday.

10 MR FORTUNE: Yes. I have remained concerned about the  
11 timing of this allegation.

12 THE CHAIRMAN: I have explored the timing as best I can.

13 I understand the that timing of it is -- I will try to  
14 summarise it beyond what Mr Quinn has said --  
15 exasperation and disbelief on the part of Mr and  
16 Mrs Roberts about what they have heard. I am not sure  
17 if we can take it any further than that.

18 Is that fair, Mr Quinn?

19 MR FORTUNE: But, sir, even now --

20 THE CHAIRMAN: Is that fair, exasperation and disbelief?

21 MR QUINN: I think that's very fair.

22 MR FORTUNE: Even now, I now hear that Dr Sands was involved  
23 in the compilation of what's called the patient journey  
24 or the chronology. That wasn't actually asked of  
25 Dr Steen over the last two days; Dr Steen accepted that

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1 it was her document.  
2 THE CHAIRMAN: Yes.  
3 MR FORTUNE: I do find it very difficult to understand how  
4 that matter wasn't put through senior counsel to the  
5 inquiry.  
6 THE CHAIRMAN: Okay. I will take that point.  
7 I think we have clarified things as best we can and  
8 I'd like to get on, Dr Sands, with your response to  
9 this; okay? Miss Danes.  
10 MS ANYADIKE-DANES: Yes. Well, you have got the concern in  
11 a nutshell, what is the belief that's expressed.  
12 Firstly, can you deal with that as to whether that  
13 is something that happened, whether either Dr Steen of  
14 her own volition came to you or in some way the two of  
15 you met, the result of that being at some time  
16 considerably after events, in 2004, when it was  
17 understood that the case was going to be or had been  
18 referred to the coroner and therefore the medical notes  
19 and records were likely to be looked at, that  
20 an opportunity was taken to add to those medical records  
21 to make them, if I can put it that way, consistent with  
22 what had been described as the viral cause of Claire's  
23 presentation or the trigger of her condition, if I can  
24 put it that way?  
25 A. Well, I am grateful for the opportunity to give evidence

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1 wanted to discuss with him and so on and so forth. Then  
2 the question comes to you at 170, really starting at  
3 line 10:  
4 "Question: If we look at the notes, which we've had  
5 up a number of times, 090-022-053, so that's the note of  
6 that ward round which shows that addition, just halfway  
7 down, the addition to 'non-fitting status' of  
8 'encephalopathy/encephalitis'. That's your handwriting,  
9 is it?  
10 "Answer: It is.  
11 "Question: Do you know when you actually added that?  
12 "Answer: After speaking to Dr Webb, I came back to  
13 Allen Ward and I put that down in the notes. I  
14 appreciate it is not signed and dated and timed.  
15 "Question: Should it have been?  
16 "Answer: Yes.  
17 Then it goes on to deal with what you might have  
18 explained to Dr Stevenson and Dr Stewart. You explain  
19 the fact you believe you had raised the issue of  
20 encephalitis at the ward round -- not encephalopathy,  
21 but encephalitis. You recognised it had not been  
22 included in the ward round note and, when you came back  
23 from having spoken to Dr Webb, you made that addition.  
24 That was your evidence really on 19 October. What you  
25 weren't asked about was this issue that you are now

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1 again on this point. This has affected me very deeply,  
2 because it goes to who I am as a person. It goes to my  
3 faith as well. I was surprised and shocked to read  
4 these allegations, to hear of them. I didn't  
5 understand, perhaps until very recently, why I was being  
6 viewed as being under suspicion or why my conduct was  
7 being questioned until the documents in front of me came  
8 to light and Mr Roberts made it clear what his concern  
9 was. So I was really surprised by that. I hadn't  
10 anticipated that.  
11 I want to say very clearly that I made no entry to  
12 Claire Roberts' notes after her death. I want to say  
13 equally clearly that I didn't take part in any cover-up  
14 in terms of -- well, for the benefit of the coroner's  
15 inquest or any other matter. I don't think I can put it  
16 more clearly than that.  
17 THE CHAIRMAN: Thank you.  
18 MS ANYADIKE-DANES: Yes. Just for the benefit of the  
19 record, you were asked last time about the timing of  
20 when you made that entry into Claire's medical notes and  
21 records. Your evidence on that was on 19 October 2012.  
22 It starts at page 164 and goes on to page 165 and on  
23 into 170. If we go to 170, because that's where you  
24 deal with it concretely. Up until then, you are  
25 explaining about why you went to see Dr Webb, what you

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1 being asked to address and you know the reason why,  
2 because Mr Quinn has just said about the timing point.  
3 If you could help us now, having made that denial  
4 about the sort of thing that the Roberts have expressed  
5 their belief happened, if we can now deal with the  
6 letter itself, because that's part of an accumulation of  
7 factors that I understand have led the Roberts to  
8 believe that that is what happened.  
9 This is paginated (indicating). I believe everybody  
10 in the chamber should have it from yesterday, but the  
11 pagination for it is 311-047-001. If we can just put  
12 these things up two pages at a time. So if you could  
13 bring up the 002, and I think, in fact, that's all we  
14 really need, because the last page deals with issues to  
15 do with Dr Steen and she's already been asked about  
16 those.  
17 So, the ward round note is at 090-022-053. If you  
18 see there, it says:  
19 "Dr Sands spoke to Mr and Mrs Roberts for a short  
20 period of time."  
21 This is their view about what happened and I think  
22 they have already expressed a view about the length of  
23 time you spent speaking to them:  
24 "Possibly 10 minutes or so, during which time  
25 Dr Sands examined Claire and explained to the parents

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1 that it was his belief that Claire may be experiencing  
2 some type of internal fitting. There was no discussions  
3 by Dr Sands with Mr and Mrs Roberts about any other  
4 diagnosis."

5 And:

6 "The parents had no further discussions with  
7 Dr Sands that day or at any time thereafter (until after  
8 her death)."

9 Would you accept that that was the only discussion  
10 you had with them?

11 A. In terms Claire's illness, I believe that was the case.

12 Q. So if there was going to be any discussion between you  
13 and them about encephalitis, encephalopathy, matters of  
14 that type, that's when it may happen?

15 A. If I may add that any talk of encephalitis with Claire's  
16 parents, I wouldn't have used that word. They have  
17 mentioned a viral infection. If I was talking in those  
18 terms, I would talk about a viral infection that may  
19 have an effect on Claire's brain or something of that  
20 type. I don't remember what exact form of words were  
21 used.

22 Q. I wonder if you could help us with this -- the parents  
23 have sort of responded to that point. Their evidence is  
24 on 13 December 2012 and I am not going to go through it  
25 all, but in essence what they say to that is: if you

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1 if I was moving away or drew somebody aside to talk to  
2 them.

3 THE CHAIRMAN: I think, in fact, you did say in October:

4 "We did think of viral infection. Specifically,  
5 encephalitis, I think, was discussed on the ward round."

6 MS ANYADIKE-DANES: That's my starting point, but I think  
7 you are saying a reason why the parents might not hear  
8 that is because you might be wanting to shield them from  
9 that and so you might either discuss that a little bit  
10 away from where the parents were or maybe as you go  
11 further up, moving on to another child, you might  
12 mention it then, which would all be included within the  
13 expression "ward round".

14 A. Yes, I think that's possible, yes.

15 Q. But in any event your evidence is that that expression  
16 would have been used, not to them, but to Dr Stevenson.

17 A. Yes, and the reason I believe that is because I have  
18 a clear recollection of discussion around a CT scan.  
19 I also recall that one of the things that I thought  
20 might show up on a CT scan might be early signs of  
21 encephalitis. Now encephalitis was not the working  
22 diagnosis, was not the number one diagnosis. It was  
23 a possibility only. Other doctors had raised that  
24 possibility. Dr Puthuchery in the A&E department has  
25 his primary diagnosis as encephalitis with a query

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1 were discussing doctor to doctor, so you to  
2 Dr Stevenson, and the term encephalitis was raised with,  
3 which it might be doctor to doctor, although they accept  
4 it might not be the way you would describe things to  
5 them, and your evidence is you did raise that with  
6 Dr Stevenson, they say they were there throughout that  
7 time. If they had heard encephalitis, effectively they  
8 would have pricked their ears up and they would have  
9 asked: what is that about? So that's their sort of  
10 starting point, that you didn't mention it to them and  
11 they did not hear it, because they were listening for  
12 anything that could help them as to a doctor's analysis  
13 of what was wrong with their daughter, who seemed worse  
14 when they came in at 9.30. Can you help with that?

15 A. I think on a ward round discussion -- parents don't  
16 always hear everything that goes on between doctors and  
17 nurses on a ward round and indeed there are some things  
18 that one might not want parents to overhear --

19 Q. I understand that.

20 A. -- in terms of sensitive things, maybe worrying things.  
21 So one might not discuss it quite as openly as that in  
22 front of parents or as loudly, if you like.

23 Q. Is it possible you did discuss it with Dr Stevenson, but  
24 not literally there at Claire's bedside?

25 A. It is possible. As we were moving away at that point or

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1 beside it. I know Dr O'Hare mentions encephalitis and  
2 then scores it out, but I think it was part of my  
3 thinking at that time of the ward round that a CT scan  
4 might show some evidence of encephalitis and I honestly  
5 think I would have shared that with at least the doctors  
6 on the ward round as a possibility, no more than that.

7 Q. I think you raised, maybe in fairness to you, the issue  
8 of CT scan was one of your contributions to the meeting  
9 on 7 December with Claire's parents. I am trying to see  
10 the actual place where you say that's something that  
11 might have happened. It is at -- 089-002-004 is one of  
12 your references to it. Second paragraph:

13 "Dr Steen advised that it is not always the case  
14 that children with low sodium levels will result in  
15 swelling of the brain [and so on]".

16 You add:

17 "A new CT scanner is in place today, which may have  
18 helped Claire had it been available in ICU eight years  
19 ago."

20 Does that reinforce the fact that you have some  
21 thinking that you were linking the CT scan and the  
22 possibility that that might have assist if she had  
23 encephalitis?

24 A. Only as one possibility. I also -- my recollection is  
25 that we would have -- that we did discuss what a CT scan

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1 might show. You see, I couldn't have gone to Dr Webb  
2 and said, "Why don't we do a CT scan?", without giving  
3 a reason or reasons. I felt it might rule out other  
4 possibilities such as intracranial bleeding, for  
5 example, but a CT scan mentioned at that point,  
6 I suppose it -- the minute may not be quite correct to  
7 say "had it been available in intensive care". The CT  
8 scanner is down in the A&E department in the  
9 Children's Hospital now, but I did say that I felt a CT  
10 scan probably would have been carried out earlier. It  
11 may have been helpful.

12 Q. So sort of by way of a concession that that might have  
13 been something we could have done?

14 A. Yes.

15 Q. I understand. I think you have already said you had  
16 noted a CT scan in the ward round. That was a note made  
17 even before you had gone to see Dr Webb.

18 A. Well, we had discussed it. I know we'd mentioned it.

19 Q. Yes. So that was their first concern, that you didn't  
20 mention it to them. Your explanation of that seems to  
21 be you wouldn't have used the expression "encephalitis".  
22 They didn't hear it. You have an explanation for why  
23 they might not have heard it. If you were trying to  
24 convey encephalitis without using that medical term,  
25 what is the layperson's expression that you can use?

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1 it started as a tummy bug or not -- we are talking about  
2 something now that is affecting her brain. That's the  
3 bit, as I understand it, that the Roberts did not  
4 appreciate.

5 If anybody had told them about tummy bugs, viral  
6 things of that sort, that's something they would  
7 understand, but their clear recollection is that nobody  
8 mentioned anything about her brain.

9 A. I must say it's my feeling that non-fitting status  
10 epilepticus, encephalitis and encephalopathy are all  
11 very much brain conditions.

12 Q. Then is it coming down to a matter of communication  
13 that, if that is what you intended to convey to Claire's  
14 parents, then you didn't do it?

15 A. I think there was a problem with communication and  
16 I think I've said that in evidence as well --

17 Q. Yes, I think you did.

18 A. -- and I fully accept that.

19 THE CHAIRMAN: I have a concern that we seem to be largely  
20 going over old ground again. I don't think that's  
21 particularly helpful. I know why you are doing this,  
22 Ms Danes, but a lot of this ground has already been  
23 covered with Dr Sands -- actually partly at your own  
24 instigation and partly at the specific request of the  
25 Roberts' representatives.

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1 A. Well, I may have put it as loosely as an infection that  
2 may be having an adverse effect or having an effect on  
3 Claire's brain, but that leaves open the possibility  
4 that that had simply triggered seizure activity or, in  
5 fact, had infected Claire's brain and I may not have  
6 been any more specific than.

7 Q. You see, from the -- in fairness to the Roberts, from  
8 their point of view, if you had mentioned anything at  
9 all to do with her brain, that would have registered and  
10 I think Mrs Roberts' clear evidence was if anything had  
11 been mentioned about her brain, she certainly wouldn't  
12 have been going off and having her lunch; she would have  
13 been staying with her daughter.

14 A. I think it is in Mr and Mrs Roberts' evidence that they  
15 were aware of internal fitting being discussed.

16 Q. Yes, but I think the difference that we come to is that  
17 Dr Steen talks about some sort of viral infection and  
18 this gets linked with tummy bug and so forth and  
19 Dr O'Hare distinguishes between an infection of that  
20 sort and encephalitis, which is in the brain area, if I  
21 can put it that way.

22 When you are adding "encephalitis/encephalopathy",  
23 what you are putting squarely there is an issue to do  
24 with Claire's brain. We are not talking just about  
25 a tummy bug; we are talking about something -- whether

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1 MS ANYADIKE-DANES: Yes.

2 THE CHAIRMAN: We could spend the rest of today going back  
3 over that. I am not sure that advances things.

4 MS ANYADIKE-DANES: I understand that and I certainly don't  
5 want to do that but my understanding is because this  
6 letter has gone out, it is out there, and Dr Sands wants  
7 the opportunity to allay, in so far as he can, the  
8 concerns that the family have that all these things  
9 amount to anything that suggests that he, together with  
10 Dr Steen, altered or added to the notes.

11 I am prepared to go through it faster or pick up the  
12 salient points, but that's what Dr Sands wants to  
13 address.

14 THE CHAIRMAN: Let me do it this way -- Mr Green, you will  
15 tell me if it is acceptable or otherwise.

16 As you will expect, I will re-read the evidence  
17 Dr Sands gave and re-read the statements and the  
18 records. I have read again what Mr and Mrs Roberts said  
19 in their statements and orally. I have now clarified,  
20 since I came out this afternoon, how it is that this  
21 allegation has come about. It is not on the basis of  
22 new evidence. It is the stage that Mr and Mrs Roberts  
23 have reached considering the evidence as it has  
24 developed over the last number of weeks. I have heard  
25 Dr Sands, like Dr Steen before him, deny absolutely that

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1 there was any fabrication or addition to the note in  
2 2004/2005 for the coroner or for any retrospective  
3 review or internal investigation.  
4 If Dr Sands wants to go on to make some particular  
5 point in answer to any specific issue raised in this  
6 letter, I will not stop him from doing so, but I do not  
7 believe that it is helpful to me for him to go through  
8 all of these lettered points one after another.  
9 MR GREEN: Sir, his position is he is able to deal with  
10 these points, if you wish him to. You have told him,  
11 through me, that that will not assist. I am content  
12 and -- I am sure he is -- in those circumstances if we  
13 move on.  
14 MS ANYADIKE-DANES: I am very grateful for that, but  
15 I wonder if I may deal with a couple of them quite  
16 quickly?  
17 A. Excuse me. If I may, I would be happy to quite quickly  
18 go through these.  
19 THE CHAIRMAN: If that's what you want to do, doctor --  
20 I don't think I have stopped anybody so far -- but on  
21 the basis that it is quick.  
22 A. Yes.  
23 MS ANYADIKE-DANES: So let's go to (b). If we do move  
24 quickly like that. The (b) is if that if you and  
25 Dr Webb had had that discussion, he had formed that view

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1 Dr Webb. If anything, it was a bit reduced.  
2 Q. Thank you. So (c) then.  
3 A. Yes. I think Dr Stevenson will have followed Dr Webb's  
4 lead completely in this matter, when the issue is raised  
5 that Claire is still in status but doesn't mention  
6 encephalitis or encephalopathy. Dr Webb has given his  
7 presumptive diagnosis or working diagnosis, because  
8 usually there is only one working diagnosis and  
9 sometimes other differentials. He has made that  
10 statement, as Dr Mulholland did, regarding the other  
11 patient that appears in file 150.  
12 Q. If we go to D, which is when Dr Webb sees Claire at  
13 5.00. Just if one is trying to keep up with the  
14 references, it is 090-022-055, not to be pulled up, but  
15 that's the reference for it. It doesn't mention the  
16 diagnosis of encephalitis. It does discount  
17 meningoencephalitis. And his plan is a 48 hour plan and  
18 that plan is not consistent with a working diagnosis of  
19 encephalitis.  
20 A. That's correct. I don't think encephalitis was  
21 Dr Webb's working diagnosis, nor was it mine. I would  
22 have deferred to Dr Webb, who was the consultant  
23 neurologist, who had made what he thought was the best  
24 diagnosis, the most clear diagnosis obvious to him and  
25 was managing things accordingly.

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1 and he makes no mention his own note of encephalitis.  
2 A. Dr Webb doesn't make any note of encephalitis, nor does  
3 he mention non-fitting status epilepticus in his note.  
4 If I might also say just again from file 150 --  
5 I may be wrong in this, but I think I am right.  
6 Dr Mulholland, who came to see a patient who was thought  
7 to have a cardiological condition, who the ward round  
8 thought might have a PDA or patent ductus arteriosus.  
9 When he does the ward round, he makes no mention of  
10 patent ductus arteriosus. He gives his own view, his  
11 diagnosis.  
12 Point (c), if I may. I believe Dr Stevenson will  
13 have followed Dr Webb's lead.  
14 Q. If we just alight at that, there other point is that he  
15 doesn't address it in terms of making a note or  
16 prescribing anything for it, but neither do you.  
17 A. That's correct. I have asked Dr Webb to come to see  
18 Claire. I have not been prescriptive at all about what  
19 he should or should not say. We have had a discussion  
20 about Claire, about what may or may not be going on. My  
21 impression was Dr Webb thought encephalitis was less  
22 likely. A CT scan, he thought, probably wasn't  
23 necessary right there and then. I think he said that as  
24 well in oral evidence, and I don't think my view of  
25 encephalitis was reinforced at all by talking to

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1 Q. So the fact that the records after, let's put it that  
2 way, when you say you made that entry, the fact they  
3 don't address the encephalitis point is because, in the  
4 interim, Dr Webb has come and he is actually not so  
5 persuaded about the encephalitis point. He has not  
6 supported that.  
7 A. He has not particularly supported that.  
8 Q. So then it says -- and I think we have already addressed  
9 this:  
10 "If you had that view at the time of the ward round  
11 thought there was a brain infection [if one uses  
12 the layperson's expression], then why didn't you  
13 provide ..."  
14 I think you have dwelt why you didn't provide any  
15 treatment for it. Then I suppose there might be  
16 an issue: why didn't you mention it at all to them if  
17 you thought that? At that time he wouldn't have come,  
18 so you would have a view that whatever you have  
19 described to Dr Webb, he thinks that  
20 encephalitis/encephalopathy is a possibility. So you  
21 have come back to the ward to write that into the note  
22 so that's clear. I suppose their point is: could you  
23 not have actually come to tell them that you've seen the  
24 specialist and he's coming to see the child and there's  
25 a bit of a concern, but don't worry, she is in good

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1 hands, that sort of communication?  
2 A. Yes. That's a fair point. I think it probably was  
3 influenced by the fact that Dr Webb didn't feel  
4 encephalitis was a pressing concern and I felt that he  
5 was coming to see Claire, I hoped quite soon, and so we  
6 wouldn't have to perhaps wait long for a more  
7 definitive, if you like, assessment.  
8 Q. So if you had thought he was going to come, when he  
9 actually did come, which is what you are impliedly  
10 saying, you might have had a word with the parents?  
11 A. It is possible.  
12 Q. Okay. Then if we go then quickly to (f), well that's  
13 a Dr Steen point. I am not sure you can address that.  
14 Maybe you can just help us with the nursing notes very  
15 quickly. Those appear at (i). There is a nurse, if I  
16 can put it that way, that accompanies you round the ward  
17 round. We think we know who it is, but quite often the  
18 nursing notes are a little bit more expansive, if you  
19 will forgive me for putting it that way, as to what's  
20 happening. There seems to be no reference in the  
21 nursing notes to anything to do with encephalitis, which  
22 was something that was discussed at the ward round.  
23 They presumably would be trailing around with the junior  
24 doctor, with you. Can you explain why that would be the  
25 case?

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1 saying "most likely postictal".  
2 Q. Although they run with the working or the differential  
3 diagnosis, it was sufficiently significant for you to  
4 you to feel you wanted to add it to the medical notes  
5 and records. We can't minimise it too greatly because  
6 otherwise you wouldn't have bothered writing it in. So  
7 you have raised it, checked it and then you are writing  
8 it in. So one might think, if it had that kind of  
9 standing, that the nurses would be asked to feature that  
10 in some way.  
11 A. I think that maybe it was more of a discussion that took  
12 place between the doctors. I think Dr Stewart mentions  
13 in his evidence that he is aware of a discussion around  
14 encephalitis. So perhaps that was a failure of  
15 communication adequately to nursing staff to raise that  
16 maybe a little higher on the radar.  
17 Q. Can I ask you just quickly, without wanting to go into  
18 it extensively or into clinical issues, if you are  
19 working with that, that it is non-fitting status  
20 epilepticus, encephalitis, encephalopathy, and that in  
21 due course Dr Webb will come and give a definitive view  
22 as to what he thinks is going on neurologically. If you  
23 are working with that and you had had a discussion with  
24 the nurses, what would the nurses have been doing if  
25 they now recognise there is a potential -- let's call it

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1 A. Well, I don't think encephalitis was ever a number one  
2 or working diagnosis, certainly not at that point. It  
3 was listed as a possible differential but only  
4 a possibility, no stronger than that. I think the  
5 nursing notes span quite a period of time, and the  
6 nursing notes, I don't think either, make mention of  
7 meningoencephalitis, which Dr Webb, the consultant, who  
8 carries more weight than I, mentions at 5 o'clock.  
9 I don't think the nursing notes make mention of  
10 encephalopathy either, which again Dr Webb has listed as  
11 his acute encephalopathy as his diagnosis at 2 o'clock.  
12 I think the nursing care plan doesn't mention non--  
13 Q. I was going to go on to the nursing care plan. It is  
14 absent from there as well.  
15 A. I don't think it mentions non-fitting status,  
16 encephalitis nor encephalopathy.  
17 Q. So your point is one can't necessarily take so much from  
18 the notes and records, because unfortunately the notes  
19 and records may not have been as full or as accurate as  
20 they might have been?  
21 A. I think they run with a working diagnosis, which was  
22 non-fitting or non-convulsive status epilepticus as the  
23 number one working diagnosis with anything else below  
24 that. Dr Webb moves, when he sees Claire at 2 pm, to  
25 mention acute encephalopathy, but he qualifies that by

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1 a brain infection -- going on? What would you be  
2 expecting them to do or to reflect in their care?  
3 A. I suppose -- closer observations and CNS observations  
4 had, I think, already been started or were started at  
5 1 o'clock.  
6 Q. No, they started at 1 o'clock, so they wouldn't have  
7 started necessarily at that time.  
8 A. Perhaps at that point they were started, in fact, you  
9 know, for 1 o'clock, because I think they are stopped --  
10 the routine observations stop at 12 and then the CNS  
11 observations start at 1. So some time between that,  
12 between 12 and 1, there is a decision made either by the  
13 ward round or perhaps in conjunction with Dr Webb, who I  
14 think -- I think he believes it was after my discussion  
15 with him that he suggested starting CNS observations.  
16 Q. Yes. I think the point from the Roberts' perspective  
17 was: if you came back and you had that initial view of  
18 yours sort of confirmed pending by Dr Webb, if I can put  
19 it that way, then it was significant, one, because you  
20 wrote it in, and two, because it might actually have  
21 affected the observations or something that the nurses  
22 did. That might have been relevant. So if that is what  
23 was going on, then at the very least it's a failure to  
24 communicate these matters to the nursing staff.  
25 A. I think there is that potential there.

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1 Q. Thank you. Just give me one moment. Yes. There is one  
2 other aspect that I know that you want to address, which  
3 is the extent to which you regarded, at the time,  
4 Claire's condition as being serious. I know it's very  
5 difficult with hindsight because after you've trawled  
6 through any number of expert reports that tell you it is  
7 serious, it might be quite difficult to divorce yourself  
8 from that and go back and think of what you actually  
9 thought at the time, but you have heard what the parents  
10 say.

11 They have a real concern that one of the reasons why  
12 Claire's treatment proceeded the way that it did was  
13 that nobody really grasped how ill she was. She  
14 gradually deteriorated until she was beyond assistance  
15 really, so that's their concern. Can you help us with  
16 anything that indicates your belief of how seriously ill  
17 she actually was?

18 A. When I first met Claire on the ward round, it was my  
19 belief that Claire was -- there was something badly  
20 wrong neurologically and that prompted me to go, leave  
21 the ward round and try to get hold of Dr Webb as soon as  
22 I could. Now that's not something that I would usually  
23 have done. That's not something I believe people would  
24 commonly do unless they were really worried about  
25 a child and I believe I have been consistent in saying

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1 A. No, I don't.

2 MS ANYADIKE-DANES: I think in fairness to you, Dr Sands,  
3 your evidence earlier was that if you had been told  
4 there was one, you would have wanted to be there.

5 A. That's true.

6 THE CHAIRMAN: And it would have been arranged, as  
7 I understand it -- the mortality reviews are arranged,  
8 as far as can be done, to make sure that the doctors who  
9 have been involved in treating the children are there.

10 A. That is usually so, but the only problem with that is  
11 that it is usually geared, if you like, for consultant  
12 staff rather than junior staff.

13 THE CHAIRMAN: Dr Steen can't remember it perhaps because  
14 her illness has affected her memory. Dr Webb doesn't  
15 recall one. Dr Herron doesn't recall one. Dr Mirakhur  
16 doesn't recall one. I am driven to the conclusion that  
17 there wasn't one and Professor Harding said, by video  
18 link to this inquiry, that if ever there was a child's  
19 death and something to learn from that and that would  
20 benefit from a mortality review, it was Claire's. So if  
21 there was one, not only can nobody remember it, but  
22 nobody can recall anything that came out of it. It is  
23 pretty hard to avoid the conclusion that there wasn't  
24 one.

25 A. I think that's a reasonable conclusion. I certainly

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1 that I was very concerned about Claire's well being and  
2 her neurological status in particular right from the  
3 very beginning, from when we first -- when I first met  
4 Claire's parents in 2004 at the meeting with Dr Rooney,  
5 at that stage, I did say at that point and in my  
6 evidence to the coroner.

7 It is my view as well, I have to say, that I am not  
8 sure that Dr Webb was as concerned as I was.

9 THE CHAIRMAN: He wasn't. He thought she was going to  
10 recover.

11 A. Yes.

12 THE CHAIRMAN: Can I ask you this in a different way,  
13 doctor? How quickly did you find out that Claire had  
14 died? That must have been a real shock.

15 A. Yes.

16 THE CHAIRMAN: If there was a mortality review of Claire's  
17 death, is that not something in which you would have  
18 been particularly interested because she was a young  
19 girl whom you had treated, about whom you had concerns,  
20 which you have expressed, but who had then died?

21 A. Yes, I would. Yes, I would, and I remember being  
22 shocked to hear that Claire had died, and there was  
23 a sense of I knew she was sick and I wasn't sure what  
24 was wrong with her and I --

25 THE CHAIRMAN: Well, do you remember a mortality review?

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1 don't remember one.

2 THE CHAIRMAN: It would have been one that you would  
3 particularly regretted missing and you might have  
4 followed up by saying, "Well, what was discussed?"

5 A. Yes.

6 MS ANYADIKE-DANES: Just one last point on that.

7 When the meeting with the family is arranged,  
8 Dr Steen asks you to accompany her and I think her  
9 explanation for that is because you knew the family and  
10 you had -- I don't mean knew the family as knew them  
11 socially. You had met them. You had done the ward  
12 round, discussed Claire with them and you had been, in  
13 part, involved in Claire's treatment.

14 A. Well, if you like, I can tell you, you know.

15 Q. I am going to ask you a bit about that. Where I am  
16 going with that point, though, is: do you think that, in  
17 those circumstances, Dr Steen could actually have  
18 presented at a mortality meeting without some discussion  
19 or assistance from you?

20 A. I think it would just have had to come directly from the  
21 notes or perhaps aided by Dr Webb or some of the junior  
22 staff, but I think my role would have been important.

23 Q. The likelihood is she would have had to discuss with  
24 you?

25 A. Yes.

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1 Q. Then I did want to go to the place where you thought I  
2 was going, which is to ask you about how you got to know  
3 there was a meeting that you were being invited to  
4 attend?  
5 A. It was in the board room in the Children's Hospital.  
6 There may have been an audit meeting or something of  
7 that kind on and Dr Steen passed me Claire's chart and  
8 asked me to look at it and asked me if I knew or  
9 remembered this patient, because her recollection of it  
10 was minimal, of this chart, and her recollection of  
11 Claire was minimal.  
12 Q. This was 2004?  
13 A. Yes. 2004, and I looked through the chart and said,  
14 "Actually, yes, I do remember at least parts of Claire's  
15 case and parts of what happened". So Dr Steen simply  
16 asked me, "Would you like to come along and meet with  
17 the parents? This meeting has been arranged. Would you  
18 be interested in coming along, meeting with them and  
19 perhaps providing any detail you can of the events of  
20 October 1996?"  
21 Q. Did you know at that stage what had brought Claire's  
22 case to the attention of the hospital?  
23 A. Actually the first time she mentioned it to me I didn't,  
24 but then when she subsequently told me where meeting was  
25 to be and it was to be chaired by Professor Rooney and

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1 MS ANYADIKE-DANES: Thank you very much indeed.  
2 THE CHAIRMAN: Okay. Mr Green, is there anything further?  
3 MR GREEN: Sir, there is not, but I am conscious that  
4 Mr Quinn raised another issue with me and Ms Danes  
5 yesterday in relation to the reference in the note to  
6 Claire's parents having gone home that evening. I don't  
7 want a situation to arise where Dr Sands has to be  
8 recalled once again.  
9 MS ANYADIKE-DANES: I quite understand. If you just give me  
10 one moment, I will find where that is. It is in  
11 the minute, I think.  
12 MR GREEN: It is in the minute. I am sorry. I don't have  
13 the reference at my fingertips.  
14 MS ANYADIKE-DANES: If you could just give me one moment.  
15 A. I interjected one point to say it would have been  
16 preferable if somebody had spoken to Mr and Mrs Roberts  
17 before they went home at 9.15 on the evening of  
18 22 October 1996. I have no reason to doubt that that  
19 portion of the minute is correct.  
20 MS ANYADIKE-DANES: It is at 089-002-085. This is literally  
21 the final page of the minute. You see fourth  
22 paragraph up from the bottom or third from the top,  
23 whichever:  
24 "Dr Sands stated that it would have helped if  
25 medical staff had spoken to Mr and Mrs Roberts before

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1 Professor Young was coming along, she did then say it  
2 was prompted by the television programme that had been  
3 aired.  
4 Q. Had you seen that programme yourself?  
5 A. No.  
6 Q. Did you know anything about it?  
7 A. Other people had seen it and asked me the same question  
8 just as you have, if I had seen it.  
9 Q. I am going to ask you one quick question following that.  
10 After that meeting, Dr Rooney put together the minutes  
11 of that meeting or a note of that meeting. Did you have  
12 any part to play in looking at that minute or correcting  
13 it or advising on it?  
14 A. No. I first saw it on the inquiry's website.  
15 Q. And thereafter, in fact the next day, the Roberts wrote  
16 a letter with further queries that they had. Did you  
17 ever see those queries?  
18 A. I did see that, yes.  
19 Q. Did you have any part to play in the answer that was  
20 ultimately provide in January?  
21 A. No.  
22 Q. You never saw the letter that went out?  
23 A. No.  
24 Q. Or drafts of it?  
25 A. No.

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1 they left at 9.30."  
2 Can you say what you meant by that?  
3 A. As I understand it, Mr and Mrs Roberts spoke to a nurse  
4 or nurses before leaving the hospital at that stage, and  
5 I thought then -- and I think now -- that it would have  
6 been helpful if preferably the most senior person on the  
7 medical side had been able to talk to them before they  
8 left and to go over things with them, to tell them how  
9 Claire was or how it was understood she was. I don't  
10 think anybody expected what happened to Claire to  
11 happen. I didn't, but I think it would certainly have  
12 been appropriate for a member of medical staff,  
13 preferably a senior doctor, preferably a consultant, to  
14 talk to Claire's parents again before they left to go  
15 home, because that's a significant step, leaving the  
16 hospital, going home, and I know -- I can only guess  
17 that that has been terribly difficult to reconcile for  
18 Claire's mum and dad. Whether a senior doctor would  
19 have said, "Please don't go home", or, "Please stay",  
20 I don't think that always happens and that's a step  
21 further maybe than what I was suggesting in 2004.  
22 MS ANYADIKE-DANES: Thank you.  
23 THE CHAIRMAN: Thank you very much.  
24 Doctor, thank you very much for coming back; okay?  
25 (The witness withdrew)

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1 THE CHAIRMAN: Mr Quinn, can I say I want the Roberts --  
2 I don't want there to be misunderstanding. I don't want  
3 the Roberts to think I am hostile to them or critical of  
4 them for the way in which this issue has emerged.  
5 I can't imagine how I would have reacted in their shoes  
6 to this story emerging over the last few years had  
7 Claire been my daughter. The fact that their views have  
8 hardened to the extent they have is understandable, even  
9 if I am inclined to think, at this stage, that it's  
10 a bit regrettable; okay?  
11 MR QUINN: I am obliged.  
12 THE CHAIRMAN: Can we move on to Professor Lucas?  
13 PROFESSOR SEBASTIAN LUCAS (called)  
14 Questions from MS ANYADIKE-DANES  
15 THE CHAIRMAN: Have a seat, please, Professor. Thank you  
16 for waiting.  
17 MS ANYADIKE-DANES: Professor, do you have your CV there  
18 with you?  
19 A. No, but you have it. Oh, sorry. I do, yes.  
20 Q. The reference to it is 306-069-001. For those who were  
21 involved in Adam's case, it was presented then, although  
22 you didn't ultimately have to give evidence in that  
23 case.  
24 A. Correct.  
25 Q. So from it we see, since August 1995, you have been

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1 A. Oh, that's nonsense. If one does a lot of standard  
2 pathology, including brain pathology, you cover a lot of  
3 those things and I would regard myself as pretty good at  
4 things like encephalitis or not.  
5 Q. Right. Another issue that has been raised is the extent  
6 to which -- maybe it's a difference that you can  
7 explain -- the distinction between what you do as  
8 a pathologist and what a forensic pathologist does.  
9 A. Yes. That's a reasonable question. Forensic  
10 pathologists are employed primarily to look at deaths  
11 where there is suspected homicide.  
12 Q. Yes.  
13 A. In a sense, that's what they do, whether it's traumatic,  
14 whatever the cause is and so on. They may do other  
15 things as well, but that's primarily why they are  
16 qualified to do that.  
17 Q. But the method they apply to analysing what they are  
18 looking at down the microscope, is there any difference  
19 between them and you about that?  
20 A. Yes. In general, forensic pathologists are much less  
21 good at looking down microscopes than all the other  
22 pathologists and I am sure everyone in this court knows  
23 that.  
24 THE CHAIRMAN: We do now.  
25 MS ANYADIKE-DANES: Right.

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1 a Professor of histopathology.  
2 A. Yes.  
3 Q. What was now Guy's and St Thomas', is now Guy's, King's  
4 and St Thomas's.  
5 A. Yes.  
6 Q. Can you help with what histopathology is?  
7 A. Histopathology is the study of disease by looking at  
8 tissues down microscopes ultimately. That's what  
9 histopathology means. It is slightly broader than that.  
10 Essentially it is tissue pathology seen at autopsy,  
11 tissue pathology seen from samples of patients taken  
12 during operations, inside hospitals or GPs' surgeries  
13 and also looking at what we call cytology, which is  
14 spreads of cells sampled in many ways, including gynae  
15 cervical smears. All that can be put into  
16 histopathology.  
17 Q. Does that mean, in the course of that work, you would be  
18 looking at brain cells as well?  
19 A. Yes, you could.  
20 Q. The reason I asked you that was, when I was putting some  
21 of the matters that you have raised in your report to  
22 the pathologists who carried out the autopsy on  
23 Claire -- in particular, I think, Dr Mirakhrur -- some of  
24 those differences she explained by the fact they were  
25 neuropathologists and you were not.

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1 A. The evidence for that is borne out in many recent cases.  
2 We need not adumbrate.  
3 Q. There are a number of protocols and guidance, perhaps  
4 not as many as you would like, that bear on the issue of  
5 autopsy and post-mortem reports and indeed the audit of  
6 autopsy. They were all put to the pathologists and  
7 I don't think any of them deny they existed. If I just  
8 run through them very quickly: the 1991 joint working  
9 party on the autopsy and audit.  
10 A. Uh-huh (positive).  
11 Q. The reason I put that to them was really to do with the  
12 consultation that should happen or at least in certain  
13 circumstances it ought to.  
14 Then the 1993 Royal College of Pathologists  
15 guidelines of post-mortem reports. And the reason I was  
16 putting that to them was:  
17 "[Their] responsibility to be satisfied that a full  
18 account has been obtained and to list the major  
19 pathological lesions present and a commentary to be  
20 written in the light of all the information available  
21 and to reconcile, as far as possible, the major clinical  
22 problems with the pathological findings and then also  
23 the issue of audit."  
24 If I just pause there, that clearly is a guidance  
25 that you recognise.

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1 A. Uh-huh.  
2 Q. In terms of their responsibility to be satisfied that  
3 a full account has been obtained, can you help us with  
4 that, because that's a matter that was specifically  
5 raised with the pathologists?  
6 A. Well, it's actually put into at least one of these two  
7 documents and also reiterated in the later ones which  
8 I had a hand in. I didn't have a hand in any of those.  
9 The purpose of the autopsy is quite simple: to answer  
10 questions raised by a death, period, by whatever means  
11 is appropriate. There are lots of ways of doing, but  
12 the crucial thing is to establish what the questions are  
13 and to -- once the process has been done, to consult, if  
14 required, with other people like other doctors who have  
15 been involved in the death, to see that all the answers  
16 add up, or whether they don't.  
17 Q. Yes. In terms of finding out what the questions are --  
18 A. Yes.  
19 Q. -- is that something, in this case, that the pathologist  
20 would be informed about from the autopsy request form?  
21 A. This being a consented case, that came from the  
22 doctors --  
23 Q. Yes --  
24 A. -- that information because there is information in the  
25 notes which one may or may not read in any detail before

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1 A. Well, I have been sitting here all this morning. I am  
2 not the first person to say it today.  
3 THE CHAIRMAN: Yes, yes.  
4 A. Quite. I mean to, summarise that, I believe, from the  
5 information that came from the autopsy, when viewed  
6 appropriately with the right people, the radiologist,  
7 the doctors who looked after the -- the answer would  
8 have dropped out of the sky as being fairly obvious as  
9 to what was going on.  
10 MS ANYADIKE-DANES: Which was?  
11 A. Hyponatraemia causing cerebral oedema causing death.  
12 Period. Because all the other possibilities have been  
13 excluded. That's what autopsy is about: excluding  
14 things as well as proving others.  
15 Q. Now you have come to this so nicely, can I ask you about  
16 the extent to which you regard encephalitis or anything  
17 of that sort as having been excluded?  
18 A. There's a lot of documents here and I should also say  
19 that I have not seen the histology slides, but I have  
20 seen everyone else's accounts of it.  
21 Q. Yes.  
22 A. I can also say at this point that whatever people were  
23 anything 1976 --  
24 Q. 1996.  
25 A. Sorry. I beg your pardon. 1996. And I just noticed it

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1 starting the autopsy.  
2 Q. Does that mean that what the questions are is not  
3 something that is necessarily confined to just those  
4 questions that are put to you from the clinicians? It  
5 is what the circumstances dictate --  
6 A. Yes.  
7 Q. -- as the questions?  
8 A. Indeed. That and also other things that may arise from  
9 observation of the autopsy that may raise questions that  
10 hadn't been raised before at all.  
11 Q. So although your autopsy request form might be your  
12 starting point, it is not necessarily your end point.  
13 A. Certainly not.  
14 Q. The responsibility for that, for making sure you have  
15 looked at all the relevant factors, which could generate  
16 questions that you should be addressing, that's  
17 ultimately the pathologist's responsibility?  
18 A. I think that's right, yes, but in collaboration with the  
19 doctors -- remember this is not a medico-legal autopsy.  
20 It is a consented one. In other words, doctors have had  
21 questions that they wanted investigated further. So it  
22 is only right they are involved in, in a sense, the  
23 final outcome process in writing.  
24 THE CHAIRMAN: This is your single biggest criticism in this  
25 case, isn't it?

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1 again this morning, it is interesting that in 2006 the  
2 coroner writes "meningoencephalitis" down as his cause  
3 of death after the inquest. So something obviously  
4 rumbled on into that stage as well despite everything  
5 one has heard this morning. It wasn't quashed at that  
6 point, unless Mr Leckey was making it up. I don't know.  
7 Q. Well, in your view, when you looked at the papers that  
8 you had --  
9 A. Yes.  
10 Q. -- what allowed you to exclude the encephalitis?  
11 A. Well, there was quite evidently very little of it for  
12 a start, even by the most generous interpretation of  
13 some of the words there. Then I looked at  
14 Wendy Squier's comments. I looked at Dr Harding's  
15 comments. There were some pictures as well which I was  
16 given as black and white prints. I found them deeply  
17 unimpressive as encephalitis. I have seen a lot of  
18 encephalitis. This is not a new disease to me. I am  
19 not a neuropathologist, but actually infectious  
20 diseases, that's my trade, and I have seen quite a lot.  
21 THE CHAIRMAN: Are you in Professor Harding's school that it  
22 is either there or not; it is not there in grades?  
23 A. Virtually, yes. I noted that this morning, thinking  
24 I was going to get asked that. I think what he and  
25 I would mean is that encephalitis sufficient to cause

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1 clinical brain damage and kill is either there or it's  
2 not.  
3 THE CHAIRMAN: Right.  
4 A. There will be many circumstances when there is a very  
5 mild. I am talking about a morphologically mild degree  
6 of encephalitis, which has no bearing on a case. It  
7 appears to me from the descriptions here even that  
8 doesn't pertain either.  
9 Q. Well, the view of both Professor Harding and Dr Squier  
10 is that they simply didn't see inflammation in the way  
11 that was described by Doctors Herron and Mirakhur, that  
12 they were looking for some form of infiltration or  
13 something more than they saw on their slides.  
14 A. Yes.  
15 Q. And they didn't see it. Dr Squier's view is not only  
16 didn't she see it with the normal range of stains that  
17 had been applied by the pathologist, she went and  
18 applied further stains to try and see if that would  
19 highlight anything, and even with those further stains,  
20 she didn't see any evidence of it.  
21 A. She phrased it slightly differently from that, but I  
22 think that's what she meant, yes.  
23 Q. You actually had a comment on the staining.  
24 A. Yes. Because that was actually put back to me to  
25 rewrite my report, which I was very happy to do. Where

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1 "Dr Squier's report of 16 June discusses some IHC  
2 [immunohistochemistry] special stains for looking at  
3 inflammatory cells in the brain, looking for [it is  
4 written down here] CD68+ positive [that's macrophages]  
5 and they are increased in some locations [but that is  
6 a fairly non-specific thing]."  
7 I was much more interested in the T cells, that's  
8 capital T cells, which is the main inflammatory cells in  
9 encephalitis. It was done on two blocks, a bit of pons,  
10 bit of mid-brain, using pan T-marker C3, but only one  
11 slide is commented on. She says and I quote:  
12 "Shows a uniform background colour and little  
13 specific activity. The preparation may have faded."  
14 Now I take it to mean that she didn't re-do the  
15 slides herself; she was looking at someone else's.  
16 Q. Sorry. I am not quite sure where you are --  
17 A. Sorry. I am looking at my -- it is paragraph 0 in my  
18 comment in italics. Next page. Next page. No, no, no.  
19 That's not the one I am reading out. The one I am  
20 reading out from is the one I then sent.  
21 THE CHAIRMAN: The one we have on the screen here,  
22 professor, pages 11 and 12, are you saying that's  
23 an original one which you then added to in this section?  
24 A. Yes, I added about five lines to it, which I know you  
25 have received, because I was thanked for it.

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1 is my corrected bit? I do beg your pardon, sorry.  
2 I will start again. Where are we? That's the final  
3 version.  
4 Q. For everybody else, it is at 239-002-011.  
5 A. Sorry.  
6 Q. If you don't have a paginated copy, it is your  
7 paragraph 0?  
8 MR LAVERY: If I heard Professor Lucas correctly, this was  
9 put back to him in order to allow him to rewrite his  
10 report. Does that mean there was a previous report we  
11 have not seen?  
12 THE CHAIRMAN: I will get you whatever there was. There was  
13 an initial response which we asked the witness to  
14 develop.  
15 A. Of which this bit is the only bit I changed. It is just  
16 a little section on how much encephalitis was there.  
17 MR LAVERY: I think that's something certainly we would like  
18 to see, Mr Chairman, if that could be made available.  
19 THE CHAIRMAN: I understand.  
20 A. I can tell you what it said. The first version said  
21 there is no encephalitis, period. I was then invited to  
22 review in detail Dr Squier's second or third commentary  
23 and I then made my paragraph a little longer, which  
24 was -- I have actually quoted her here, so I can just  
25 read her out:

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1 THE CHAIRMAN: I tell you what. Can we go on with the rest  
2 of the professor's evidence and we will then track this  
3 one change and, before the professor finishes, we will  
4 give you a chance to see it and ask any questions you  
5 want.  
6 A. It is there.  
7 MS ANYADIKE-DANES: Can we look at the final version as it  
8 is now up on the screen?  
9 A. Okay.  
10 Q. Just for clarity it starts:  
11 "I tread carefully here. I have not seen the brain  
12 histology slides, but am aware of the differing opinions  
13 of the Northern Ireland pathologists and the external  
14 referees, Doctors Squier and Harding. In brief, from  
15 the histology descriptions and the photographs supplied,  
16 it does not look like meningoencephalitis to me. I am  
17 a little surprised that no-one, even in retrospect, has  
18 performed specific immunohistochemical slides on the  
19 tissue slides to determine for sure the presence or  
20 absence of inflammatory T-cells or reactive astrocytes  
21 and microglia. In my book, infiltrating CD8+ T cells  
22 are necessary to diagnose encephalitis in most cases.  
23 They are there in the brain, or they are not. If they  
24 are not, then it is not encephalitis."  
25 A. Essentially, the only difference is that I have put

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1 a bit in between that saying: Wendy Squier did refer to  
2 that and it doesn't make a convincing case for  
3 encephalitis, which she said. All I am doing there is  
4 reinforcing that rather more scientifically.  
5 Q. In other words, you are agreeing with her and  
6 Professor Harding on that issue?  
7 A. Oh, yes, absolutely.  
8 THE CHAIRMAN: This came about because, at the end of the  
9 page on screen, the end of the left page, it says:  
10 "I am a little surprised that no-one had performed  
11 stains."  
12 In fact, those had then been --  
13 A. But only a limited amount, actually. I then make the  
14 point that if you were going to do it properly, you  
15 could have done a bit more.  
16 THE CHAIRMAN: Okay.  
17 A. But in the end, the end result would be the same: there  
18 is no encephalitis.  
19 MS ANYADIKE-DANES: I think Professor Harding's point was he  
20 was not going to apply any more stains because there  
21 wasn't anything on what he saw. There we are. There are  
22 the three degrees of it: there is Professor Harding at  
23 one end of the extreme, Dr Squier in the middle, and you  
24 at the other. You were of the view there was no  
25 credible evidence of encephalitis.

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1 A. I would have done it. I would have done the whole thing  
2 slightly differently. What happened in this autopsy is  
3 the brain is removed and externally described. It is  
4 then fixed for a period of time and then subsequently is  
5 sliced. Samples are taken and looked at down the  
6 microscope, and that was all. That's fine except that  
7 if -- I would have thought, even in 1996, as a personal  
8 view, that if there was a query of a viral encephalitis  
9 going on, one would actually keep a sample of fresh  
10 tissue, not in the bucket of formalin, the fixative, but  
11 sent it to virology saying, "Look for it".  
12 Q. I think they did take a sample and a query was raised as  
13 to -- at least I asked that very question, whether  
14 having taken it, they could have done -- sent that off  
15 and seen whether they grew anything, using the  
16 layperson's expression. The answer to that from both,  
17 I believe, Dr Herron and Dr Mirakhor is that there  
18 actually was some brain tissue in the cerebral spinal  
19 fluid and that didn't produce anything.  
20 A. That's right. They looked at the fluid, which is  
21 another way -- it is a surrogate marker of the brain.  
22 It surrounds the brain. It is produced by the brain and  
23 that apparently, using the tests available in 1996,  
24 which is very different from what it is 16 years  
25 later --

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1 A. From what I am able to read, yes. As I say, I haven't  
2 seen the slides myself.  
3 Q. And from the photographs of the slides?  
4 A. And the slides, correct.  
5 Q. Thank you. If we just expand on that, though, if you  
6 are being asked to address a query as the pathologists  
7 were, there were four clinical problems that had been  
8 identified in the autopsy request form: the first was  
9 cerebral oedema, the second was status epilepticus, the  
10 third was SIADH, essentially, and the fourth was a query  
11 of viral encephalitis.  
12 A. Yes.  
13 Q. So the pathologists responded to that by saying, in  
14 relation to the second, status epilepticus, there was  
15 nothing they could really do unless things had got to  
16 such a stage that you saw the footprint of this in some  
17 way on pathology. The third one, on a metabolic cause,  
18 there was nothing they were going to be able to do to  
19 assist with that and I think they refer to that in the  
20 commentary of their autopsy report. The fourth was  
21 something they could assist with. That was a query as  
22 to whether it was there and they could certainly assist  
23 with that. Am I understanding you correctly that if you  
24 were receiving a query of that sort, then you do more  
25 extensive staining?

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1 Q. Yes?  
2 A. -- found nothing. I saw that, but they didn't take any  
3 brain tissue.  
4 Q. Sorry to correct you there. His answer was there was  
5 inadvertently some brain tissue in the cerebral spinal  
6 fluid and therefore he was content that they had  
7 addressed the question --  
8 A. Okay.  
9 Q. -- of whether that could have cultured anything or  
10 produced anything.  
11 A. And the answer was the whole thing was negative --  
12 Q. Yes.  
13 A. -- because there was no viral encephalitis.  
14 Q. Yes. So in terms of what else you think they might have  
15 done if they were faced as they were, with this query  
16 over a viral encephalitis. So they could have taken  
17 a fresh sample. Well that, hasn't achieved anything.  
18 What else do you say -- you say you would have done it  
19 slightly differently.  
20 A. That's what I meant. I would have kept a bigger chunk  
21 of tissue as a routine procedure, put it in the  
22 freezer -- what one actually does is put it in the  
23 freezer and await the histology to tell you what to do  
24 next. It comes as a sequential process, otherwise you  
25 are bombarding laboratories with vast amounts of tests

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1 which are unnecessary.  
2 Q. Can I ask you then about the stains? Are you saying  
3 that they should have applied different stains?  
4 A. Well, in Belfast in 1996, they could most certainly have  
5 done the immunohistochemistry stains for T cells and  
6 other cells themselves on the spot.  
7 Q. Yes. Their view, if I put it to you, is they didn't do  
8 that because they found the low-grade sub-acute  
9 encephalitis. So once they had got that, there was not  
10 any need to find anything more. They had found enough.  
11 A. Yes.  
12 Q. Sorry. I am summarising.  
13 A. You are summarising very well indeed. The problem is  
14 "low-grade". When you get to a low grade, you are then  
15 hitting against the buffers: is it there at all? In  
16 pathology terminology, "low grade" is often used for  
17 "mild" and "I am not quite sure if it is really there or  
18 not". If you mean -- if you say "severe", there is no  
19 misunderstanding that you mean something is certainly  
20 there.  
21 Q. So then if you were being particular about it, because  
22 you are now dealing with probably the one thing that you  
23 could make some contribution to the clinical problems,  
24 if I can put it that way --  
25 A. Yes.

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1 clarified matters for them?  
2 A. Yes, it would have eliminated encephalitis completely at  
3 that point.  
4 Q. It doesn't go towards the cause of death at all, but the  
5 other thing they picked up from the autopsy report and,  
6 certainly, it is what Dr Steen was hoping that they  
7 would, which is if there was any explanation, on  
8 pathology, at all as to Claire's learning difficulties.  
9 A. Yes.  
10 Q. And they looked at their slides and came to the  
11 conclusion that she had a neuronal migration disorder,  
12 which is not something --  
13 A. This is not an area I want to be questioned about at  
14 all. I don't do that. It's very subtle stuff, but I do  
15 know that Dr Squier, who has probably spent about  
16 40 years looking at that sort of thing, thinks it is not  
17 there. I am stopping.  
18 Q. Thank you very much. Then perhaps if I can cover with  
19 you just a few other areas in your report. The chairman  
20 has made the point that that is one of your main  
21 criticisms, if criticisms is the right expression, and  
22 that is this failure, at whichever stage it happened,  
23 for the pathologist to either perform some  
24 reconciliation themselves, to try to see what they had  
25 seen in pathological terms of the clinical information

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1 Q. -- if you have got it on your standard stains to be low  
2 grade, then is it worthwhile then applying some further  
3 stains to see what you've got or is that sufficient?  
4 A. In my personal view --  
5 Q. Yes.  
6 A. -- it would be advisable to pursue this further to take  
7 confirmatory tests and you might -- I can see the  
8 audience thinking, "Come on, this can't be that  
9 difficult, you can see inflammatory cells". It's not so  
10 easy because lymphocytes look almost the same, nearly,  
11 as oligodendrocytes, which the brain is full off. How  
12 do you tell the difference? I think that is what the  
13 neuropathologists were looking at. They weren't looking  
14 at inflammatory cells, they were looking at some of the  
15 background normal tissue of the brain.  
16 The point about doing special stains is that it  
17 sorts that out instantly. One looks down the microscope  
18 and you know exactly what's there and is not there and  
19 it is cheap.  
20 Q. Once you got to a sort of not terribly conclusive answer  
21 that you have got a low-grade presentation, if I can put  
22 it that way, then it doesn't cost very much or take very  
23 long to see whether you can confirm?  
24 A. No, it costs about £20 and takes one day.  
25 Q. That's the staining point and, in your view, would have

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1 that they had been given or, better yet, to do that in  
2 combination with the clinicians themselves, to see if,  
3 combining their expertise, they could come out with some  
4 better explanation for what actually had happened to  
5 Claire and why. How serious do you regard that as  
6 a deficiency? Is it that there seems to be no evidence  
7 of that having happened?  
8 A. Well, as I've heard today, and as I know from the  
9 papers, there doesn't seem to be evidence that there had  
10 been a meeting about this and yet we know they regularly  
11 had them. This case seemed to have slipped through the  
12 net. It just fell between the stools, whatever metaphor  
13 you want to use, for reasons I imagine are entirely  
14 accidental, because these things happen. Had it come up  
15 for a meeting and, progressively, all the possible  
16 causes are crossed out, you are left with that.  
17 Why didn't -- I mean, you are going to ask me why  
18 didn't the pathologists say outright, "It might be  
19 hyponatraemia causing brain oedema, causing death", and  
20 the answer -- and I don't know whether you have asked  
21 them this -- is they may never have heard of it before  
22 You don't think of things you had never heard of.  
23 Q. I think they thought they had addressed that possibility  
24 by reference to their comment about metabolic causes.  
25 A. That's a bit mealy-mouthed. I have done hyponatraemia

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1 deaths myself. I have been very lucky in the sense that  
2 I was alerted as to what it might well be. So I had  
3 that as background. So my role in those autopsies is to  
4 confirm there is absolutely no other possible cause to  
5 explain why the person died as they died. And you are  
6 therefore left with that as the explanation. You are  
7 given it on a plate, but you still have to do the rest  
8 of the job by pointing out it is not something else. So  
9 if you know about it, it is easier.

10 Q. I think Dr Steen's view -- and she is the person who  
11 drafted the autopsy request form -- her view is that she  
12 had done enough to alert the pathologists to the fact  
13 that that's a possibility and, in any event, she had  
14 provided them with the medical notes and records, which  
15 weren't extensive, which certainly included information  
16 from which they could conclude that. If I am looking at  
17 the autopsy request form where she gets that from, if we  
18 just pull up 090-054-183, and it's under the "History of  
19 present illness", it is the line that starts:

20 "Serum sodium dropped to 121 at 23.30 hours on  
21 22 October. Query inappropriate ADH secretion."  
22 And underneath that:  
23 "Fluids restricted."  
24 Then:  
25 "Respiratory arrest."

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1 fluids",  
2 and then on the second line:  
3 "Query SIADH."  
4 Let's have it there just so that you see. So that's  
5 11.30, and it's at that time that you see the sodium  
6 level of 121 is recorded, and that's the suggestion that  
7 we need to increase --

8 STENOGRAPHER: We have lost the LiveNote feed.

9 MS ANYADIKE-DANES: Oh!

10 THE CHAIRMAN: Sorry?

11 STENOGRAPHER: The LiveNote has crashed.

12 THE CHAIRMAN: That means the transcript isn't coming up on  
13 anybody's screen. Is that right?

14 STENOGRAPHER: Yes.

15 THE CHAIRMAN: Could we pause for a moment or two?

16 MS ANYADIKE-DANES: Sorry.

17 THE CHAIRMAN: Professor, give us five minutes to see if we  
18 can sort this out. Okay?

19 MS ANYADIKE-DANES: Thank you.

20 (4.20 pm)

21 (Short break)

22 (4.24 pm)

23 THE CHAIRMAN: Thank you, Professor.

24 MS ANYADIKE-DANES: So what I had been showing to you --

25 let's pull it up again -- 090-022-056. Thank you. So

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1 So she felt that a combination of that and maybe the  
2 reference on the following page, 184 -- yes? Sorry.

3 MR FORTUNE: There is the reference to seizures and also  
4 "See chart".

5 MS ANYADIKE-DANES: Yes.

6 MR FORTUNE: Bottom left-hand corner.

7 MS ANYADIKE-DANES: Yes. Probably it's the "See chart".

8 The "See chart" is to indicate that this is being  
9 accompanied by Claire's medical notes and records. So  
10 in her view she's highlighted what her serum sodium  
11 level was, the fact it has dropped to that, when it did  
12 in relation to her timings, if I can put it that way,  
13 and that they are already querying "Inappropriate ADH  
14 secretion". So her view is that that's -- the question  
15 of hyponatraemia is something that was sufficient for  
16 the pathologist to glean from that and the medical notes  
17 and records, and if they had looked at the medical notes  
18 and records, which, as I say, aren't particularly  
19 extensive, then what they would have seen is -- I'm not  
20 going to take everybody through it, because we've been  
21 through it so many times, but just for the reference  
22 it's 090-022-056 -- that is the 11.30 reference that is  
23 -- that correlates with what's put there on the chart,  
24 and that has:

25 "Hyponatraemia, query fluid overload and low sodium

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1 what I was putting to you is that Dr Steen was saying  
2 that she had indicated sufficiently on the form enough  
3 for the pathologist to have seen that hyponatraemia was  
4 an issue and that if you matched the fall in the serum  
5 sodium to 121 at 2330 hours on the 22nd and you went to  
6 look in the medical notes and records, this is what you  
7 would have seen: you would have seen that there is  
8 an identification of hyponatraemia, irrespective of the  
9 two ways in which it could have resulted. And then if  
10 you had gone over the page -- can we go over the  
11 page the page to 057? Okay.

12 Then you would see, if you work your way down to the  
13 entry by the paediatric neuropathologist, Dr Webb at  
14 4.40, you can see:

15 "SIADH, hyponatraemia, hyposmolality, cerebral  
16 oedema, coning following prolonged epileptic seizures."

17 So hyponatraemia was there as well. It is also in  
18 other places, which it is unclear would have necessarily  
19 been in the medical notes and records at that time, like  
20 the discharge sheet, but in any event looking just at  
21 the medical notes and records, it is there. So the  
22 point that I was putting to you is that, according to  
23 her, she would say she has identified hyponatraemia for  
24 the pathologist. Is that sufficiently clear as far as  
25 you are concerned?

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1 A. Absolutely.  
2 Q. So then if that is identified there and it is something  
3 that they could and should have picked up, then when  
4 they carry out the autopsy and they reach the view that  
5 they do about the low-grade meningoencephalitis -- and  
6 you say low-grade means "hardly there" --  
7 A. Borderline.  
8 Q. Borderline, certainly not having very much effect, if I  
9 can put it that way.  
10 A. Yes.  
11 Q. Does that mean that you are of the view that the  
12 pathologists should have been raising the issue of  
13 hyponatraemia more explicitly than is covered by  
14 "metabolic causes"?  
15 A. Well, they certainly could have. Should, could.  
16 I mean --  
17 Q. They could have?  
18 A. They could have. That's right.  
19 Q. Would it have been proper for them to have done that in  
20 your view?  
21 A. Yes, but -- sorry, yes, but they also write in the  
22 comment, which I have in front of me:  
23 "... possibility, though a metabolic cause cannot be  
24 excluded."  
25 Obviously, in the back of their mind there is

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1 A. Yes, and then they could have tried to work out why it  
2 happens. Trying to work out why it happens gets more  
3 complicated because one thing pathologists are not good  
4 at is looking at fluid charts and doing the counting.  
5 We are hopeless at that. All of the things I have been  
6 involved in where fluid balance and salt and water and  
7 potassium and sodium balance have been critical, we have  
8 relied on other people to actually go through that and  
9 establish it.  
10 Q. So if you wanted to advance things further, apart from  
11 getting in some specialist yourself, which starts to  
12 take you out of your territory of a pathologist --  
13 A. Yes.  
14 Q. -- your next step is to say, as you said, "Let's talk  
15 about it".  
16 A. That's right.  
17 Q. Now you have --  
18 A. Which is what apparently, in all other cases where  
19 a child dies and they have meetings, they do. The  
20 interesting thing is: why didn't it happen in this case.  
21 Q. Well, in fairness the -- what the pathologists would say  
22 is although they can't specifically remember it  
23 happening, it is what they believe did happen and the  
24 source of that belief is because, firstly, if one sees  
25 on the daybook, if I can put it that way, there is

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1 something there. That's when you go back to your  
2 clinical colleagues and say: right, this is where we are  
3 so far, let's talk about it.  
4 Q. Yes. A point I am asked to raise is: in your view,  
5 could they have got -- to the exclusion of other  
6 relevant factors, and therefore what we are really  
7 talking about is hyponatraemia before they went to talk  
8 to their clinical colleagues?  
9 A. I think they could have, just by applying pure  
10 pathology, they could in my view -- probably should --  
11 have excluded encephalitis because it isn't there.  
12 Q. Yes.  
13 A. There is no pathological indicator of recent death from  
14 status epilepticus, fitting or otherwise. So you can't  
15 really say anything about that. The business about  
16 SIADH, of which there are great long lists of causes as  
17 we know, but the one most people were thinking about is  
18 encephalitis, which isn't there, so that is cut out. So  
19 you really left actually with thinking about: it is  
20 something to do with the biochemistry in life.  
21 Q. Yes. So they could have actually spelt out  
22 hyponatraemia?  
23 A. Yes.  
24 Q. But in any event, even if they didn't spell it out, they  
25 could have got into the territory of it?

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1 an entry which specifically identifies the fact that two  
2 further blocks were being prepared for Dr Mirakhur and  
3 she wanted those because that was going to be part and  
4 parcel, as I understand it, of her presentation.  
5 A. Okay.  
6 Q. She also prepared 35 mm slides. You have seen the  
7 photographs of those. Those are the photographs from  
8 her slides. She was preparing those for a presentation.  
9 So that's the evidence.  
10 A. Yes.  
11 Q. And then the assumption comes from: because that's we  
12 would do.  
13 A. Just one tiny caveat: you can prepare for a meeting and  
14 it still might not happen. I mean, that's happened for  
15 me many sometimes. You get ready for what we call  
16 a CPC, clinicopathological conference and for some  
17 reason it is pulled. You say, "Let's do it next week or  
18 next month or whatever", and it doesn't always quite  
19 happen.  
20 Q. So far as you are concerned, given the stage at which  
21 they had reached, how important was it to have one?  
22 A. Well, important, because from the autopsy report they  
23 tend to be favouring meningoencephalitis, but it is very  
24 mild and then they raise other issues. The case is  
25 simply not resolved and that's why it matters, because

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1 this comment ends with a big question mark.  
2 Q. Yes. So I think --  
3 A. When you stand back and look at it, it is just a big  
4 question mark there, is it not? In further evidence,  
5 Dr Herron, in one of his later submissions, says:  
6 "We don't make diagnoses in consented autopsy  
7 cases."  
8 That's a slightly contentious point, but I can see  
9 what he is getting at: we make comments and we make  
10 observations so that we can discuss them with the  
11 colleagues who asked for the autopsy in the first place.  
12 Q. So in your view, that is exactly what should have  
13 happened, not just because it is good practice to do it,  
14 but because in this case matters were left hanging.  
15 A. Precisely. The autopsy only got going because doctors  
16 asked for it. You don't close the circle until you go  
17 back to the doctors to close it, to discuss it.  
18 Q. Yes. I think I have put that as that's perhaps your  
19 greatest concern in terms of what happened --  
20 A. Yes.  
21 Q. -- that process.  
22 A. Just personally, just from the observation of what I  
23 have seen, had there been a sensible -- a conversation  
24 between the relevant parties who knew about the case  
25 with the notes in front of them and all the information,

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1 dried, it may be that just posting a copy of the report  
2 is all that's required. But when there are questions  
3 left hanging in the air, as this case would prima facie  
4 seem to be, then you must have a conversation.  
5 Q. So if you are going to write to the parents as they  
6 wanted to know, not surprisingly, what was the result  
7 from the autopsy, you are going to have to have the kind  
8 of meeting that you are that you talking about --  
9 A. Yes.  
10 Q. -- so you can pull it together and form a view that can  
11 then be communicated and explained to the parents?  
12 A. Yes.  
13 Q. Is that -- one of things that I had put to Dr Steen  
14 earlier this morning is a comment that you made when  
15 they did write. She wrote to the GP. Dr Webb wrote to  
16 the parents. I think the comment from your report is  
17 they had rather over-interpreted, if I can put it that  
18 way, the commentary section of the autopsy report. Is  
19 that what you are driving at, that you thought they had  
20 got too much out of that?  
21 A. Yes.  
22 Q. Or at least more than they should in the absence of  
23 having discussed matters with the pathologists?  
24 A. I think so, yes. I think they made it more  
25 straightforward than the pathologists intended from

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1 the answer would have fallen out as being pretty  
2 obvious, because other things have been excluded.  
3 Q. And if what was dependent on all of that is not just so  
4 that you understand what happened to this child and how  
5 and why this child died. Because it's consent, one of  
6 the things you're doing is so that you can then  
7 communicate to the child's parents as to what happened.  
8 So do I take it from what you say that you couldn't have  
9 been giving a satisfactory explanation to Claire's  
10 parents as to what had happened without having had some  
11 kind of meeting where the clinicians would have brought  
12 their understanding of what happened during her life, if  
13 you like, and the pathologist brought their findings on  
14 autopsy?  
15 A. Yes. That is correct. In this case, where it's  
16 difficult -- some consent... -- I do quite a lot of  
17 consented autopsies, sometimes at the request of  
18 families who are not happy with what went on in  
19 a hospital or a GP's surgery. This is called a private  
20 autopsy. Answers are either startlingly different from  
21 what the death certificate said or exactly congruent  
22 with it. The amount of conversation you have  
23 afterwards, after the autopsy has happened, rather  
24 depends on where you are in terms of trying to work out  
25 the clinical scenarios. If it is all pretty cut and

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1 their comment at the end of the autopsy report.  
2 Q. And if that -- if the view that the pathologists had  
3 reached was where you had got to, had you been  
4 conducting it -- and I understand you wouldn't have,  
5 because you would have discounted and eliminated even  
6 the low grade, but leaving that aside, say you had  
7 formed the view that it was that, then how do you  
8 think -- or at least what do you think ought to have  
9 been explained to the parents?  
10 A. Well, the sensible thing is to have a conversation with  
11 the clinicians first.  
12 Q. Yes.  
13 A. I mean, this does come up quite often, "What are we  
14 going to tell the parents?", and I say, "Hang on. Let's  
15 sort this out, otherwise it is going to look silly".  
16 You arrange a meeting. It may be in a corridor or it  
17 may be a proper formal meeting with 35 mm slides or  
18 Powerpoints or whatever, but there needs to be some  
19 discussion so that the clear answer and correct  
20 answer -- as correct as one can make it -- is issued.  
21 Q. Yes.  
22 A. Because, after all, the autopsies only happened because  
23 the parents very kindly said yes when asked.  
24 Q. So the view that the parents have been left with and  
25 were left with until 2004 was what was the trigger of

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1 their daughter's demise, if I can put this that way, was  
2 something viral.  
3 A. Yes. That is right. That persisted through for the  
4 next two years, didn't it, until the inquest, because  
5 that's what comes out from there too?  
6 THE CHAIRMAN: Nine years, I am afraid, from 1997 until 2006  
7 when the --  
8 A. Sorry. I beg your pardon. Two years after 2004 is what  
9 I meant actually. Nine years.  
10 MS ANYADIKE-DANES: And from what you have seen, that was  
11 incorrect -- or at least there was not sufficient  
12 evidence to justify that.  
13 A. A lot this must have been gone over during the inquest.  
14 I don't know how long it went on for and I haven't seen  
15 the transcript. It would appear that Dr Herron did the  
16 talking from the witness box as pathologist. That's  
17 right, even though he then said, "Actually, it wasn't  
18 really my diagnosis in the first place". I know about  
19 that. That was what came out. So nine years after the  
20 event, he must have been reasonably happy with that to  
21 be able to say on oath from the witness box, "On balance  
22 of probability, this is what it is all about", otherwise  
23 the coroner would have picked him up.  
24 Q. And are you saying from the pictures that you have seen  
25 of the slides and other material --

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1 in microbiology, he has a different view to that. In  
2 his view, he thinks it is quite possible she had  
3 an encephalitis and, for various reasons, that had not  
4 yet manifested itself in a way that could be identified  
5 at autopsy; can you assist with that?  
6 A. Well, I was pointed to this, because he only gave  
7 evidence about a month ago. I was sent the transcript  
8 and I read through it and I know Keith Cartwright quite  
9 well as well, but I haven't spoken to him about this at  
10 all. I read through it and all I can say is I know why  
11 he is saying what he said because the numbers would  
12 appear that although, as he explained at great length,  
13 the numbers are very peculiar and we don't need to go  
14 into that again. I would simply discount all that CSF  
15 stuff because it does not fit with the brain morphology.  
16 In this sort of situation, the brain morphology trumps  
17 all other ways of investigating it.  
18 Q. So if you are looking for the strongest evidence, that's  
19 the brain morphology?  
20 A. Precisely. This may cause some dismay among laboratory  
21 clinicians, but I can assure you that this is by no  
22 means unique. All tests are unique, even morphology.  
23 Here we have something consistent that there is little  
24 or no encephalitis. The CFS indicates there is a lot of  
25 it. That's just wrong because there isn't. What happens

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1 MR LAVERY: Dr Herron certainly, at the inquest, did not  
2 make a diagnosis because it wasn't for him to make  
3 a diagnosis.  
4 A. It is possible then the coroner, faced with confusion  
5 all round, took the best he could.  
6 MR LAVERY: Secondly, there was no issue on anything being  
7 decided on balance of probabilities at the coroner's  
8 inquest. I am not sure where Professor Lucas is  
9 getting --  
10 THE CHAIRMAN: There is a multiple finding at the coroner's  
11 inquest, isn't there?  
12 A. But it does put meningoencephalitis first.  
13 THE CHAIRMAN: But in a sense, when you put down multiple  
14 findings in Claire's case, looking it now, professor, it  
15 seems that was because there hadn't been the necessary  
16 discussions to rule out the things that should have been  
17 ruled out.  
18 A. That is one very reasonable interpretation, yes.  
19 MS ANYADIKE-DANES: Can I just put one point, lest I omit  
20 it, which would be incorrect: you, to a certain extent,  
21 have agreed with the evidence of Professor Harding and  
22 Dr Squier about the absence of any real evidence that  
23 there was encephalitis.  
24 A. Yes.  
25 Q. Now Professor Cartwright, who was the inquiry's expert

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1 is one doesn't know why the numbers came out the way  
2 they did, but this happens all the time. We interpret  
3 tests in the knowledge of the total context of the case  
4 and, if something doesn't fit and everything else points  
5 in some other direction and is more consistent, then I  
6 am afraid the aberrant lab test goes out and you  
7 discount it as an error for some reason.  
8 Q. Are there reasons in your experience for why the CSF  
9 sometimes doesn't fit?  
10 A. Yes. I mean, there are lots of reasons. I mean, the  
11 specimens could be the wrong specimen; it could be  
12 someone else's. One hopes that's not the case, but it  
13 does happen. One in 10,000 specimens is going to be the  
14 wrong one by definition. That's why we do two HIV tests  
15 for everyone so the chance of that happening is  
16 essentially zero. There is a very good reason for that.  
17 It may be the person who counted the lymphocytes was  
18 having a bad day. I am not going to speculate.  
19 I simply don't know. It is simply the CFS results were  
20 not matching the brain morphology and the brain  
21 morphology, in this case wins.  
22 Q. In your experience, sometimes the CFS result cannot  
23 be relied on?  
24 A. Yes, and other things as well.  
25 THE CHAIRMAN: You say all tests are fallible.

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1 A. All tests.  
2 THE CHAIRMAN: So if you have one test result which is out  
3 of context in the case and out of context with the other  
4 results, you can just discount it?  
5 A. You should think about it very carefully before  
6 accepting that it means very much and not necessarily  
7 put very much weight on it.  
8 THE CHAIRMAN: Thank you.  
9 MS ANYADIKE-DANES: There were some other points that were  
10 raised with you really in relation to the report itself.  
11 There is an issue, as you know, about the report not  
12 being signed, leaving aside that, there is an issue as  
13 to attribution. The report shows on its face Dr Herron,  
14 which is, I suspect, one of the reasons why, all those  
15 years afterwards, he assumed it was his report. In your  
16 expert report to the inquiry, you put it slightly  
17 differently. You said that usually the consultant's  
18 name is there and you're trying to, if you are being  
19 fair to your registrar, who has actually done some of  
20 that work -- maybe even much of the work -- you would  
21 hope that the consultant would include the registrar's  
22 name. Could I take it that you are indicating the  
23 registrar's name should always be on the report?  
24 A. Yes. That's right. They would normally write it in  
25 themselves, "as is done by them with Dr X", or something

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1 A. Right.  
2 Q. -- and then he had produced a pie diagram --  
3 A. Oh, yes. I did see that, yes.  
4 Q. -- which I don't have quite at my fingertips at the  
5 moment. In any event he said quite a lot of that was  
6 the lab time taken with getting the blocks, producing  
7 the specimens and so on and so forth. Their time in  
8 actually looking at the slides and carrying out -- and  
9 writing up their report was in the scheme of things  
10 quite short. So he wasn't saying that it had taken them  
11 three months to fix the brain, but what he does say is  
12 they were, you know, a busy unit and the lab technicians  
13 take some time to doing this kind of work?  
14 A. Yes. I mean, fair point, and it still actually pertains  
15 in many neuropath labs. They were traditionally and are  
16 still very slow.  
17 Q. Your point, though, was to go on to say, and I think  
18 this was recognised by Dr Herron, that part of the  
19 difficulty about that is if you wait so long for  
20 whatever good reason before you can get into your  
21 clinicopathological correlation, then the clinicians may  
22 have moved on to other things and the precise details of  
23 it all may not be to the forefront of their mind --  
24 A. Yes.  
25 Q. -- and that rather hinders that correlation process that

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1 like that.  
2 Q. Then your other points that you make are -- well, the  
3 first which you have explained, the lack of  
4 clinicopathological correlation after the autopsy and  
5 histopathology. You have explained that and why you  
6 thought that was significant. Then you say that if one  
7 is looking purely from the point of view of what would  
8 be necessary to comply with the guidelines, you have  
9 a point in terms of timeliness.  
10 A. Yes.  
11 Q. Can you explain that?  
12 A. This is right at the end, isn't it?  
13 Q. Yes, it is. In fact, I can give you the reference. If  
14 you are looking at a paginated version, it is  
15 239-002-014.  
16 A. Yes. Got it. This relates to the guidelines of autopsy  
17 reports published by the college in 1993. I didn't go  
18 through it block by block, but obviously this is a long  
19 delay after the event, partly relating to fixing the  
20 brain for three months rather than just three for four  
21 weeks, which was meant to be standard at that time.  
22 Q. Well, Dr Herron gave evidence on that. It wasn't that  
23 the brain was being fixed for that length of time. What  
24 he said was that there is a four weeks-or-so period of  
25 time for fixing the brain --

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1 you think is so important?  
2 A. It does, and also some of the staff move on as well, you  
3 know. They are not there in the hospital any more. You  
4 may remember the case.  
5 Q. But if you -- sorry.  
6 A. I just say. That may not pertain here, but that is a  
7 risk of holding things over for so long, that the people  
8 with memory aren't there any more.  
9 Q. Yes, but you've always got your medical notes and  
10 records?  
11 A. You've got the records. That's right.  
12 Q. So the timeliness point in fairness may not be a big one  
13 or at least there may be good reasons for why it  
14 happens. I think Dr Squier's evidence was --  
15 THE CHAIRMAN: I understand why that happened. I understand  
16 things are slow. I think in Claire's case it may have  
17 had a detrimental effect.  
18 A. Yes.  
19 MS ANYADIKE-DANES: If then -- maybe then you should address  
20 that. Are you able to assist with if there is any kind  
21 of time within which you would be wanting to have your  
22 correlation, if I can call it that way, discussion with  
23 the clinicians?  
24 A. Ideally just one says as soon as possible.  
25 THE CHAIRMAN: The sooner, the better, isn't it?

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1 A. The sooner, the better. There's no absolute limit to  
2 this at all.  
3 MS ANYADIKE-DANES: Is there any reason why even before you  
4 issued your final report why you couldn't be having that  
5 discussion then and there?  
6 A. Yes, that's right. If you just think in medicolegal  
7 cases, where, for example, you know there is going to be  
8 an inquest, and you also know the inquest actually is  
9 not until next July, because for some reason you know  
10 that, you may not be in a terrible push to finish the  
11 case, because there is no great need. No-one is going  
12 to look at it until May at the earliest, for example.  
13 So that's just an example of in a sense why one plans --  
14 how one plans work. One plans it on a question of what  
15 matters, but for some reason this got sort of shifted  
16 three months, by which time it just seemed to have  
17 slightly dropped off the radar.  
18 Q. Yes. Thank you. Then I think really those are your  
19 three points. The timeliness point. The lack of  
20 commentary, well, maybe that's a separate point. Your  
21 third point about the:  
22 "No mention of a clinicopathological or audit  
23 meeting in a complex case",  
24 that's the meeting with the other clinicians?  
25 A. Yes.

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1 A. Not really, no, it isn't. It needs a bit more. The  
2 point is this is done on a word processor. So there is  
3 no great harm and problem going back after a meeting and  
4 adding another paragraph. "Case discussed on  
5 12th January. This is what happened." That's what we'd  
6 do anyway.  
7 THE CHAIRMAN: But from what you're saying the reason why it  
8 is unhelpful is that it is too vague. It is "low grade"  
9 this and "a possibility of a metabolic cause cannot be  
10 entirely excluded".  
11 A. You can look at this paragraph in many ways. I would  
12 look at it as a plea from the pathologists saying,  
13 "Please, doctors, come and tell us what you think is  
14 happening so we can provide a satisfactory conclusion".  
15 This reads to me like a plea for further help.  
16 MS ANYADIKE-DANES: So that kind of wording, just to pick up  
17 from the Chairman:  
18 "The reaction in the meninges and cortex is  
19 suggestive of ...",  
20 that sort of wording, which I think you might have  
21 referred to as rather mealy-mouthed earlier --  
22 A. Yes.  
23 Q. -- that's because -- is that -- is your interpretation  
24 of that because they actually can't be more definitive  
25 than that?

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1 Q. But do I understand your second bullet point to mean  
2 that there is supposed to be a reconciliation or  
3 an attempt at it in the autopsy report itself?  
4 A. In a consented autopsy there should be.  
5 Q. There should be?  
6 A. Not necessarily in a coronial one, because that's  
7 slightly different again.  
8 Q. Yes.  
9 A. Yes, there should, because, as I say, the relatives have  
10 been asked. They have agreed to an autopsy. It has  
11 been done. The system expects that everything is  
12 reconciled, and if the case is -- if the case is  
13 soluble, and I have to say that not all cases are  
14 soluble, but I think this one was, then there is a final  
15 commentary saying, "This is how it is. This is how it  
16 adds up. This is what happened".  
17 Q. Well, if we look at -- because the pathologists in this  
18 case believe that that's what they had done --  
19 090-003-005 -- insofar as they could.  
20 A. Insofar as they could at that stage. That's right.  
21 Q. Let's have a look at it.  
22 A. Yes. I've got that in front of me as well.  
23 Q. Now in terms of what they knew and had found out and  
24 what was in the medical notes to assist, is that  
25 a sufficient attempt to reconcile at that stage?

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1 A. At that stage.  
2 Q. At that stage, yes.  
3 A. They need help. I mean, again just to reiterate the  
4 point that the concept of possibly hyponatraemia  
5 producing this pathology, it doesn't -- it hasn't struck  
6 them as being a serious runner, but it is there in the  
7 background. Again I just reiterate I suspect that's  
8 simply because they hadn't heard of it. It's not all  
9 pathologists have. Most pathologists when they come  
10 across hyponatraemia learn it the hard way for the first  
11 time, as they did.  
12 Q. Well, it's --  
13 A. It's not part of medical student training. It's not  
14 something -- I mean, I do lots of autopsy lectures to  
15 trainees across England, across the breadth of the land.  
16 I don't think I've ever particularly mentioned it  
17 myself. It's not something that, "These are the ten  
18 things you have to know if you're going to be an  
19 autopsy pathologist. Make sure you know about  
20 hyponatraemia". It's not like that. It's actually  
21 fairly obscure. I know you won't think it, having been  
22 in an inquiry for many months, if not years, but I can  
23 tell you on the path... -- I spoke to a couple of  
24 friends who are pathologists the other day, saying,  
25 "Tell me about your experience of hyponatraemia. When

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1 did you learn about it and when did you first see  
2 a case?" There was much scratching of heads as to quite  
3 when they'd heard of it, but they admitted they probably  
4 had seen one case in their professional lives over tens  
5 of thousands of autopsies. This is not a common  
6 condition. So it's not like big things at the front of  
7 your mind when you're looking at obscure cases.  
8 THE CHAIRMAN: Thank you.  
9 MS ANYADIKE-DANES: Then just finally --  
10 THE CHAIRMAN: Mr Fortune?  
11 MR FORTUNE: Could we ask Professor Lucas to scratch his  
12 head a little bit more? Given the paragraph under the  
13 heading "Comment" --  
14 A. Right in front?  
15 Q. Yes. No. In fact, it is the end paragraph. Would he  
16 like to --  
17 THE CHAIRMAN: It's on the screen, professor, in front of  
18 you. It's on the screen.  
19 A. Oh, sorry. That one. Yes, yes.  
20 MR FORTUNE: Would he like to assist you, sir, in how he  
21 would have interpreted the paragraph if he had been the  
22 clinician writing to the general practitioner? We know  
23 that Professor Lucas has said that Dr Steen has  
24 over-interpreted the contents of that paragraph, but it  
25 is not an easy paragraph, is it, to put into words for

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1 general and not very specific conclusion in the  
2 "Comment" section.  
3 MR FORTUNE: And this leads into one of the difficulties  
4 that I suspect has appeared in the minds of those of us  
5 at the Bar and perhaps yourself as to whether these are  
6 matters that are still clinical but running into  
7 governance or governance running back into clinical,  
8 because the difficulty is there is such an overlap.  
9 THE CHAIRMAN: Yes. Up to a point, but when you are  
10 offering -- when the parents agree, as Professor Lucas  
11 has emphasised this afternoon, when the parents are kind  
12 enough to agree to an autopsy in any form, what they are  
13 entitled to expect is that it will lead to the best  
14 possible and clearest possible explanation to them of  
15 what happened their daughter --  
16 MR FORTUNE: Nobody is disputing that.  
17 THE CHAIRMAN: -- and they didn't get it.  
18 MR FORTUNE: Nobody is disputing that.  
19 MS ANYADIKE-DANES: Just one final point from me to you,  
20 professor, and that is that at that same part of your  
21 report, 239-002-014, you say not only was there no  
22 mention of clinicopathological correlation. You also  
23 say "or audit". Now audit is one of the things that the  
24 guidelines say you should do. Can you help us with  
25 that? What exactly do you mean that there should been

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1 a general practitioner?  
2 A. I think that is very well put. It isn't.  
3 THE CHAIRMAN: It is exactly why -- it is exactly why the  
4 clinician needs to speak to the pathologist.  
5 A. Yes. I read this as an invitation to the clinicians who  
6 asked for the autopsy to have a general discussion about  
7 this case.  
8 THE CHAIRMAN: And this also leads me away, Mr Fortune, from  
9 thinking there was ever an audit. The evidence of the  
10 audit -- the evidence of an audit is disappearing into  
11 -- even further.  
12 MR FORTUNE: We know, sir, that there is no evidence of any  
13 telephone conversation or meeting between the  
14 pathologists and the clinicians.  
15 THE CHAIRMAN: But I'm not even looking for a paper trail of  
16 discussions and so on. The things which people did and  
17 the things which people wrote in letters to the GP and  
18 the parents are all consistent with the clinicians and  
19 the pathologists not having sat down together and worked  
20 it out.  
21 MR FORTUNE: Yes, and one of the difficulties --  
22 THE CHAIRMAN: That's why you end up with  
23 an over-interpretation and why Dr Webb is praised up to  
24 a point for his letter being closer to the mark than  
25 Dr Steen's when they are both working from the same very

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1 in relation to an audit?  
2 A. Audit to me in this context means having a meeting with  
3 clinicians and discussing the case.  
4 Q. Ah! Okay.  
5 A. That's all, and reflecting on what one learns from it,  
6 which might possibly change future practice.  
7 Q. Yes. Not audit in the sense of how quickly they came  
8 back and their response time and all that sort of thing?  
9 A. No, no, no, no, no. Audit is in terms of the answer,  
10 the diagnostic answer.  
11 Q. I understand. You had raised with me an issue to do  
12 with quite how often clinicians get these things wrong  
13 or make errors in terms of the cause of death.  
14 A. Yes.  
15 Q. I don't know if you raised that with me because you  
16 want -- there was something in this case that you wanted  
17 to draw the Chairman's attention to.  
18 A. Well, in the con... -- if I -- in the context of -- the  
19 question that has been raised many, many times is why  
20 this wasn't a coronial case.  
21 Q. Yes.  
22 A. Why it was a consented autopsy. Just to make sure we  
23 are all absolutely clear, I am pretty sure the law in  
24 Northern Ireland is no different then than it was in  
25 England. You do a consented autopsy or you ask for

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1 a consented autopsy when there is a cause of death that  
2 is natural and accepted by the registrar of births and  
3 deaths. You can't do it otherwise. Otherwise I think  
4 you are breaking some law/guidelines, whatever. Ergo --  
5 and the point I also made to you earlier is that, you  
6 know, when a death happens, there is only two things  
7 that can occur, assuming it is not a murder or something  
8 ghastly like that. Either doctors write a death  
9 certificate, which has to be a natural cause of death,  
10 or the case goes to a coroner. It's two sides of  
11 a coin. In 1996 about 35, 40% of all deaths were  
12 reported to the coroner, which meant that 65% weren't.  
13 We know from many audits and many studies on the  
14 variability of doctors writing death certificates that  
15 are accurate, and I am sure that has come up in this  
16 inquiry before, and you also know I assume about how  
17 variable are coroners in interpreting precisely the same  
18 sort of guidelines as to what is a natural and what is  
19 not a natural cause of death, and I produced as  
20 a reference a paper which you again saw this morning  
21 showing that all coroners completely differ among  
22 themselves. That's an interesting point.  
23 Therefore -- I suppose what I'm really getting to  
24 say is although the natural cause of death that was  
25 written down here, status epilepticus, is a natural

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1 referred to the coroner, but I don't believe they did.  
2 MS ANYADIKE-DANES: No. I think the Chairman's point in  
3 fairness was how confident could they be on the evidence  
4 that they had that it actually was status epilepticus,  
5 whether or not triggered by encephalitis.  
6 A. They were confident enough, but just as a matter of  
7 recorded research and anecdotal observation, if you do a  
8 lot of consented autopsies, you will be contradicting  
9 the cause of death in at least 50% of cases and quite  
10 significantly so. That is how medicine is. This is not  
11 a surprise to me.  
12 THE CHAIRMAN: Thank you very much.  
13 MS ANYADIKE-DANES: Thank you.  
14 Mr Chairman, I don't have anything further.  
15 THE CHAIRMAN: Okay.  
16 MS ANYADIKE-DANES: I don't know whether --  
17 THE CHAIRMAN: Any questions from the floor? Mr Lavery?  
18 No.  
19 Professor, thank you very much indeed. Thank you  
20 for your time and your contribution. I think there is  
21 a car arriving for you in a few minutes. Okay?  
22 A. Thank you.  
23 (Witness withdrew)  
24 DISCUSSION OF HOUSEKEEPING MATTERS.  
25 THE CHAIRMAN: Ladies and gentlemen, just before we finish

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1 cause of death -- it is not forensic or anything like  
2 that. It is not suspicious under normal circumstances.  
3 The fact that it's wrong is in a sense neither here nor  
4 there. It's what they thought at the time. Remember  
5 the stringency for writing a cause of death certificate  
6 is to the best of your knowledge and belief. That's  
7 what is said in the 1953 Act and that still pertains and  
8 it certainly pertained in 1996: to the best of your  
9 knowledge and belief.  
10 THE CHAIRMAN: I think the question, professor, here is with  
11 what confidence that that cause of death could have been  
12 identified on the day that Claire died in order to  
13 decide not to refer Claire's case to the coroner?  
14 A. Okay. Well, I hope I've got it right, but, I mean, as  
15 far as I can understand at the time she died they  
16 thought she died either of status epilepticus or  
17 possibly with an encephalitis. Both of these are  
18 natural causes.  
19 Q. Yes.  
20 A. They are not nec... -- they are not by definition  
21 referable. Had they said "Oh, gosh!" -- I mean, I'm  
22 putting it very crudely, but I don't intend to. Had  
23 they said, "Ah, I wonder if this possibly relates to  
24 dilution of the blood causing hyponatraemia", then if  
25 they had thought that for a moment, then this has to be

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1 and as Professor Lucas is leaving, Mr Sephton, have you  
2 any word from Dr Webb?  
3 MR SEPHTON: I understand that a letter was sent this  
4 morning. Certainly I --  
5 THE CHAIRMAN: To the Inquiry?  
6 MR SEPHTON: To the Inquiry, yes.  
7 THE CHAIRMAN: Oh, right. Well, if there is, I will be able  
8 to pick it up when we go back. I haven't heard about  
9 that.  
10 MR SEPHTON: If not, I have an unsigned copy, which I can  
11 forward to my learned friend right now.  
12 THE CHAIRMAN: Okay, and then we can pick it up tomorrow  
13 morning. That's fine. Thank you very much.  
14 Rather curiously tomorrow morning I think the idea  
15 is we start at 9.30. We break at 11 o'clock for  
16 a coffee morning and a charity raiser in the foyer and  
17 then resume at 11.30. Okay? So we will start with  
18 Professor MacFaul tomorrow morning at 9.30. Thank you  
19 very much indeed. Sorry. Sorry. Mr Green?  
20 MR GREEN: I am grateful for the careful and measured way in  
21 which you expressed yourself during Dr Sands' evidence.  
22 I know that he is also grateful. He is also grateful,  
23 as I am, for the fact that you interjected him, thereby  
24 causing Professor Lucas to have to start his evidence  
25 later.

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1 I simply rise at this stage because I am still going  
2 to be inviting you, sir, at least to consider making  
3 some sort of determination on the issue I raised in the  
4 written submission. It is there on paper. I am not  
5 going to repeat it, but I simply flag it up so that you  
6 are not taken by surprise if I mention it at some point  
7 tomorrow.

8 THE CHAIRMAN: Yes. We will pick it up tomorrow. I should  
9 say to you I have a reticence about doing this, because  
10 while I entirely acknowledge how Dr Sands can recognise  
11 a serious difference between being accused of not having  
12 done his job properly, on the one hand, and having lied  
13 and fabricated evidence, on the other, there is in the  
14 history of this inquiry a number of other examples of  
15 similar allegations or issues having been raised. I am  
16 reticent, subject to anything that's said tomorrow,  
17 about starting to issue preliminary findings on specific  
18 issues.

19 Having said that, I am also conscious of the fact  
20 that because the inquiry is going to go on through into  
21 next summer, I will not be presenting a report to the  
22 Minister for Health until the end of next year and it's  
23 rather a long time for Dr Sands and others to wait.

24 MR GREEN: Sir, if you were to agree with the proposition  
25 that the allegation is evidentially -- I don't mean this

1 in any way disrespectfully to Mr Roberts -- evidentially  
2 when objectively analysed without a proper foundation  
3 and that it is scandalous in the proper sense of that  
4 word in the sense that it's a real slur on Dr Sands'  
5 reputation, and it has been published in the media with  
6 might I say an unfortunate and tendentious slant, then  
7 you may be able to draw a distinction between that sort  
8 of allegation and the sorts of issues which were raised  
9 particularly looking at the transcript from the Adam  
10 Strain portion of matters where on one view of the  
11 evidence certain individuals did try to slip a lie past  
12 you.

13 THE CHAIRMAN: Okay. I will come back to this tomorrow.

14 Okay. I understand the point. Thank you very much.

15 9.30 tomorrow.

16 (5.08 pm)

17 (Hearing adjourned until 9.30 tomorrow morning)

18 --ooOoo--

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