

1
2 (10.00 am)
3 (Delay in proceedings)
4 (10.10 am)
5 THE CHAIRMAN: Good morning. Mr Stewart?
6 MR STEWART: I call Dr Seamus McKaigue, please.
7 DR SEAMUS MCKAIGUE (called)
8 Questions from MR STEWART
9 MR STEWART: Good morning.
10 A. Good morning.
11 Q. You've been kind enough to furnish the inquiry with four
12 witness statements, one in Adam stain's case, WS129/1,
13 and three in this case, WS156/1, 2 and 3 with attached
14 items of medical literature. Are you content that they
15 be adopted by the inquiry as your formal evidence?
16 A. Yes. On recently reading through, I think, 156/1, and
17 question 3, I make reference to answers given in
18 questions 5, and it should be "2" and not "3".
19 Q. Very well. I'm grateful for that clarification.
20 THE CHAIRMAN: Sorry, let's just bring it up, doctor. It
21 was on the screen a moment ago.
22 A. Yes. It should be, "See (2) and (5)".
23 THE CHAIRMAN: Okay, thank you.
24 MR STEWART: Thank you. You also have furnished us with
25 a copy of your CV. If I could ask that page 306-086-003

1 A. Yes.
2 Q. And where was the scan?
3 A. I believe I accompanied her for a CT scan.
4 THE CHAIRMAN: That would be the normal thing you would do?
5 A. That would be the normal thing.
6 MR STEWART: What would the normal routine have been in
7 order to accomplish that?
8 A. Claire was transferred by ambulance for the CT scan
9 after she had been stabilised in the intensive care
10 unit.
11 Q. Yes.
12 A. So by that stage, I would have been familiar --
13 reasonably familiar -- with her condition and what the
14 problem was. I had stabilised her and had made her safe
15 for transport.
16 Q. Can you describe the routine of getting a patient from
17 the Children's Hospital across to the Royal Victoria
18 Hospital for a CT scan? What did that entail?
19 A. The routine would be that a CT scan would have to be
20 booked, you'd have to have a time. You would then
21 organise an ambulance and the nurses usually did
22 the telephoning. The patient then had to be physically
23 transferred -- in Claire's case, physically transferred
24 on to a trolley, which the ambulance service provided.
25 You had to move across all the monitoring, including

1 be shown, please. This is from your CV. This is
2 a record of your employment, indeed to date. And
3 you have been acting as a consultant paediatric
4 anaesthetist at the Royal Belfast Hospital for Sick
5 Children since 1995.
6 A. Yes.
7 Q. And you practice there still?
8 A. Yes.
9 Q. In relation to Claire Roberts, your involvement started
10 early in the morning on 23 October 1996.
11 A. Yes.
12 Q. And you were, in fact, the on-call duty paediatric
13 anaesthetist at that time.
14 A. Yes.
15 Q. Did you receive a telephone call at about 3.30 in the
16 morning to return to the hospital?
17 A. Yes. That's right.
18 Q. Do you remember that?
19 A. I remember being called -- essentially being summoned
20 into hospital because a child had a respiratory arrest.
21 Q. Yes. And when you got there, what did you do?
22 A. I am unsure whether I went directly to the ward in
23 question, which was Allen Ward, or whether I went to the
24 intensive care unit.
25 Q. Did you subsequently accompany Claire for a CT scan?

1 ventilation if there was a ventilator. Then you
2 physically transferred her out of the hospital into the
3 ambulance. The ambulance drove the quarter of a mile to
4 the main Royal and then you transferred her along the
5 corridors into the CT scanning room. You then had to
6 transfer her off the trolley on to the board which moved
7 in and out of the CT scanner. So you had to, if you
8 like, reverse everything.
9 There was full monitoring throughout all of that,
10 throughout the transfer process. The X-rays were taken
11 and then the whole thing was reversed.
12 Q. And how long did this process take before she was
13 returned to the intensive care unit?
14 A. I would say on a typical -- at that time of the day,
15 a typical could be 40/50 minutes.
16 Q. In 1996, had any concerns been raised that there was no
17 CT facility within the Children's Hospital itself?
18 A. I am myself not -- cannot recall any concerns, but it
19 was obviously a talking point, I believe. I'm not aware
20 of any particular burning concerns.
21 Q. Very well. You had had an involvement with the
22 Adam Strain case in the sense that at the inquest you
23 were involved in the drafting of a set of
24 recommendations that were presented to the coroner; do
25 you remember that?

1 A. Yes.
2 Q. That set of recommendations referenced the Arieff paper
3 on hyponatraemia in healthy children; had you read that
4 at that time?
5 A. Yes.
6 Q. When you returned to the intensive care unit, did
7 you have a chance yourself to read the medical notes and
8 records that accompanied Claire?
9 A. Yes.
10 Q. And did you subsequently enter into the medical notes
11 and records your own synopsis of her condition as you
12 could determine and as you could find yourself?
13 A. Yes, I did.
14 Q. And does that appear at page 090-022-058, starting down
15 there at 7.10 in the morning?
16 A. Yes.
17 Q. And that goes on then over the page to 059, if that
18 could be drawn up beside it. It appears from this that
19 you had read through the medical notes and records and,
20 at the top of the second page, the paragraph beginning:
21 "Initially admitted to hospital with decreased level
22 of consciousness with the clinical picture of acute
23 encephalopathy. Status epilepticus subsequently
24 developed, requiring phenytoin, valproate and midazolam.
25 Serum sodium also noted to be low, down to 121,

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1 there, and while I have no direct recall of the
2 handover, there would have been a handover done.
3 THE CHAIRMAN: From Dr Steen to you?
4 A. Yes.
5 THE CHAIRMAN: Or from Dr Bartholome?
6 A. I believe it was Dr Steen.
7 THE CHAIRMAN: Thank you.
8 MR STEWART: Do you recall a conversation with Dr Steen or
9 Dr Webb?
10 A. I recall -- after Claire arrived back from the CT scan,
11 I recall a specific conversation.
12 Q. And what was that?
13 A. That was -- the CT scan had shown the presence of severe
14 cerebral oedema and with the history of encephalitis,
15 status epilepticus and development of SIADH and
16 hyponatraemia, and the fact that she had fixed dilated
17 pupils and was unresponsive, I believed that she was not
18 expected to survive. On that basis, I initiated
19 a discussion about: could a death certificate be issued
20 for Claire, or would the case have to be referred to the
21 coroner?
22 Q. Why did you initiate that conversation?
23 A. Because I believed she was going to die.
24 Q. Did you think yourself there might be a doubt as to
25 whether or not a death certificate could be issued and

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1 presumably on the basis of SIADH."
2 What was your understanding of the clinical picture
3 at that time?
4 A. Well, I think that paragraph is a good summary of it.
5 Q. If we go down further, we can see it's entered in there:
6 "CT scan shows severe cerebral oedema."
7 Had you formed a view at that stage of what might be
8 the cause of the oedema?
9 A. Yes. I had come to the view that based on the handover
10 and the previous written notes that Claire had
11 encephalitis, status epilepticus, and had subsequently
12 developed SIADH.
13 Q. Was hyponatraemia a cause? Did it seem a likely cause
14 of the hyponatraemia along with those other things?
15 A. Yes.
16 MR FORTUNE: Sir, forgive me. Before my learned friend
17 continues, can we establish from Dr McKaigue whether, on
18 his arrival at the hospital, and in particular in PICU,
19 he met and had the opportunity to speak to either
20 Dr Steen or Dr Webb, and in effect had a handover and
21 what he learned then? Because that may affect how he
22 has written his note.
23 THE CHAIRMAN: I understand. Can you help us, doctor?
24 A. Yes. I recall Dr Steen being there. I think it was at
25 some stage later Dr Webb arrived. But Dr Steen was

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1 a question about whether or not she should be referred
2 to the coroner?
3 A. Well, I wanted to satisfy myself. I had knowledge that
4 she had encephalitis, she had status epilepticus, had
5 developed SIADH and hyponatraemia, and the recent
6 experience of hyponatraemia that I had was in the
7 Adam Strain case. Adam Strain had received a large
8 volume of No.18 Solution very quickly --
9 Q. Yes.
10 A. -- and Claire had received No.18 Solution. So the
11 hyponatraemia, I believed, was on the basis of SIADH.
12 THE CHAIRMAN: Because there wasn't the same overload, same
13 comparative overload, as Adam had received?
14 A. Yes.
15 THE CHAIRMAN: So if it was hyponatraemia, it has come about
16 by a different route?
17 A. Yes. I personally was not -- not being a paediatrician,
18 I wasn't aware that encephalitis or status epilepticus
19 could cause SIADH, so I wanted to clarify with --
20 I believe, Dr Webb was present at that stage -- with the
21 paediatricians. I recall it was Dr Steen who said ...
22 I can't remember exactly, but it was either she had seen
23 a case like this before or she was aware that this could
24 happen in cases of encephalitis, meningoencephalitis,
25 that SIADH and hyponatraemia could occur.

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1 So this was, if you like, pathophysiology in action.
2 And whenever the hyponatraemia was recognised, the No.18
3 Solution which was the normal intravenous fluid at that
4 time, the rate was reduced to treat the hyponatraemia.
5 So on that basis, I satisfied myself that personally,
6 for me, there were no red flags for me to report the
7 case to the coroner.
8 THE CHAIRMAN: When you said earlier that you had knowledge
9 that Claire had encephalitis and status epilepticus,
10 that's from the notes and records over the previous
11 24 hours, which showed that that's what she was being
12 treated for?
13 A. That's what the paediatricians were saying.
14 THE CHAIRMAN: Right.
15 MR STEWART: You say you satisfied yourself that there were
16 no red flags. Do you mean red flags in the sense
17 of: this is a case which ought to be referred to
18 the coroner?
19 A. Yes.
20 Q. At that stage did you understand hyponatraemia to be
21 a treatable condition?
22 A. Yes.
23 Q. Did you wonder whether or not it had been treated?
24 A. Well, I accepted what Dr Steen told me, that the fluids
25 had been reduced to two-thirds maintenance rates, which

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1 over the previous days.
2 A. Yes.
3 THE CHAIRMAN: Let me ask you: would it be very, very
4 unusual for you to be in a discussion with the named
5 paediatrician who'd never seen the child?
6 A. It could happen in a ... Well, I'm trying to think ...
7 It can sometimes happen in a resuscitation/A&E scenario,
8 but if a child's in hospital, then that would be
9 unusual.
10 THE CHAIRMAN: When I am saying this, I'm not pointing the
11 finger at Dr Steen. Whatever Dr Steen was doing the
12 previous day -- I'm working on the assumption that she
13 was working -- she hadn't just disappeared for some
14 reason, she was doing some duties for the Trust, but
15 whatever those duties were on the Tuesday morning, she
16 had not seen Claire; right? In that scenario, what is
17 happening is there are three of you talking about
18 Claire's condition and what has brought this about.
19 You are inevitably entirely new to it because you've
20 been called in in the early hours of Wednesday morning.
21 Dr Steen is new to it because she has been called in
22 in the early hours of Wednesday morning. And Dr Webb
23 isn't new to it, he has been treating Claire since
24 around lunchtime on Tuesday, but treating her on the
25 basis that she was likely to recover because that was

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1 was the treatment for hyponatraemia occurring with
2 SIADH.
3 Q. When you said subsequently and in a witness statement to
4 the inquiry:
5 "With hindsight I would have preferred any
6 discussions I had with Dr Steen and Dr Webb to have been
7 documented."
8 What did you mean by that?
9 A. Well, that conversation was a very important
10 conversation for me. It influenced my decision
11 personally not to report the case to the coroner and,
12 therefore, it should have been documented.
13 THE CHAIRMAN: Did you know, doctor, when you were having
14 this conversation that Dr Steen had not seen Claire from
15 her admission until Dr Steen received a similar call to
16 the one which you did in the early hours of Wednesday
17 morning?
18 A. I don't think I was aware of that.
19 THE CHAIRMAN: You were taking Dr Steen as the responsible
20 paediatrician, which she was on the documentation?
21 A. Yes.
22 THE CHAIRMAN: But in any normal course of events, when
23 you're in the disaster scenario that you were in in PICU
24 that morning, the named paediatrician will almost
25 invariably know the child and have treated the child

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1 the view which he held when he left the hospital at
2 about, say, 5-ish/6-ish, on Tuesday evening. So the
3 fact that Claire has ended up in intensive care in this
4 terminal state is completely unexpected for Dr Webb, who
5 was the only one of the three of you who'd been treating
6 her over the previous 24 or 36 hours.
7 What that takes me to is wondering about the degree
8 of confidence which the three of you could have had in
9 order to conclude that you were so sufficiently clear
10 about Claire's cause of death that she did not need to
11 be referred to the coroner. Do you understand where I'm
12 going to?
13 A. Yes. I accepted the diagnoses which I was told and
14 which were written in the chart.
15 THE CHAIRMAN: Okay. Thank you.
16 MR STEWART: Do you think in hindsight that perhaps you
17 could have been more proactive?
18 MR FORTUNE: In what way?
19 MR STEWART: Satisfying yourself that the matter was indeed
20 one that it was safe not to refer to the coroner.
21 A. Well, I had to form a view and I did that as best
22 I could on the information I had at the time. I did
23 actually initiate that conversation, so I was actively
24 thinking about how this child was not going to survive,
25 and I initiated that conversation.

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1 Q. You gave an account of that conversation in your first
2 witness statement and it's perfectly consistent with
3 what you say, but there's one additional comment that
4 you make. I wonder if WS156/1, page 8 might be shown.
5 This, in the middle of the paragraph, is where you
6 describe this discussion:
7 "I discussed Claire's condition with Dr Steen.
8 I believe Dr Webb was also present, but I cannot be
9 certain. I do not recall who else was present. I do
10 not recall what time this conversation took place, but
11 I believe it was most likely after Claire had returned
12 to PICU following her CT scan. By this stage, it was
13 clear to me that Claire's prognosis was extremely grave
14 and she would most likely die. I was then endeavouring
15 to find out would Claire's cause of death fit the
16 criteria for a death certificate to be issued or would
17 the coroner have to be informed. Dr Steen gave
18 a summary of Claire's current clinical condition. I
19 cannot recall exactly, but I believe that Dr Steen was
20 aware that hyponatraemia could accompany
21 meningoencephalitis and that she further commented that
22 the treatment of hyponatraemia in such circumstances was
23 managed by fluid restriction. The other comment
24 I remember her making, I don't have the exact words, but
25 it was to the effect that Claire's parents had gone

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1 been through enough and we want to get the child home to
2 them.
3 A. Yes.
4 THE CHAIRMAN: So it's a perfectly reasonable, legitimate,
5 human concern, but it is of no relevance whatever to
6 whether a child's death is referred to the coroner.
7 A. No.
8 MR STEWART: Indeed, you say four lines down:
9 "I was then endeavouring to find out would Claire's
10 cause of death fit the criteria for a death certificate
11 to be issued."
12 What did you understand the criteria to be in 1996?
13 A. Well, a doctor could write a death certificate if the
14 cause of death was due to natural causes and they had
15 been treated in the last 28 days, seen and treated by
16 a doctor in the last 28 days. A doctor couldn't issue
17 a death certificate if the cause of death wasn't known
18 and if the death was due to trauma, violence, neglect
19 and misadventure -- and I think, as well, negligence.
20 Those are the criteria that I used to decide whether or
21 not a case should be reported to the coroner.
22 THE CHAIRMAN: So the death certificate can't be issued if
23 the cause of death is unknown?
24 A. Absolutely.
25 THE CHAIRMAN: So in order to issue the death certificate,

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1 through enough and she wanted to be able to get Claire
2 home to them. At some point I brought up the issue of
3 Claire being a potential organ donor."
4 In relation to that comment about Claire's parents
5 having gone through enough and getting Claire back
6 to them, is that a relevant consideration when it comes
7 to determining whether or not the coroner should be
8 informed?
9 A. No.
10 Q. What do you think the import, the purpose, of that
11 statement might have been?
12 A. Well, I think I'm ... My interpretation of what
13 Dr Steen was saying there was that she clearly believed
14 that Claire was -- there was no chance of her
15 recovering. What had happened had happened and I think,
16 just on compassionate terms, not to draw this out
17 unnecessarily.
18 THE CHAIRMAN: I don't want to seem cold, but you could say
19 that in virtually every child's case, couldn't you? You
20 could say in the case of virtually every child that the
21 parents have been through enough.
22 A. Yes.
23 THE CHAIRMAN: There isn't a parent whose child has died
24 in the Children's Hospital who haven't been through the
25 mill and you could say in every case the parents have

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1 the doctor has to be confident as to the cause of death?
2 A. Yes.
3 THE CHAIRMAN: Right. You have said, "I wasn't aware that
4 encephalitis or status epilepticus could cause SIADH",
5 and that Dr Steen said that she had seen such a case
6 before or was aware that this could arise.
7 A. I can't remember which version it was.
8 THE CHAIRMAN: Whichever it was, the fact that such a case
9 had been seen before or Dr Steen was aware of such
10 a case, that means that it can happen, but the question
11 surely in Claire's case was: is that what happened? So
12 how do you move from saying, "This can happen in
13 a case", to saying confidently, "This is what has
14 happened in Claire's case. I therefore know why she
15 died. I can issue a death certificate"?
16 A. What I ... I wasn't actually making any of the
17 diagnoses --
18 THE CHAIRMAN: Yes.
19 A. -- in Claire's case. Therefore, I was accepting the
20 diagnoses which had been made. And I was satisfying
21 myself that the diagnoses were in keeping with the
22 history I had received and also the fact that the
23 hyponatraemia was not caused by maladministration of
24 No.18 Solution because that's what happened in
25 Adam Strain's case.

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1 THE CHAIRMAN: I don't know the extent to which you've been
2 able to follow the hearings here in Banbridge, doctor,
3 but you will have heard some of the inquiry experts say
4 that they fundamentally disagree that Claire's case
5 should not have been referred to the coroner. I'll put
6 it more clearly. They say that Claire's case should
7 have been referred to the coroner. Maybe they have had
8 the advantage of more time to look through the notes and
9 records and consider things than you had in the early
10 hours of that Wednesday morning, but would you disagree
11 with what they have advised the inquiry?
12 A. What I was doing then was forming a view and then making
13 a judgment. I didn't have the time and I didn't go
14 through the charts in all that great detail. I was
15 forming a view and making a judgment on what information
16 I had then, just flicking back a few pages in the notes
17 to look at what was written. A judgment -- I accept
18 that I can make a wrong judgment. And again, it is
19 quite hard because, as a person, I have developed and
20 got a lot more experience and knowledge over the last
21 16 years. So I was there as an anaesthetist, I wasn't
22 a paediatrician, I'd never looked after children like
23 Claire before. So I was very much accepting what the
24 two paediatricians were saying.
25 THE CHAIRMAN: Do I take it that sometimes there is a real

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1 some assistance to you, sir, to find out just how many
2 times, if he can remember, at that time he'd met that
3 situation.
4 THE CHAIRMAN: Can you help us, doctor?
5 A. I was a consultant by that stage for about 15 months.
6 I believe I would have been involved in making decisions
7 about whether or not to refer previous deaths in the
8 intensive care unit to the coroner. I can't remember
9 specific cases, but I would --
10 THE CHAIRMAN: Probably only a few by that stage?
11 A. Well, if there were, say, 24 or 30 deaths a year,
12 I would have in the previous year ... So I would have,
13 on that grounds, been involved in that decision-making
14 process.
15 THE CHAIRMAN: Thank you.
16 MR STEWART: Can you recall any contributions Dr Webb made
17 to the discussion about referral to the coroner?
18 A. No.
19 Q. At that time did anyone ever say, "Why don't we ring up
20 the coroner's office and see if they can give a steer?"
21 was that ever done?
22 A. No.
23 THE CHAIRMAN: I understand that there's a system now for
24 doing that. Was there a system at that time for doing
25 it? Sorry, there's a system that's changed or developed

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1 debate between the doctors about whether a child should
2 be referred to the coroner? If we take you and two
3 others -- it doesn't matter if it's Dr Webb and
4 Dr Steen, but there are other scenarios, I'm sure, where
5 there are three of you discussing what should happen.
6 A. I don't think there ever ends up a debate. I think if
7 somebody expresses a view that a case should be referred
8 to the coroner, then that's it.
9 THE CHAIRMAN: And things have changed since 1996. As I
10 understand it, the bar has been lowered so more cases
11 are referred to the coroner than was the position 16
12 years ago.
13 A. Yes.
14 MR FORTUNE: Sir, could we find out from Dr McKaigue whether
15 he has been in that situation prior to Claire's death,
16 that this wasn't his first time when confronted with the
17 information that Claire was likely to die? Because
18 presumably, he's drawing on his experience as well as
19 his judgment.
20 THE CHAIRMAN: Sorry, you mean in the sense that this wasn't
21 the first child whose death he'd been involved with in
22 PICU?
23 MR FORTUNE: Yes. He has told us he has been a consultant
24 for some time before this. Presumably he's been
25 confronted with this situation before and it may be of

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1 to the extent that there is a doctor who works as a link
2 between the hospital --
3 A. Yes, the medical examiner. If you expect a patient to
4 die, some doctors may in actual fact in the past have
5 contacted the coroner's office on a hypothetical basis.
6 And then, after a patient has died, the coroner's office
7 can be contacted directly and advice sought.
8 THE CHAIRMAN: Right. The other thing I just want to
9 clarify with you: this conversation about whether
10 Claire's death would be referred to the coroner or not,
11 was this taking place in the early hours of Wednesday
12 morning after you had taken her for the CT scan and
13 taken her back?
14 A. Yes.
15 THE CHAIRMAN: Was that decision taken before any brainstem
16 testing?
17 A. I believe so.
18 THE CHAIRMAN: Is that regular?
19 A. Yes, that would be regular enough. You can anticipate
20 death.
21 THE CHAIRMAN: Yes. I got a bit confused yesterday when
22 Dr Taylor was giving his evidence. He was saying that
23 that decision isn't normally taken in his practice until
24 after the second brainstem test and I was suggesting to
25 him then that in Claire's case it was taken before the

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1 brainstem testing. He thought that would be unusual and
2 then later on in the day I was corrected and I indicated
3 that, in fact, in Claire's case, the decision was taken
4 after the brainstem test, but in fact it was taken
5 before either brainstem test?
6 A. No, this was a discussion -- this was a discussion that
7 I initiated.
8 THE CHAIRMAN: Right.
9 A. There was not a decision at that point taken whether or
10 not to refer the death to the coroner.
11 THE CHAIRMAN: When was that decision taken? Were you
12 involved in that later decision?
13 A. I wasn't involved in that. I believe ... I mean,
14 I have been following the inquiry transcripts to my best
15 ability, but I believe that was taken at some point
16 later. This was just a discussion that I was having.
17 I didn't actually think I would see Claire again. I was
18 going to be going off duty.
19 THE CHAIRMAN: Right. So this was a discussion, not
20 a decision at that point? Right.
21 MR STEWART: Dr Steen has given a statement in which she
22 says she thinks the decision not to refer to the coroner
23 was made by her in conjunction with the consultants in
24 PICU; is that how you recall it?
25 A. No.

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1 discussion there.
2 Q. Was there a discussion that you heard?
3 A. No, I wasn't aware of any discussion.
4 Q. Thank you. Were you aware of any discussion about the
5 restriction of a post-mortem examination to the brain
6 only?
7 A. No.
8 Q. I wonder if we go --
9 THE CHAIRMAN: Sorry, how common is that?
10 A. Again, I was a consultant in the Children's Hospital for
11 15/16 months, so I wouldn't have had a lot of experience
12 to draw on. I think that would be best asked of
13 somebody else. Prior to that, I was working mainly in
14 adult practice.
15 THE CHAIRMAN: Thank you.
16 MR STEWART: 090-022-061. If we have that page alone,
17 if we may. This is later on, on 23 October. The first
18 brainstem death protocol test was conducted, I think at
19 6.00 in the morning, and the second one at 6.25 in the
20 evening. The top entry is Dr Taylor's entry, then
21 Dr Steen has entered:
22 "Diagnosis of brainstem protocol completed ...
23 Discussed with the parents. Agree that ventilation
24 should be withdrawn. Consent for limited post-mortem
25 given."

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1 THE CHAIRMAN: In saying "no", you are distinguishing
2 between this discussion which you have told us about for
3 the last few minutes and a decision?
4 A. Yes.
5 THE CHAIRMAN: But if that's right, if this was
6 a discussion, but not a decision, to what extent is it
7 important that it isn't recorded in the medical records?
8 Because it's not a decision -- sorry, I got the
9 impression when you were saying you wish this
10 conversation had been recorded and that would be
11 consistent with it being decisive ...
12 A. It influenced my decision not to refer Claire to the
13 coroner.
14 THE CHAIRMAN: Right.
15 MR FORTUNE: Sir, in fairness to Dr McKaigue, he did say
16 that he had to satisfy himself personally as to whether
17 he should inform the coroner. And he said that at the
18 beginning of that part of his evidence about initiating
19 this discussion.
20 THE CHAIRMAN: Yes. Thank you.
21 MR STEWART: Yes. I think you said you wanted to satisfy
22 yourself about the medical certificate of cause of
23 death. Was there a discussion about what would be
24 entered on the medical certificate of cause of death?
25 A. It didn't involve me and it wasn't part of that

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1 Then you have entered in at 18.45:
2 "Ventilation discontinued at 18.45."
3 When you made that entry, you could see that
4 Dr Steen had, in fact -- by indicating that consent had
5 been given for a limited post-mortem, you could see that
6 she had decided that she herself could issue
7 a certificate of cause of death and she was not going to
8 be referring it to the coroner?
9 A. Yes.
10 Q. Did you interest yourself at that stage in what she had
11 entered on the medical certificate of cause of death?
12 A. Yes, I did.
13 Q. And did you ask?
14 A. No, I didn't discuss that with her.
15 Q. Did you try to find out, did you go and find the book
16 and look at the stub?
17 A. Could you ...
18 Q. Did you ask Dr Steen what she had put?
19 A. I read what she had written there.
20 Q. Oh, you read that after?
21 A. Well, I ... I remember reading that very shortly after
22 Claire's death.
23 Q. Given that you believed that meningoencephalitis was
24 part of the clinical picture, that SIADH and
25 hyponatraemia were part of the picture, were you

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1 surprised that she had not put those on the death
2 certificate?
3 A. I was surprised that encephalitis wasn't on the death
4 certificate, but, on the other hand, Dr Webb had again,
5 I think in his written note, talked about SIADH being
6 related to status epilepticus.
7 Q. Given that you were surprised that the medical
8 certificate issued didn't accord with your
9 understanding, what did you do in consequence?
10 A. It was difficult to write all those things on the death
11 certificate.
12 Q. The death certificate does give enough room to write
13 a few words more, doesn't it?
14 A. The way that I understood death certificates had to be
15 written was that there was a single cause of death
16 attributed to each line.
17 THE CHAIRMAN: Just to clear up this point, Dr McKaigue,
18 when you were saying earlier that you had had the
19 discussion with Dr Steen and Dr Webb in the early hours
20 of Wednesday morning, if there was any further
21 discussion between Dr Steen and any consultant in PICU
22 about a decision not to refer Claire's death to the
23 coroner, it wasn't with you?
24 A. No.
25 MR QUINN: Mr Chairman, may I come in here for a moment,

25

1 to status epilepticus.
2 THE CHAIRMAN: And on that basis then you were satisfied
3 that the cause of death was known rather than unknown?
4 A. Known and naturally occurring.
5 THE CHAIRMAN: Right.
6 MR FORTUNE: I only rose because I was concerned that the
7 verb "persuaded" might have a loading to it.
8 MR QUINN: If I could just come in? "Persuaded by the
9 expertise and knowledge of the paediatricians" perhaps
10 would be a better way to put it.
11 MR FORTUNE: Well, I'm grateful for that clarification
12 because what you obviously want to hear, sir, from
13 Dr McKaigue is how he reached his judgment,
14 independently or otherwise.
15 THE CHAIRMAN: Okay, thank you. Just before we go on,
16 I don't know if you were able to pick up on Dr Taylor's
17 evidence from yesterday. There was some discussion
18 yesterday about deaths arising from encephalitis and he
19 thought there had been a number of them in the
20 mid-1990s, which is why, if Claire died as a result of
21 complications from encephalitis or directly from
22 encephalitis, that in itself was not unknown in the
23 Royal in the Children's Hospital at that time. We then
24 looked through the primary diagnosis of death for 1995
25 and 1996, which had been given to us by DLS from the

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1 just to put the family's position? Maybe through you,
2 Mr Chairman, could I ask the question: would it be fair
3 to say that this witness was persuaded by the
4 paediatricians that it should not be referred to
5 the coroner? Perhaps that would encapsulate what
6 we have heard in the last ten minutes.
7 THE CHAIRMAN: Would that be an unfair summary that you were
8 persuaded by your discussion with doctors?
9 A. No, I formed a view. I very definitely formed a view
10 and made a judgment.
11 THE CHAIRMAN: In reaching that judgment, and forming that
12 view, was that because you were accepting what you'd
13 heard, in particular what Dr Steen had said, not
14 necessarily in these terms, that while you weren't aware
15 that encephalitis or status epilepticus could cause
16 SIADH, Dr Steen had said that she'd seen such a case or
17 was aware of such a case --
18 A. Yes.
19 THE CHAIRMAN: -- and that led to you being satisfied that
20 Claire's death did not need to be referred to the
21 coroner because Dr Steen knew of such a situation in the
22 past?
23 A. Because SIADH, which causes hyponatraemia, can occur as
24 a complication of meningoencephalitis and
25 status epilepticus. I believe that Dr Webb linked SIADH

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1 hospital, and it wasn't very clear at all that there was
2 such a run of deaths. Were you aware or can you recall
3 being aware of a number of deaths around the mid-1990s
4 of children from encephalitis?
5 A. No. I have to say that in the mid-1990s I was in adult
6 practice then. I had one -- approximately 15/16 months
7 in the intensive care unit, in Children's.
8 THE CHAIRMAN: You were in Children's in 1995/1996.
9 A. As a consultant, yes.
10 THE CHAIRMAN: Let me just tidy that up a little bit with
11 you: when you joined the Children's in 1995, can you
12 remember what month in 1995?
13 A. August.
14 THE CHAIRMAN: How long did you stay there?
15 A. How long did I stay there?
16 THE CHAIRMAN: Sorry, you are still there?
17 A. I'm still there, yes.
18 THE CHAIRMAN: At the time Claire died in October 1996,
19 you'd been in the Children's Hospital from August 1995.
20 Thank you.
21 MR STEWART: Just to pick up where we were: about that time,
22 you'd seen in the medical notes and records Dr Steen's
23 entry that she had issued the death certificate and
24 cited on it as a cause of death, "cerebral oedema
25 secondary to status epilepticus". Did you then,

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1 subsequently on the same day, fill out the PICU coding
2 form? And that's available at 090-055-203. That's your
3 signature, I think.
4 A. Yes, that's my signature, and the date corresponds.
5 Q. You filled this out for a very specific purpose, and
6 that's clinical coding.
7 A. Yes.
8 Q. Can you describe a little bit about why you make the
9 entry you do and in the way that you did?
10 A. The coding form was -- the term that remains in my
11 memory was "depth of coding". There must have been
12 a move within the Trust to better code or improve the
13 depth of coding for patient episodes. That's what
14 prompted this relatively new development. I recall,
15 I believe, that this was a new development, this was an
16 ad hoc, unofficial sort of Trust form. It was something
17 we made ourselves in the intensive care unit.
18 Q. The system, which was the PAS, Patient Administration
19 System, clinical coding, this was the formal hospital
20 coding system?
21 A. I don't know what exactly PAS did or what the code --
22 I don't know really know anything about coding, I was
23 just asked to improve the depth of coding, and I think
24 we all agreed to do that. This free text allowed the
25 coders to improve the depth of coding.

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1 A. I suppose the diagnosis which prompted her admission to
2 ICU was the respiratory arrest.
3 Q. Yes. But moving on down, it seems that the first of the
4 diagnoses that you have entered is hyponatraemia.
5 A. Yes.
6 Q. That seems to be at variance with what you understood
7 Dr Steen to have entered on the medical certificate of
8 cause of death.
9 A. Whenever a medical certificate of cause of death is
10 being formulated, there is a sequence and there is a set
11 of rules to be followed.
12 Q. Yes.
13 A. Those rules were clearly different from the rules I was
14 employing to generate that document.
15 Q. Why did you choose not to enter status epilepticus on
16 this document?
17 A. I can't really think of an answer for that at the moment
18 because I'm a bit unsure about the rules. This
19 document, again, was -- there are other documents, there
20 are two other documents which have been generated
21 in relation to her admission to ICU.
22 Q. Yes.
23 A. I have seen those.
24 Q. All right. Well then, we may return to this, but can
25 I then go to what's called the "Discharge/transfer

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1 Q. There was also, running at the same time, I believe, an
2 internal PICU coding database --
3 A. Yes.
4 Q. -- that's been described in various ways, used at that
5 time on an ad hoc basis. Did you choose to use it for
6 Claire's case as well?
7 A. Yes. It would have been used as well, yes, because
8 there was a separate pro forma whereby codes were --
9 a separate pro forma was used to generate codes for the
10 PICU in-house database and we had our own home-made
11 coding schedule.
12 Q. We may ask to see if we can see a copy of the in-house
13 PICU coding, but can we just read through this? The
14 initial part is, I suppose, the history:
15 "Admitted from ward following respiratory arrest."
16 The next section is, I suppose what was done when
17 she arrived at PICU:
18 "Intubated, ventilated, arterial line, central line,
19 CT scan, IV infusion, brainstem tests x2."
20 Then we come back to what I suppose might be coded
21 as her conditions:
22 "Hyponatraemia, hypernatraemia, hypokalaemia.
23 Concentrated potassium infusion. Died."
24 There's no mention there of status epilepticus or
25 indeed encephalitis. Why would that be?

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1 advice note" from the PICU, which is at 112-030-045?
2 Perhaps we could put it side by side. This is the
3 discharge note and it's signed by an SHO called
4 Dr Mannam, I think, on 29 October. Do you see the
5 discharge, which is:
6 "Transferred: died 23 October 1996. Principal
7 diagnosis: cerebral oedema. Other diagnoses:
8 status epilepticus, hyponatraemia."
9 How come one person in PICU is able to discharge
10 with a diagnosis of status epilepticus and
11 hyponatraemia, but you're coding it in a different way?
12 A. The only explanation I can offer is that by the time
13 Claire arrived in the intensive care unit, the diagnosis
14 which had superseded the others was respiratory arrest.
15 Q. Okay. Let's have a look at WS156/1, page 14. This is
16 where you're asked what would be the causes of the
17 cerebral oedema:
18 "I cannot recall. There may have been more than one
19 cause. It is likely that some or all of the following
20 would have been mentioned: hyponatraemia,
21 meningoencephalitis and seizures."
22 You can see the import of this question. If these
23 are the considerations that were mentioned at the time
24 and if the discharge note has another set of diagnoses,
25 why didn't you code that yourself? Why did you only

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1 code hyponatraemia? Why did you not make sure that that
2 was the same as the medical certificate of cause of
3 death?
4 A. I can't explain that. It ... And the only explanation
5 I can come up with now is that it was related to the
6 rules that we used on the coding sheet, to put on the
7 coding sheet. I know it sounds -- it's very obvious,
8 you know, the differences between the documents, but
9 different documents for a different purpose.
10 Q. Okay. You mentioned the rules. Were these rules
11 reduced to writing?
12 A. I don't think so.
13 Q. Who would have told you of these rules?
14 A. I think that if anybody -- well, I think it would have
15 been part of the process of introducing this new coding
16 sheet, which was new, it was ... We weren't ...
17 I don't think we were told on high to introduce it,
18 I think it was something that we took upon ourselves to
19 introduce.
20 Q. And you don't remember what those rules were?
21 A. No, I don't. I'm trying to work backwards from what
22 I recorded on the document.
23 MR McALINDEN: Mr Chairman, perhaps the witness could be
24 asked what the purpose of the coding was, the depth of
25 coding. Perhaps that might help to explain the

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1 signature of "M Newell" and we believe that to be
2 Margaret Newell, the coder, and she has coded it on
3 28 October.
4 If we can to page 302-153-003, this is the document
5 we saw yesterday, and this is the result of Margaret's
6 work. You can see she has taken in quite a number of
7 the conditions mentioned, and it seems apparent that she
8 has actually taken time to go through the medical notes
9 and records in order to produce this coded encapsulation
10 of the case.
11 Did you see this when it came back, the actual
12 coding, or would that not have been returned to you?
13 A. No.
14 Q. Can I ask, would Dr Steen have seen that discharge note
15 from PICU we looked at a moment ago, which was
16 112-030-045? Would she have seen that?
17 A. She might have seen it. I think that was a document
18 that, at least, was in duplicate.
19 Q. It was, because we can go and find the duplicate part.
20 That's the top copy.
21 MR FORTUNE: I was just about to ask the basis on which this
22 witness can answer this question.
23 MR STEWART: This was in duplicate and we find the other
24 half of it, the lower half, at 090-009-011. Can we put
25 it alongside it? Although it's given a different

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1 situation.
2 THE CHAIRMAN: Okay. That's the coding form at 090-055-203?
3 MR McALINDEN: Yes.
4 A. I think it was in some way to provide evidence for how
5 sick patients were and the intensity of treatment that
6 we were providing to our patients. That's what I think
7 was the depth of coding. Ultimately, I think there was,
8 from a point of view of obtaining more money for the
9 Children's Hospital -- it was important to be able to
10 demonstrate that we were looking after very, very sick
11 children, who required all these extra procedures
12 needing to be done to them.
13 MR STEWART: Weren't these procedures in order to allow the
14 diseases and conditions to be notified to the Department
15 of Health so that statistical and epidemiological
16 analysis could ensue?
17 A. Well, I am not an expert on how the hospital coded
18 everything. I have read Mr McWilliams' statement and
19 I understand from it that the coders used a number of
20 sources for their information.
21 Q. Yes. And indeed, in this case, you can see at the
22 bottom of the page on the right-hand side it says:
23 "This form is to be retained in the unit for coding
24 clerk (Margaret)."
25 And you can see below your signature is the

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1 heading, which is "Case note/discharge summary" as
2 opposed to "Discharge/transfer advice note", the actual
3 content and the writing is the same. Would the purpose
4 of this have been to be attached to the medical notes
5 and records? Would one copy have actually gone to the
6 notes and records, the 090 copy, and the other part sent
7 elsewhere?
8 A. That's a carbon copy of the top copy --
9 Q. Yes.
10 A. -- isn't it?
11 Q. Yes. We've looked at it and think that it is. Although
12 you'll see on the right-hand copy, it's "Case
13 note/discharge summary" -- it's not the same as the
14 "Discharge/transfer advice note" -- but the actual
15 handwriting is correctly --
16 A. Yes. So one would assume then that that was included in
17 the chart.
18 Q. Yes. And that would have been available then to
19 Dr Steen if she had access to the chart?
20 A. That would be the normal process.
21 Q. Thank you. Can I just ask one further question. Do you
22 see on the left hand copy here, which is the clearer of
23 the two, we have "cerebral oedema",
24 "status epilepticus", and then down below,
25 "hyponatraemia". It does seem to have been written in

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1 slightly different handwriting, and it certainly is out
2 of line. Can you help, could that have been written in
3 later? Could that section be enlarged?
4 MR FORTUNE: Sir, before this witness answers --
5 THE CHAIRMAN: If it's added in later, it's not added in
6 much later because it appears in the duplicate, doesn't
7 it?
8 MR STEWART: Oh yes, and furthermore it's quite clear that
9 it has been sent to the general practitioner. There's
10 no intention in any sense to doctor the document, if
11 I use that phrase, but it does seem to have been written
12 in a separate hand.
13 MR FORTUNE: Well, before Mr Stewart invites us all to
14 become handwriting experts, I would invite you, sir, to
15 look very carefully. Can we have it blown up again,
16 please? The A of "oedema" and the A of "hyponatraemia",
17 there is a similarity that might draw the inference of
18 the same hand.
19 MR STEWART: I merely asked the doctor to comment on it and
20 he's unable to do that.
21 THE CHAIRMAN: Okay. Have you finished with this point?
22 MR STEWART: Yes.
23 THE CHAIRMAN: I just wanted to go back for a moment to
24 090-055-203. At the instigation of Trust counsel
25 Mr McAlinden, you were asked what the purpose of this

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1 Q. Yes, 112-030-045. You can see the body of the text is
2 taken from the text at the bottom left.
3 A. Yes. I have said in one of my witness statements that
4 the typed document was produced by -- this is,
5 I believe, the secretary in the intensive care unit,
6 compiled from the written commentary on the discharge
7 note. The diagnosis of respiratory arrest was the
8 diagnosis which prompted her admission into ICU and
9 I have said that this document was -- the purpose of
10 this document was to allow us to look back and profile
11 her admissions. In other words, with a diagnosis of
12 respiratory arrest, that was clearly an emergency
13 admission, as opposed to an elective admission. By
14 looking at these documents, we could glean, in a very
15 crude sort of way, surgical admissions, medical
16 admissions, cardiology admissions, and so on.
17 Q. So what happens to this document, where is it placed?
18 A. It would have been filed in the intensive care unit.
19 Q. And a copy --
20 A. And there may have been a copy sent for the notes.
21 Q. Thank you. May I ask you now about audit and the
22 paediatric audit committee meeting and whether or not
23 Claire's case was in fact reviewed at a mortality
24 meeting. You have given us your recollection that you
25 believe that you were present at a meeting where

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1 form was. The gist of your response, doctor, was that
2 it's to provide evidence of how sick the patients were
3 and what treatment you were providing. That's the
4 coding form on the left side of the screen.
5 A. These would have been surrogate markers.
6 THE CHAIRMAN: Right. A lot of the treatment that Claire
7 got through Tuesday afternoon and the evening was in the
8 form of anticonvulsants.
9 A. Yes.
10 THE CHAIRMAN: Are they referred to in this coding form?
11 A. No. This coding form was the treatment that was
12 provided in the intensive care unit.
13 THE CHAIRMAN: Sorry? Only in PICU, right, thank you.
14 MR STEWART: 090-006-008. This is the last of the PICU
15 documents and it's the ICU discharge summary. You were
16 asked about the initials at the top right-hand corner in
17 your witness statement request, and it says:
18 "File per S McK."
19 And it's dated 27 November. Could those initials
20 refer to you?
21 A. As I said in my witness statement, they could.
22 Q. And the diagnosis is given there as "respiratory
23 arrest", and that's again a different diagnosis to the
24 discharge summary itself; could you explain that?
25 A. Yes, could we put up the top copy?

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1 Claire's case was discussed. I wanted to ask the basis
2 upon which you have that belief. First of all, can
3 I ask you what you do remember?
4 A. Well, I remember that Dr Steen presented Claire's case
5 at one of the mortality presentations.
6 Q. Do you remember when that was?
7 A. No.
8 Q. Do you remember who else was there?
9 A. No.
10 Q. Did you take any notes of it?
11 A. No.
12 Q. Do you have any documentation relating to it?
13 A. No.
14 Q. Were there any lessons learned from it?
15 A. Not that I remember.
16 Q. How do you know it was Claire's case?
17 A. Because I remembered Claire's case, so therefore
18 I remembered Dr Steen presenting it.
19 Q. Was the autopsy report available?
20 A. I have no recollection of the presentation of the
21 autopsy report, but I -- on the basis of normal practice
22 of the mortality meeting, the presentation would not
23 have been arranged until the neuropathology reports were
24 available.
25 Q. And in this case, that was in February of 1997.

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1 A. Yes.
2 Q. In your witness statement given at 156/1, page 35,
3 towards the bottom, these are questions relating to the
4 mortality meeting, you say at (a):
5 "I believe that I was present at the audit meeting
6 when Claire's case was presented. I believe that
7 Dr Steen presented the case. I cannot recall the date
8 of the meeting. I have no documents to provide."
9 And the question is asked of you:
10 "In particular, state whether you attended the
11 mortality/morbidity meetings on or about 8 November 1996
12 in relation to Claire, and if so, state was discussed
13 and furnish minutes thereof."
14 And you have advised:
15 "I attended an audit meeting on 8 November 1996.
16 I believe I presented a case. I do not have any details
17 in this case. I have no recollection of what was
18 discussed."
19 Did you believe then that Claire's case might have
20 been discussed on 8 November and, because you were
21 there, you therefore conclude that you must have
22 actually heard Claire's case being presented?
23 A. No, I actually have a document which was the flyer for
24 that meeting, and I have handwritten on it that
25 I presented a case. That's how I know for sure I was at

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1 properly have been presented at a meeting
2 until February, maybe March?
3 A. Yes.
4 MR STEWART: Do you remember what Dr Steen said about
5 Claire's care at that meeting?
6 A. I cannot recall the detail. There was a presentation.
7 Despite what was said yesterday about audit meetings
8 being heated --
9 THE CHAIRMAN: Sometimes.
10 A. -- the norm was that they weren't. So if there was
11 particular issues, then I -- that's when you would tend
12 to remember.
13 MR STEWART: Did Dr Webb say anything at that meeting?
14 A. I don't know if Dr Webb was at that meeting. I can't
15 recall.
16 Q. Can you remember any single thing about the meeting?
17 A. No. Other than Dr Steen presenting the case.
18 THE CHAIRMAN: Doctor, can I ask you one point about that?
19 You say you don't remember whether any lessons were
20 learned. Can I suggest a lesson? The lesson is that if
21 you don't do regular electrolyte testing on a child with
22 encephalitis, you run the risk of SIADH developing and
23 causing the child's death. If encephalitis is the
24 correct diagnosis or, for that matter, if
25 status epilepticus is the correct diagnosis, then the

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1 an audit meeting on 8 November 1996.
2 Q. We don't think Claire's case was presented at that
3 meeting and that date came about because the DLS advised
4 the inquiry that the only event where Claire's death
5 would have been discussed was the paediatric directorate
6 audit meeting where deaths during the previous month
7 were discussed, ie November, and they further advised
8 the inquiry at 302-024-001, when enclosing a copy of the
9 RBHSC paediatric audit meeting minutes for
10 8 November 1996, and that:
11 "The attendance register has not been retained ...
12 it is therefore not possible to know whether Claire
13 Roberts' death was discussed at any particular meeting."
14 The implication of that correspondence was that it
15 may have been discussed on 8 November and that's why
16 I think you were asked, "Were you there on 8 November?",
17 and you were.
18 A. I was definitely at an audit meeting on 8 November and
19 I presented a case. I remember Dr Steen presenting
20 Claire's case at an audit meeting. I would not have
21 been presenting Claire's case at a mortality meeting.
22 THE CHAIRMAN: Maybe the way through this is that since you
23 do remember Claire's case being presented and you were
24 at a meeting in November, they're almost certainly not
25 the same meeting because Claire's care could not

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1 lesson to be learned from Claire's death is that you
2 need to do regular electrolyte testing, isn't it?
3 A. Yes.
4 THE CHAIRMAN: I don't understand if the view held
5 in October 1996 was that either encephalitis or
6 status epilepticus was the foundation for the
7 development of SIADH, which in turn leads to
8 hyponatraemia, which in turn leads to cerebral oedema,
9 which in turn leads to Claire's death; is that not
10 a lesson to be learned?
11 A. Yes, that is a lesson to be learned, but would that not
12 have come out at the meeting? Would that not have been
13 presented at the meeting?
14 THE CHAIRMAN: Well, the reason I asked that was because
15 you've no recollection of any lesson being learned from
16 the meeting and there's just no -- nobody has any
17 recollection.
18 A. I can't remember specific, "Here are the learning
19 points", rather than, "This is what happened", and the
20 audience are supposed to draw their own conclusions.
21 THE CHAIRMAN: The only way in which this would come out
22 would be if it was identified at the meeting and picked
23 up as a specific issue that Claire's electrolytes or
24 bloods were not tested between Monday evening and
25 Tuesday night. Mr Walby said here quite bluntly

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1 yesterday that if the Roberts sued the Trust, the case
2 would be settled because there was a failure to carry
3 out a blood sample. So if we take that approach, then
4 the lesson to be learned from the meeting is: we made
5 a mistake in Claire's case, we did not repeat the blood
6 test between Monday evening and Tuesday night, and had
7 we done that, Claire's death might have been avoided or
8 at the very least the SIADH element could have been
9 identified and treated. That might still leave an
10 unknown issue of some form of encephalopathy, but at
11 least we can learn from Claire's death because we made
12 a mistake there.

13 I don't get the impression from you that whatever
14 was discussed at that meeting went along those lines.
15 In fact, it involves Dr Steen -- not necessarily
16 personally, but on behalf of the group -- putting up her
17 hands and saying, "We got this wrong". And that is
18 something which indisputably went wrong, isn't it?

19 A. Yes.

20 THE CHAIRMAN: I do not see in any of the masses of
21 documentation any acknowledgment from 1996/1997, or in
22 2004, that this is what went wrong. If that had been
23 discussed along the lines that I've outlined at that
24 meeting, would you not have remembered it?

25 A. I think I would have remembered that.

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1 MR McALINDEN: Professor Young was in London all day
2 yesterday, so I managed to get him in Heathrow last
3 night, where he looked at the documents online. He is
4 very happy to waive privilege in relation to that issue.

5 We still haven't had any word from Tughans in
6 relation to the position of Dr Webb. They were supposed
7 to inform us at 10 o'clock this morning as to the
8 position, but there has been no information provided.

9 THE CHAIRMAN: Okay.

10 MR McALINDEN: So there's one document which is
11 a consultation note with Professor Young, taken prior to
12 the inquest, which is 7 April. Dr Webb has no
13 involvement in that, so that document can go to you at
14 this stage. The other two documents -- one is
15 a consultation with Dr Webb, obviously that matter is
16 still to be resolved.

17 THE CHAIRMAN: That's a telephone --

18 MR McALINDEN: Yes. The third document is a consultation
19 note which seemed to have occurred just before the
20 inquest started, the morning of the 27th. Both Dr Webb
21 and Professor Young were there. Obviously
22 Professor Young is happy that the inquiry has that
23 document, so the only reason for the hold-up is the lack
24 of confirmation from Dr Webb's legal team in relation to
25 his position.

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1 THE CHAIRMAN: Thank you.

2 MR STEWART: Thank you, sir. I have just one more question.
3 Did you have any discussions with Dr Taylor on
4 23 October 1996 in the intensive care unit?

5 A. Yes. I handed over my care of Claire to him some time
6 between 8 and 9 o'clock and I would have outlined the
7 history as I understood it, namely that Claire came in
8 with encephalopathy on the basis of encephalitis,
9 status epilepticus, developed SIADH, got hyponatraemia
10 and has had a respiratory arrest.

11 MR STEWART: Thank you.

12 THE CHAIRMAN: Are there any questions for Dr McKaigue
13 before he finishes? Mr Quinn? Before I come to you,
14 Mr McAlinden? Nobody else? No questions?

15 Doctor, thank you very much for your time. It has
16 been very helpful and you're now free to leave.

17 (The witness withdrew)

18 Ladies and gentlemen, we'll take a break. I think
19 we're going to facilitate Dr Murnaghan next and we'll
20 start in about 10 or 15 minutes. Thank you.

21 (11.30 am)

22 (A short break)

23 (11.49 am)

24 THE CHAIRMAN: Just before we start, have we any word from
25 Professor Young and Dr Webb about the privilege?

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1 THE CHAIRMAN: Okay. If they're not consenting, then I'm
2 going to bring them back tomorrow morning to deal with
3 this issue. I'm very anxious to avoid the scenario that
4 we had at the end of June where the Brangam Bagnall
5 consultation note came in and then we had to start
6 recalling witnesses and disrupting the schedule.

7 We'll contact Tughans before lunch and say that
8 if we don't have confirmation this afternoon, then we
9 will deal with the privilege issue tomorrow morning.
10 And, in effect, that would be representations by Dr Webb
11 as to whether he can't claim privilege, if that's what's
12 doing. We will need an answer one way or the other. It
13 also might help with Mr Walby's evidence later today if
14 we had that cleared in advance. I'm already
15 inconveniencing him by bringing him back a second day
16 and then asking him to wait. I want to avoid bringing
17 him back for a third day if at all possible. Thank you.

18 DR GEORGE MURNAGHAN (called)

19 Questions from MR STEWART

20 MR STEWART: Dr Murnaghan, welcome back. Just to remind
21 ourselves of where, in 1996, you stood: you were, at
22 that time, director of medical administration in the
23 Trust and, from early 1997, you were re-designated
24 director of risk and litigation management.

25 A. No, sir. That re-designation did not apply to me. That

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1 happened subsequent to my resignation.
2 Q. Are you saying that you were never director of risk and
3 litigation management?
4 A. That's not what I'm saying. I said that the second
5 title that you ascribed to me did not arise until after
6 I left the Royal site.
7 Q. Are you saying you were not the director of risk and
8 litigation management?
9 A. Correct.
10 THE CHAIRMAN: It's on your CV, doctor.
11 MR STEWART: In the Adam Strain case, we looked at a letter
12 that you had signed as that person. In fact, I think it
13 was one of the letters notifying consultants that the
14 medical negligence case had in fact settled.
15 THE CHAIRMAN: Just while you're looking for that, on
16 Dr Murnaghan's CV --
17 A. I accept that part, chairman. My memory going back --
18 what is it, 16 years now? -- is that at all times I was
19 director of medical administration. I may be wrong,
20 but --
21 MR STEWART: Can we please look at 060-010-015? This is
22 a note of 9 May 1997. Do you see at the top left-hand
23 corner it says:
24 "From Dr GA Murnaghan, director of risk and
25 litigation management."

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1 A. Correct.
2 Q. And you were accountable to the chief executive.
3 A. Correct.
4 Q. So you had very close links with the highest levels of
5 clinical governance in the Trust.
6 A. Yes.
7 Q. Indeed you shared a floor, I think we remember from the
8 evidence, in the same office as they did; is that right?
9 A. Could you repeat that for me? I just missed --
10 Q. Your office was on the same floor --
11 A. Correct, it was, yes.
12 Q. -- in the same building?
13 A. Yes.
14 Q. But at the same time, I think you told us you maintained
15 pretty close --
16 A. I beg your pardon. I changed my location somewhere --
17 I don't know exactly, somewhere between 1994 and 1995
18 time to another building on the Royal complex.
19 Q. Did you continue in 1996 to --
20 A. Because you'll see on this 1997 letter that there is an
21 address, third line from the top:
22 "1st floor, east wing."
23 Q. Yes.
24 A. I transferred from the place that you described was the
25 same floor as the chief executive and medical director

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1 Does that jog your memory?
2 A. Honestly, it doesn't, and I have no memory of the title
3 changing from one to the other. But if it's there, it's
4 there --
5 Q. Thank you.
6 A. -- and I accept that.
7 Q. Is it correct that you in fact resigned your post the
8 following year in February 1998?
9 A. Correct.
10 Q. Further, just to remind ourselves of the context,
11 in June 1996, you had been involved with Adam Strain's
12 inquest.
13 A. Is that a question?
14 Q. Yes.
15 A. The answer to that is "yes".
16 Q. And also at that time in 1996, at the time that
17 Claire Roberts was admitted to the Royal Belfast
18 Hospital for Sick Children, you were also handling the
19 claim brought by Adam Strain's family, the medical
20 negligence claim.
21 A. That's correct.
22 Q. You were also at that time charged with the coordination
23 of medical audit within the hospital; is that correct?
24 A. That's correct.
25 Q. And you also reported to the medical director.

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1 to this other office, which gave us more office space
2 in the east wing. Somewhere -- 1994/1995 time.
3 THE CHAIRMAN: Okay, thank you. But that didn't --
4 A. It didn't preclude me from having access.
5 THE CHAIRMAN: In fact, it was a necessary part of your job
6 that you had direct contact with the medical director to
7 whom you reported and the chief executive to whom you
8 were accountable?
9 A. Yes.
10 THE CHAIRMAN: Thank you.
11 MR STEWART: And did you also continue your practice in 1996
12 of walking around the hospital and talking to people?
13 A. Certainly.
14 Q. I think you led us to understand that in fact you liked
15 to keep tabs on what was going on on the ground.
16 A. Yes.
17 Q. The inquest, you described to us in your previous
18 evidence, was something of a surprise to you because
19 external criticism was received in relation to the care
20 and the management of a patient and that you hadn't seen
21 external criticism being levelled in that way before at
22 a doctor in the hospital. That was what you told us; do
23 you remember that?
24 A. Could you bring that up for me, Mr Stewart, please?
25 Q. Yes. It is the evidence that you gave to this inquiry

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1 on 11 September 2012 at page 181. Perhaps I could read
2 to you, if I may, at line 5, you said:
3 "But at that time, and in the context of what had
4 happened, it was an extreme example."
5 We are talking about Adam Strain's case:
6 "I had never come across a situation where an
7 external expert had criticised the clinical management
8 of any colleague in any of the multiple specialties that
9 we had at the Royal. I had never come across anything
10 like that."
11 A. That is my correct interpretation of the situation then.
12 Q. So in other words, the Adam Strain inquest was something
13 remarkable?
14 A. Correct.
15 Q. And accordingly, and because of that criticism, it was
16 something from which lessons could be readily derived.
17 A. And were intended to be so done. I've already explained
18 how that was my intention, but didn't happen.
19 Q. We'll return to that in a moment. The point I want to
20 ask you about is medical audit. Witness statement
21 WS015/2, page 22. You were asked about the purpose of
22 medical audit. The actual question is posed on the
23 previous page, page 21. If we could have the two up
24 together:
25 "Please state whether there existed a formal

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1 Q. Very well. Can we take them step-by-step? There was no
2 medical audit done to review the external criticism that
3 the coroner had accepted and which you found so
4 remarkable. And you've also referred to the seminar
5 which you had intended to organise. Just so that we can
6 remind ourselves, the notes appear at 059-001-001 and
7 002. If those two pages could be displayed side by
8 side. This was the note you took at the end of the
9 second day of Adam Strain's inquest. Do you want me to
10 read this out in full:
11 "Attended Coroner's Court. Ms Strain was
12 represented by a barrister who made a major 'meal' of
13 most witnesses. Generally, the outcome was satisfactory
14 with a fair write-up in Friday's Evening Telegraph.
15 Other issues identified which relate to structure and
16 process of paediatric renal transplant services. Agreed
17 with [Dr Carson] that should deal with this as a risk
18 management issue and arrange a seminar with Doctors
19 Mulholland, Hicks, Gaston, Taylor, Savage, O'Connor,
20 Keane and [yourself] present [underlined] ASAP."
21 And you ended up by saying:
22 "Additionally [you] telephoned the editor of the
23 Belfast Telegraph to thank him for his correct and
24 sensitive reporting of the inquest."
25 And then you told us in your evidence to the inquiry

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1 approach to assessing and developing the competence of
2 the staff ..."
3 And it is (b) and (c) I'm interested in:
4 "A formal approach to: (b) disseminating outcomes
5 and lessons learned internally, both before and after
6 the inquest; (c) disseminating outcomes and lessons
7 learned externally, both before and after the inquest."
8 And you have responded:
9 "This was the intended purpose of the medical audit
10 process."
11 By that, did you intend to mean that any lessons
12 deriving from an inquest could be in fact disseminated
13 through the medical audit process?
14 A. Yes, and that is the purpose of my answer there.
15 Q. Did you ensure or take any steps to ensure that
16 a medical audit of Adam's case did take place?
17 A. As I've just, in my penultimate answer -- I've explained
18 that I intended so to do, but it didn't happen, and
19 I remain sorry that that didn't happen.
20 Q. I think you're referring to a seminar --
21 A. Yes, which would have fed into the medical audit
22 process.
23 Q. Which, with respect, is not the same as the medical
24 audit --
25 A. I accept that. One is linked to the other, Mr Stewart.

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1 that this was in fact intended to be a discussion of the
2 totality of the Adam Strain case and you intended it to
3 address the issues arising at the inquest.
4 A. That's correct. Chairman, if I may just put this in
5 context --
6 THE CHAIRMAN: Sure.
7 A. -- because Mr Stewart is asking me about medical audit.
8 The list on the right-hand page there has names of
9 at least five members of staff of the Royal Belfast
10 Hospital for Sick Children, all of whom were involved
11 in the inquest in one way or another. And all of whom
12 would have been invited at least and expected to attend
13 when Adam Strain's unfortunate death was discussed.
14 THE CHAIRMAN: Yes.
15 A. So while I didn't feed directly into it, I knew that the
16 death would be discussed subsequently. This meeting was
17 intended to reinforce that issue. And as I've
18 previously explained in my evidence in the Adam Strain
19 module, unfortunately it didn't happen, and regrettably
20 it didn't happen.
21 THE CHAIRMAN: Yes, sorry, just to clarify, doctor: you say
22 you knew it would be discussed subsequently; do you mean
23 that you knew it would be discussed subsequently even
24 without this seminar which you were planning?
25 A. Yes.

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1 THE CHAIRMAN: Right. And it would be discussed
2 subsequently, quite apart from the seminar, through the
3 audit process?
4 A. Yes --
5 THE CHAIRMAN: Right.
6 A. -- or the mortality process.
7 THE CHAIRMAN: Yes.
8 A. Whichever. And at that time they were virtually
9 coterminous. I hope that helps.
10 MR STEWART: But if your key responsibility was to
11 coordinate medical audit, why did you not coordinate and
12 ensure that Adam's case was the subject of a medical
13 audit?
14 A. Mr Stewart, I can't answer that question because my
15 coordination means that one ensures that medical audit
16 is happening, but not the particular -- of any
17 particular patient.
18 Q. Not even when it is one when an external expert does
19 something you had never come across before?
20 A. But as I've explained, there were at least five
21 colleagues from the Children's Hospital who would have
22 been present and would have ensured that that did occur.
23 Q. It doesn't seem to have occurred. Can you explain how
24 Dr Elaine Hicks was involved in the Adam Strain case?
25 A. I have problems with my memory in regard to the exact

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1 and failed to do so in the period before summer holiday
2 time, July and August. Next, I went on leave myself the
3 second fortnight in July and, close to or during my
4 holiday, the end of my holiday, I got sick."
5 Perhaps on to the next page, 210. It's mostly the
6 chairman asking, but maybe 211. The point you're making
7 there is that your staff took forward the process of
8 inviting people.
9 A. If you would go back to the previous page, please.
10 Q. Yes. Did you spot it there? 210.
11 A. If you go to 21, the chairman paraphrases me:
12 "I'm the one to take all the blame for this."
13 I think that's what you --
14 Q. That wasn't what I was searching for because I do
15 remember you saying that. What I was searching for was
16 the fact that you were getting your staff to organise
17 it, and we've heard evidence from all those other people
18 who have all been asked, "Were you contacted about
19 a seminar? Were you invited to a seminar? Were you
20 asked about a seminar?", and not one of them has said
21 they remember anything about that. The conclusion might
22 be that they weren't contacted and no invitation was
23 issued. Can you comment on that, please?
24 A. I can't. No, I cannot, because all I can do is depend
25 on my written evidence.

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1 detail of when she and Dr Mulholland shared
2 responsibilities and one or other took over from one or
3 the other. I don't know.
4 Q. I asked --
5 A. If I may finish. Her name is there because I believed
6 at that time that she had a directorate
7 responsibility --
8 Q. Can we go --
9 A. -- and that is what my memory makes me believe.
10 THE CHAIRMAN: Yes, it seems that she was going to be the
11 incoming paediatric lead.
12 A. Yes.
13 THE CHAIRMAN: Right.
14 A. That's what my memory tells me.
15 MR STEWART: You told us last time that, sadly, the seminar
16 didn't happen. Holidays intervened. On your part, you
17 were off on sick leave and the matter wasn't taken
18 forward.
19 A. That's correct.
20 Q. Your evidence, which appeared at page 208 of the
21 25 June 2012 transcript, indicated to us the process by
22 which you set about organising the seminar. At line 3:
23 "My staff, who are very good at organising meetings
24 of this kind and did always work on a matrix of
25 availability, did their best to get colleagues together

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1 Q. You can depend on your staff.
2 A. And I absolutely depend on my staff.
3 Q. Why did your staff not then remember about this seminar
4 to ask people when the holiday season was over?
5 A. I can't answer for that.
6 Q. Why did they not then liaise with you when you returned
7 from your sick leave to discuss this as a pending
8 matter?
9 A. Unfortunately, I can't answer that either, other than to
10 say that time had moved on and other issues had arisen.
11 This is where the whole problem is, chairman.
12 THE CHAIRMAN: I'm afraid it is part of the problem,
13 Dr Murnaghan.
14 A. It's a significant part of the problem for which I take
15 responsibility.
16 THE CHAIRMAN: Let me go on at a tangent to Mr Stewart's
17 point. You were saying that apart from the seminar, you
18 knew that what had emerged about Adam's death and the
19 external criticism from Dr Sumner, you knew that that
20 would be discussed subsequently through the
21 audit/mortality process. Well, do you know if anything
22 ever emerged from the audit/mortality process as
23 evidence that anything had been learned from Adam's
24 death?
25 A. No, I don't. What I do know -- again at a tangent,

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1 chairman, to use your term -- was that there was
2 widespread discussion within the RBHSC of the issues
3 that arose and particularly when Dr Sumner's report came
4 in and then his evidence subsequently.
5 THE CHAIRMAN: You see, the widespread discussion seems to
6 vary. Let me take as an example the lady who you
7 referred a few minutes ago, Dr Hicks, who was the
8 incoming paediatric lead. I think from her evidence the
9 other day, which I'm paraphrasing, she had heard about
10 Adam's death around the hospital, but she didn't have
11 any specific learning or any lesson learned from it. If
12 the incoming paediatric lead doesn't pick up anything,
13 does this not bring us back to what we were talking to
14 you about in June and September, which is to the extent
15 that there was any learning from Adam's death, it was
16 confined to paediatric anaesthetists?
17 A. We're talking now about something for which I have
18 coordinating responsibility, but it was an internal
19 issue within the Children's Hospital --
20 THE CHAIRMAN: Yes, but the --
21 A. -- and there is a remove between the two.
22 THE CHAIRMAN: I understand. I'm sure I'll be corrected
23 from the floor if I'm wrong, but a criticism which was
24 levelled during the Adam segment is, to the extent that
25 anything was learned from Adam's death, it was confined

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1 they don't appear to learn anything. In fact,
2 Miss Duffin, the director of nursing, wasn't even aware
3 of Adam's death according to her evidence to the
4 inquiry. So to the extent that there's widespread talk
5 through the hospital about what happened in Adam's case,
6 it entirely bypasses the nurses and entirely bypasses
7 the director of nursing.
8 A. That worries me and concerns me both because --
9 THE CHAIRMAN: Sorry, let me just develop this. It also
10 worries me because when we come to Claire's case,
11 Miss Duffin knew nothing about that either.
12 A. Nor did I.
13 THE CHAIRMAN: I don't doubt, Dr Murnaghan -- I mean, as
14 I said yesterday, and I don't want any misunderstanding
15 about this, I don't doubt that an awful lot of good work
16 is done for the protection of our children in the
17 Children's Hospital. And maybe I don't get a typical
18 snapshot of it at this inquiry. But what I apprehend or
19 see at this inquiry is that at difficult times, as in
20 Adam's case and as in Claire's case, the system didn't
21 work very well, if it worked at all.
22 A. That appears to be a reasonable conclusion. Now, if
23 I may go back. In the context of the clinical
24 environment, a ward area such as Allen Ward, it's
25 smaller than a village, and everybody talks about and

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1 to paediatric anaesthetists and the issue which was
2 debated in this chamber was whether that was far too
3 narrow a group of people to confine the learning to.
4 For instance, let me take one group who were
5 entirely excluded from everything: the nurses. There's
6 no evidence whatsoever that a single nurse was spoken to
7 about what happened in Adam's case at the time.
8 I think, in fact, when you were here in June you assumed
9 they had been and were rather taken aback to find they
10 weren't. They weren't spoken to at the time of the
11 inquest. They don't appear to have been spoken to after
12 the inquest. There's a whole group of people who have
13 the most hands on-contact with the patients. Isn't that
14 right, the nurses do?
15 A. Well, there was another group, who were the renal
16 physicians as well. They were as intimately involved as
17 the anaesthetists.
18 THE CHAIRMAN: In terms of hands-on treatment of patients,
19 it's nurses who have the most hands-on treatment of
20 patients; right?
21 A. Of course.
22 THE CHAIRMAN: So there's a group of people who are -- I'm
23 sure this is a rather crude way of putting it -- the
24 first port of call because they're the ones who are with
25 the children on the wards, and they're not spoken to,

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1 knows about what's going on, or else they've got their
2 heads in the sand, or they're too busy to know. But
3 essentially, in my clinical practice, in all the years
4 that I was in the various hospitals I worked in, there
5 was nothing that happened that a senior nurse and all
6 the other nurses didn't know about. And as a matter of
7 fact, I was subject, always, to the senior nurse in the
8 ward at any time. And anything I did in that ward in
9 regard to a patient was done with the consent of the
10 senior nurse, who in turn filtered down, as she would,
11 because they met on a regular basis at changeover time
12 and everything was discussed. So much so that if
13 I walked into a ward at handover time, I couldn't get
14 hold of a nurse.
15 THE CHAIRMAN: I see. Thank you.
16 MR STEWART: So time moved on, as you said, Dr Murnaghan,
17 the seminar was forgotten, the audit didn't happen.
18 What about the medical negligence litigation, was any
19 attempt made to extract any lessons from that?
20 A. I think I remember that I, either in June or September,
21 referred to a memorandum that I sent to the clinicians
22 involved saying that the matter had been settled.
23 Q. I think there was correspondence between yourself and
24 Mr George Brangam, the solicitor, in which Mr Brangam
25 advised that there was really no defence to these

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1 proceedings and it was on that basis that settlement was
2 then effected. On the basis that there was no defence
3 to them, that might have seemed to you to be therefore
4 a case where a simple lesson or two could be extracted.
5 Did that occur to you?
6 A. I cannot explain what happened at that time, Mr Stewart,
7 I honestly can't.
8 Q. Was there any --
9 A. My memory doesn't help me in that regard.
10 Q. Was there a system for the extraction of lessons from
11 medical negligence claims at that time?
12 A. Yes, there was.
13 Q. What was that system?
14 A. That system would have been direct conversation between
15 me and the clinicians involved.
16 Q. And would you then have disseminated what you had
17 obtained from the clinicians to others?
18 A. No, because I didn't practice in each of the multiple 11
19 or 12 directorates.
20 Q. All right.
21 A. The job was too diffuse for me to do all of that. That
22 was delegated to the clinical directors in the
23 directorates.
24 THE CHAIRMAN: Okay. So if a patient was injured or a
25 patient died as a result of an error by an anaesthetist,

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1 Trust. That's at WS061/2, page 232; do you recognise
2 that document?
3 A. I do.
4 Q. Can we then go to page 241, which details the
5 responsibilities of the medical risk management group
6 and outlined at the top it has those specific
7 responsibilities. At the top, it just describes what it
8 is describes what it is:
9 "Medical risk management group has responsibility
10 for clinical risk management within the Trust and its
11 undertakings. The group will report through the risk
12 management steering group to Hospital Council on
13 clinical risk management and related matters."
14 It carries on:
15 "The responsibilities of the risk medical management
16 group involve and affect health and safety and
17 non-clinical risk management. For this reason, there
18 must be close liaison between the medical risk
19 management group and the Trust health and safety group,
20 and the director of medical administration will be the
21 link between the two groups."
22 It goes on to say what, on behalf of the medical
23 risk management group, you will do:
24 "Advise on all aspects of medical risk management,
25 provide specialist advice, co-operate with the collation

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1 when the case settled, you would speak to the
2 anaesthetist, but also speak to the anaesthetic lead?
3 A. The clinical director. Yes, I would.
4 THE CHAIRMAN: And you would, on that basis, expect that
5 that clinical director would ensure that, I suppose,
6 number 1, that an eye would be kept on this particular
7 doctor, but that more generally, if there was a lesson
8 to be learned, that that lesson would be learned in that
9 directorate?
10 A. Yes.
11 THE CHAIRMAN: Right.
12 A. Because all sorts of issues arose. Some were
13 particular, some were --
14 THE CHAIRMAN: Yes. Some were serious and some were less
15 so.
16 A. Yes, some were very serious.
17 MR STEWART: Was there any follow-up on that?
18 A. In this particular.
19 Q. Or in a general sense, any follow-up?
20 A. There wasn't the follow-up then that there is now.
21 Q. All right. In 1996, your manifold duties included
22 serving on health and safety committees.
23 A. Yes.
24 Q. And we have now obtained a copy of the November 1993
25 health and safety policy of the Royal Group of Hospitals

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1 and location of information."
2 And then it goes on to set forth the specific
3 responsibilities of the group. Number 3:
4 "Untoward incident reporting (clinical)."
5 Do you remember having responsibilities as part of
6 that group for untoward clinical incident reporting?
7 A. I do, on a daily basis.
8 Q. On a daily basis?
9 A. Yes, I would receive a bundle of forms on a daily basis.
10 Q. Can you take us through the system and procedure that
11 was in place for untoward clinical incident reporting?
12 A. Essentially, untoward clinical incident reporting was
13 performed by nurses, and they had a book, a ward book.
14 THE CHAIRMAN: Is that the statement book?
15 A. Statement book, exactly. Those statements were compiled
16 by nurses in duplicate, a copy was kept in the book, and
17 a copy was sent to my department. They arrived on my
18 desk for review to determine whether any action needed
19 to be taken or whether the appropriate action had
20 already been taken.
21 For instance, I'll give you an easy and common one.
22 I'll give you two different ones. One: granny fell out
23 of bed in the middle of the night. Cot sides had not
24 been put in place and, for granny, in future, cot sides
25 were put in place as appropriate, day, 24 hours, or only

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1 at night. And they would say on the report what had
2 been done.
3 THE CHAIRMAN: Okay.
4 A. That's an easy one. The second easy one is that
5 a syringe needle was found in the bed. The sister in
6 the ward would have gone to war in relation to that
7 matter in the ward area and most commonly it would have
8 been a medical student or a junior doctor who had left
9 the needle behind, but it might have been a nurse
10 because she was giving an intramuscular injection.
11 MR STEWART: What training and guidance was given to nurses
12 as to (a) the definition of an untoward clinical
13 incident, and (b), the criteria for reporting it?
14 A. That, I don't know, but it was just custom and practice
15 and I saw an awful lot of very minor issues coming to
16 me, and the majority, the vast majority, 95/96 per cent
17 of them, were of a very minor nature: slips, trips,
18 falls and so forth.
19 Q. And that's valuable work and very useful information.
20 A. Yes.
21 Q. And it helps patient safety. But the big cases are also
22 important. In fact, in a sense, because the
23 consequences are so very grave, they're so very much
24 more important. In other words, were you relying upon
25 nurses who'd received no guidance to report on the

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1 Q. Yes. Did you ever have cause to speak to the medical
2 staff, to doctors, about reporting on themselves and on
3 each other; was that ever an issue?
4 A. No. Certainly not about what would now be known as
5 whistle-blowing.
6 Q. Was any guidance available to them at that time?
7 A. No, there wasn't. Not that I know of.
8 Q. When you got a medical negligence claim in, would you,
9 as part of your process of responding to it and
10 investigating it, would you have said, "Let's see if
11 there's a statement book entry"?
12 A. I don't think I would.
13 Q. Why not?
14 A. Because I would have depended on the chart, the record,
15 the clinical record.
16 Q. Why would --
17 A. And in the context of medical negligence, what we are
18 talking about is medical negligence, that is
19 something -- or clinical negligence, where something was
20 done allegedly by a doctor or nurse or some other of the
21 paramedical staff, that was alleged to have injured
22 a patient. Now, in that context, the patient's chart is
23 where I started. And that gave me (a) the clinician or
24 clinicians involved, (b) the chronicle of what happened
25 and how it was dealt with at that time and so forth, and

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1 errors of clinicians?
2 A. I relied both on clinicians and nurses. There was the
3 occasion when I would seek out a clinician and he would
4 ask me, "How did you find out about this?", and I would
5 say to him, "The nurses told me".
6 THE CHAIRMAN: The statement book, as it has been described,
7 is most commonly filled with reports of something
8 untoward happening involving a nurse. Does the
9 statement book also apply to doctors?
10 A. The occasional statement came from a doctor.
11 Occasional. Most commonly, the way the statement from
12 a doctor came was a knock on my door.
13 THE CHAIRMAN: Right.
14 A. And there was the third evidence [sic] where a nurse
15 told me and then I went to see the clinician.
16 THE CHAIRMAN: Okay. Thank you.
17 MR STEWART: So nurses were better at reporting than
18 doctors; is that right?
19 A. That, I think, is a reasonable conclusion to draw.
20 Q. And tell me this: when you got, for example, a medical
21 negligence claim coming in --
22 A. Before you continue, I'd better add to my answer that
23 the nurses were better, but they were better because
24 they were reporting on a virtually daily/weekly basis
25 about minor issues.

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1 therefore who I was to approach.
2 Q. You have a system for the reporting of adverse clinical
3 incidents. You're on the committee that is charged with
4 this responsibility and you're also charged with
5 investigating medical negligence claims. Why would you
6 ignore a vital piece of internal evidence, if it
7 existed?
8 A. Well, because I might not have had it.
9 Q. You'd call for it, wouldn't you? You're the director of
10 medical administration. You'd say, "Let me have
11 a look", "How is this case being coded?", or, "How have
12 the nurses responded?", "Where's our internal evidence?"
13 A. Yes, but the internal evidence was not necessarily
14 provided in that way, it was provided in the chart, and
15 didn't -- and unfortunately, now, when we look at it, in
16 the way you're seeking to find out, it didn't come to me
17 in that form. It went into the chart.
18 Q. But you can have a situation --
19 A. I didn't get a statement made up.
20 Q. But you could then face a situation where a chart
21 indicates one thing but a whistle-blower has made
22 a statement in the statement book that says something
23 quite different, and you don't bother to look? Is that
24 really the way you ran the operation?
25 A. Chairman, I'm not too taken with the use of the word

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1 "bother".
2 THE CHAIRMAN: Well --
3 A. I almost take offence at that.
4 THE CHAIRMAN: Are you saying that for these more serious
5 incidents the statement book really was either entirely
6 irrelevant or peripheral?
7 A. The statement book couldn't have given me detail, it
8 could only have given me a one or two liner.
9 THE CHAIRMAN: But it gives you a starting point, doesn't
10 it?
11 A. Yes.
12 THE CHAIRMAN: The fact is that when you get a statement
13 book -- and accepting what you say about 90 or 95
14 per cent of the issues raised in the statement books are
15 minor, which you don't need to follow up on, because you
16 know they're followed up on on the ward --
17 A. And possibly if there was an accumulation of them over
18 a short period of time, I would have gone walkabout.
19 THE CHAIRMAN: The more major ones, if I got you right, the
20 ones involving doctors, say, you say normally it wasn't
21 the statement book, normally you would get a knock on
22 your door; right?
23 A. Commonly and usually.
24 THE CHAIRMAN: Yes. But I think what Mr Stewart is focusing
25 on is that here we have, in Claire's case, a sequence of

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1 left it out of the statement book, so it's almost
2 aggravating the offence.
3 A. Yes.
4 THE CHAIRMAN: In Claire's case --
5 A. It didn't happen.
6 THE CHAIRMAN: And that's I think what Mr and Mrs Roberts
7 are most worried about. They accept things go wrong,
8 people make mistakes, children aren't treated as well as
9 they should and, in this awful case, Claire dies. But
10 the system broke down completely because not only was
11 there no entry in the statement book, not only did
12 nobody report anybody else, and we've just heard from,
13 insofar as Dr McKaigue could remember from the mortality
14 or audit meeting, there was a basic lesson that wasn't
15 learned from it. And it wasn't quite the same in Adam.
16 There was something different in Adam, Adam being a case
17 where the problem, if I might put it bluntly, was that
18 a very, very good paediatric anaesthetist, Dr Taylor,
19 made a terrible mistake and it's almost more difficult
20 to deal with when somebody is very, very good and the
21 impression I've got from Adam's case is that everybody
22 danced around or shied away from ensuring that Dr Taylor
23 had learned a lesson from it because, until he came to
24 this inquiry, just before he came to this inquiry, he
25 appeared not to be facing up to things.

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1 events which don't appear to have featured in the
2 statement book and haven't led to a knock on your door,
3 with the result that you were entirely unaware of it.
4 A. I think I might be able to assist Mr Stewart insofar as,
5 if it got into the statement book, because I would have
6 seen it and done something about it. In that regard,
7 we were along two parallel lines rather than addressing
8 the issue in the way that he wanted to because of the
9 way he put the question to me.
10 THE CHAIRMAN: However it came about, if Claire's case had
11 been recorded in the statement book at all --
12 A. Absolutely.
13 THE CHAIRMAN: -- then that would have come to you because
14 the statement book is in triplicate. One copy of the
15 triplicate comes to you --
16 A. Yes. And one would have gone to the nurse manager's
17 office.
18 THE CHAIRMAN: Right. But this brings us back to an issue
19 which we raised earlier in the last couple of weeks with
20 one of the nurse managers about how do you know, because
21 we're not all very good at putting our hands up and
22 saying we did something wrong, and her answer was: it's
23 such a small community that I found out within a day or
24 two anyway and that's when I really go after the nurse
25 because not only has she done something wrong, but she's

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1 But if you go to Claire's case then, we have
2 a scenario where, as Mr Walby said yesterday, there's
3 a fundamental mistake made in Claire's case, which is
4 not repeating a blood test. He says -- and I think it's
5 quite clear in the evidence that he's right -- if that
6 had been picked up, it would almost certainly have shown
7 a falling sodium level into the potential danger zone,
8 so that at least that aspect of Claire's condition could
9 have been treated, whatever would have happened with the
10 viral condition. And that would have at least increased
11 Claire's chances of surviving and may indeed have saved
12 her life entirely.
13 A. Indeed.
14 THE CHAIRMAN: But this isn't picked up in 1996/1997, nor
15 is, for instance, the overdose of drugs picked up in
16 1996/1997. In fact, that's not even picked up in
17 2004/2006. And that does not -- and I know 2004/2006 is
18 beyond your time, you're there in 1996/1997 -- but the
19 parents in this inquiry are looking for reassurance that
20 these mistakes, when they happen, are picked up and
21 lessons are learned. We know that did not happen in
22 Claire's case.
23 You can only take us up to the time when you left,
24 Dr Murnaghan, but what reassurance can you give that
25 this was a one-off or something close to a one-off?

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1 A. Chairman, if we take Adam's case first, I was in the
2 loop. I think I've explained my role in that loop --
3 THE CHAIRMAN: Yes.
4 A. -- both on the clinical side and on the negligence side.
5 THE CHAIRMAN: Yes.
6 A. In Claire's case -- and I know that the parents are
7 here -- I wasn't in the loop at all. The first I knew
8 about Claire was after the UTV documentary. I just ...
9 One only can say that I wasn't in the loop at all.
10 I never knew about Claire's unfortunate clinical episode
11 and her absolutely regrettable death, with which
12 I sympathise with everybody involved. But I didn't know
13 anything about it and I'm only picking up now on what
14 I read about it.
15 I can explain as best I can from my memory what
16 systems were supposed to be in place, but the systems
17 are only as good as the people that run them and drive
18 them.
19 THE CHAIRMAN: Yes.
20 A. The systems were intended to be there, but they were
21 part of an incremental process of introduction and
22 getting it on the go, and they're driven much better
23 now, I understand, than they were then.
24 THE CHAIRMAN: Okay, thank you, doctor.
25 MR STEWART: Back in the middle 1990s, Mr McKee has told us

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1 top right ... No, it's number (ix) there. I don't
2 understand where (ix) comes from.
3 Q. It comes from Mr McKee's witness statement to this
4 inquiry and it's the ninth exhibit to it.
5 A. Thank you. It's insofar as I thought I recognised the
6 writing, but I don't now.
7 Q. You don't recall this document?
8 A. No. The reason I don't recall this document is because
9 if that -- if this copy came from Mr McKee's files, so
10 to speak, there's no circulation on it.
11 Q. All right. Well, this --
12 A. And there usually would be a circulation list written on
13 it.
14 Q. The reason I ask you is that this may in fact have gone
15 into events at the time the Trust came into being in
16 1993, but it's about a procedure and a system which
17 should have been in place until 1993 for adverse
18 clinical incidents to be identified and reported up.
19 A. Correct.
20 Q. Was there a system until 1993 for the identification of
21 such incidents?
22 A. Formally, I don't remember, but informally there
23 probably was because I would have been in regular
24 communication with board officers in Linenhall Street,
25 in the Eastern Board Health and Social Services.

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1 that the occasional adverse clinical incident case was
2 reported to the department; is that right?
3 A. That's correct. I reported about these matters to the
4 Trust board and to the hospital council when a
5 significant matter arose, like Adam's, for instance.
6 Q. What about reporting to the Department of Health?
7 A. I can't remember specifically about what the reporting
8 line was to the Department of Health, but I know it
9 happened.
10 Q. You know it happened?
11 A. Yes.
12 Q. I wonder if you can help us just understand how this
13 particular circular was operated. It's at WS061/2,
14 page 321. This is from 1991, circular ET5/90, and this
15 is about untoward incidents and the reporting of these
16 and the various times they may be reported and to whom.
17 Do you recognise this document?
18 A. At this remove, I don't, no.
19 Q. This was in order that an untoward incident such as is
20 defined over the page at 322 -- if we go to the bottom
21 of the page.
22 A. Just one second, if I may. Could you go back to the
23 first page, please?
24 Q. Yes. Side by side.
25 A. I wanted to look at -- I thought I saw up on the very

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1 Q. This brings us back to the work of the medical risk
2 management group that you were on, along with the
3 medical director, who chaired it, and then you were
4 liaising between that group and the health and safety
5 group. Surely things must have been more formalised,
6 given the existence of these committees with such high
7 level representation than just: informally there would
8 have been a system?
9 A. I can't answer that question, Mr Stewart, I'm sorry.
10 Q. Is that because you can't remember?
11 A. Exactly.
12 Q. All right. I just want to ask you about your own
13 description of yourself as a link or a facilitator
14 between the Trust and the coroner's office. This is
15 something you described in your initial statement to the
16 police in Adam Strain's case. That's at 093-025-068.
17 Halfway down:
18 "From my experience of other meetings with
19 the coroner, it was common for myself to be present as
20 a facilitator and as the link between the coroner and
21 the Royal Hospitals Group and the Trust."
22 A lot of your work entailed making contact with and
23 liaising with the coroner?
24 A. Yes, it did.
25 Q. And therefore the issue of whether or not a case be

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1 referred to the coroner must have been something that
2 you dealt with a regular basis?
3 A. Not on a regular basis because my colleagues would have
4 decided themselves on the basis of the known
5 circumstances in which -- as Dr McKaigue has explained
6 earlier this morning.
7 Q. Was any guidance or assistance given to practising
8 clinicians as to when they should go to the coroner or
9 what they should do if they're undecided?
10 A. I don't know whether I should use the word
11 "occasionally" or "rarely", but it's one or other of
12 those. It might have been once or twice a year.
13 Q. What form did that guidance take?
14 A. I would get a telephone call: should I, on the basis of
15 this or that clinical circumstance, ring the coroner's
16 office and ask for guidance? My answer always in those
17 circumstances was: when in doubt, ring.
18 Q. If in doubt, do it?
19 A. Yes.
20 Q. Was there anything written down, any criteria circulated
21 for anyone to keep as an assistant?
22 A. Well, the coroner had issued guidance. Now, I don't
23 know whether that guidance had been circulated by my
24 staff or otherwise.
25 Q. Did you direct that it be circulated?

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1 issue resolved. We'll do well to have an answer for
2 2 o'clock, but can we start with Mr Walby at 1.45?
3 Thank you very much.
4 (12.45 pm)
5 (The Short Adjournment)
6 (1.45 pm)
7 THE CHAIRMAN: Just to confirm publicly the position: over
8 lunch, we received a message that, on behalf of Dr Webb,
9 any claim for privilege is not being asserted. The
10 result of that is that I think we now have the documents
11 in file 140 for which privilege has been waived. Those
12 are some correspondence which we had previously
13 received, but of new relevance, potentially, are three
14 consultation notes.
15 Mr McAlinden, I have to say this: I accept that the
16 Trust is fully entitled to assert privilege. It's
17 in the statutory framework under which I operate. What
18 I am unhappy with is the Trust asserting privilege and
19 then waiving privilege during the proceedings and after
20 witnesses to whom the privilege relates have finished
21 their evidence.
22 MR McALINDEN: I appreciate it's unsatisfactory.
23 THE CHAIRMAN: It does run the risk that we may have to
24 recall -- I don't know yet because the notes are being
25 looked at inside. I don't expect there will be anything

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1 A. I can't remember because I have no document to rely on,
2 but I do know that the coroner had a document where he
3 set out in detail what types of case should be referred
4 to him. I've referred to that in one or other of my
5 witness statements, as did Dr McKaigue earlier today.
6 MR STEWART: Very well.
7 Thank you, sir. I have no further questions for
8 Dr Murnaghan.
9 THE CHAIRMAN: Okay. Any more questions?
10 MR QUINN: No.
11 THE CHAIRMAN: Doctor, thank you very much for coming back.
12 Thank you for your time, you're now free to leave.
13 (The witness withdrew)
14 I'm going to recall Mr Walby. It's 12.45. Do you
15 want to break for lunch from 12.45 to 1.45 and start
16 early? Does that make more sense?
17 MR McALINDEN: It might allow further enquiries to be made
18 of Dr Webb's status.
19 THE CHAIRMAN: I've just got a note. Apparently, Tughans
20 are complaining of the late notice of this, but anyway.
21 Mr Conrad Dixon, who I think is the solicitor in Tughans
22 who's been here before, he hasn't been able to contact
23 Mr Alistair Wilson, who's in court this morning. There
24 has been no contact with counsel either, and Mr Dixon
25 will contact Mr Wilson at lunchtime to try and get this

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1 as dramatic as the consultation note in Adam's case, but
2 it is disruptive.
3 MR McALINDEN: Yes.
4 THE CHAIRMAN: What I would ask the Trust to consider in
5 future is, while you have the right to assert privilege,
6 whether in each instance you need to do so, because
7 there's nothing in these documents which you've
8 disclosed which seems to me to be so confidential that,
9 in the rather different circumstances of an inquiry such
10 as this, mightn't have led to a reconsideration at the
11 start of it, whether you claim privilege in the first
12 place.
13 MR McALINDEN: Yes.
14 THE CHAIRMAN: If we do have to recall people, we'll fit
15 them in as best we can -- hopefully next week, if
16 they're available -- but this inquiry generally has been
17 going on for too long and this particular segment of it
18 must be trying everybody's patience, particularly the
19 patience of Mr and Mrs Roberts. They want to know what
20 happened, we want to get to the heart of what happened,
21 but we have to try to do that in as effective and
22 efficient a way as we can.
23 MR McALINDEN: I very much hope that there will be no need
24 to recall anyone arising out of the disclosure of the
25 documentation.

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1 THE CHAIRMAN: Thank you very much.
2 Mr Walby, could you come back again? Thank you very
3 much. You're still under oath from yesterday.
4 MR PETER WALBY (continued)
5 Questions from MR STEWART (continued)
6 MR STEWART: Good afternoon.
7 THE CHAIRMAN: Yesterday we had got to questions about ...
8 MR STEWART: I think, sir, yesterday afternoon I was trying
9 to establish what had been done and what had not been
10 done in the light of the information coming through to
11 you in 2004 about Claire's case. I made a point to you
12 that there was no report made to the department at that
13 time, nor was there an attempt made to locate all the
14 documentation that might relate to the case and secure
15 it, nor was any formal investigation launched into the
16 case.
17 THE CHAIRMAN: Thank you.
18 MR STEWART: Then I was going to take you to where you start
19 to become formally involved in the process, whereby
20 the coroner was informed and the case referred to him.
21 We take up that trail at WS177/1, page 45. The upper
22 e-mail is a communication to you from Dr McBride of
23 15 December:
24 "Peter, I have asked Nichola to copy you the minutes
25 of the meeting with the Roberts family. At the meeting,

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1 note review and, (b), an expert opinion from
2 Professor Young and, (c), an expert opinion from others.
3 We haven't been able to locate or identify any others
4 who may have given an expert opinion at the time; would
5 that be correct?
6 A. I was not aware of any.
7 Q. And was the case note review that of Professor Young or
8 was there any additional case note review?
9 A. I'm not aware of any others than Professor Young's.
10 Q. All right. When you were coordinating notes and
11 reporting to date, did you seek any of those additional
12 items of information that may have existed?
13 A. The e-mail trail which you have in this file was all
14 that I became aware of. I obtained the notes, the
15 clinical notes, in order that I would report the case to
16 the coroner.
17 Q. The e-mail trail continues then at 139-151-001. It's
18 a letter we looked at yesterday. And you get back to
19 him to say:
20 "Michael, I have reported Claire Roberts' death to
21 the coroner yesterday as requested. Mr Leckey asks that
22 the parents should now be invited to contact his office
23 in order to express their concerns directly to him and
24 he will take things from there. I think the letter to
25 Mr and Mrs Roberts should come from your office rather

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1 on my recommendation, we clearly indicated that,
2 following our case note review and the expert opinion of
3 Professor Young and others, we were significantly
4 confident that their daughter's fluid management was
5 a contributory factor to her death amongst the many
6 others involved. In these circumstances, at the meeting
7 with the family, we indicated we would be referring the
8 matter to the coroner. At the meeting, we sought to
9 determine their view on this action as we are aware that
10 HRM Coroner would wish to be informed of their wishes in
11 arriving at this determination. It is clear that our
12 requirement to refer their daughter's case to the
13 coroner has the full support of the family. I need you
14 now to take responsibility of this matter. Nichola will
15 take the lead in liaison with the family and I would ask
16 that you now begin to coordinate notes of the meetings
17 and a report to date so that you are in a position to
18 share this information with the coroner for appropriate
19 action. It will be for the coroner to determine whether
20 he should have discussions with others at this stage."
21 So your instructions were pretty clear there: to get
22 together what you had and to make the report to
23 the coroner.
24 A. That's correct.
25 Q. Looking at that, it looks as though there is (a) a case

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1 than mine, given its adversarial name. I attach a copy
2 of the coroner's booklet for you to include with your
3 letter."
4 Ultimately, the letter was in fact put onto the
5 medical director's writing paper and sent --
6 A. Correct.
7 Q. -- and that appears at 140-061-001 and 002. This is
8 very curious.
9 THE CHAIRMAN: It might be that we don't yet have it on the
10 record for bringing up on screen this document. What
11 date is on that letter, Mr Stewart?
12 MR STEWART: 16 December 2004, from Mr Walby to the coroner,
13 and presumably it will appear also in the coroner's
14 file. I apologise. (Pause).
15 THE CHAIRMAN: If we go to the coroner's file, it's from
16 Dr McBride to Mr and Mrs ...
17 MR STEWART: In fact, it does come from the litigation
18 management office now we look at it.
19 THE CHAIRMAN: Sorry, I know it takes you out of sequence.
20 Can we try to come back to that?
21 MR STEWART: Yes, of course.
22 THE CHAIRMAN: The coroner's file has a letter dated
23 17 December from Dr McBride to Mr and Mrs Roberts.
24 MR STEWART: That's separate. This is a formal letter which
25 makes the referral to the coroner on 16 December. It

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1 also appears at 139-149-001. That's the first page,
2 thank you, and 002.
3 THE CHAIRMAN: Okay.
4 MR STEWART: So this is your letter formally reporting the
5 death to the coroner on the 16th, and indeed I see it
6 finally does come from your office, the litigation
7 management office. I know that you've already commented
8 on this in one of your subsequent witness statements,
9 but I want to draw your attention to your recital of the
10 circumstances in the second paragraph.
11 A. Could I stop you just so that you're aware of what
12 happened? As the previous item you put up showed, the
13 e-mail to Dr McBride was saying I reported the death to
14 the coroner yesterday, and it's dated the 16th. So
15 I reported it by telephone to the coroner on the 15th.
16 Q. Thank you.
17 A. And we had a discussion, and as indeed on a number of
18 occasions where -- it's rare for me to report a death to
19 the coroner, you can understand. Normally, my awareness
20 of a death that the coroner was investigating came from
21 a clinician to the coroner and then the coroner would
22 ask me to deal with matters. I think there have been
23 ten occasions that I have reported a death to the
24 coroner in my 12 years of doing this work, and on each
25 of those occasions I telephoned the coroner because,

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1 10 months is an error --
2 Q. Yes.
3 A. -- and my reading of that was not to give any opinion as
4 to whether -- any description as to whether the seizures
5 had gone on continually or whether they had stopped.
6 There was certainly evidence from the GP's letter that
7 there seemed to have been a seizure which had led
8 partially to the admission of Claire. Therefore, I did
9 not appreciate that there had been a halting of the
10 seizures and I apologise for that. The 10 months error,
11 as you know, comes from the autopsy report. There has
12 been some discussion as to whether the autopsy report
13 was or wasn't in the clinical notes during the previous
14 few days when the meeting was with the Roberts family.
15 All I can say is that when the notes came to my
16 office for me to report the death to the coroner, what
17 I considered was an original autopsy report, albeit
18 unsigned, was in the notes.
19 Q. It was definitely in the notes then?
20 A. It was.
21 Q. And that's where you got this piece of information from?
22 A. Because it says it twice, at the top and at the bottom,
23 and I didn't think to query it.
24 Q. And you didn't cross-reference it against the content of
25 the medical notes and records?

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1 apart from officially reporting the death, there clearly
2 was an issue as to whether the family were aware that
3 there was an issue of a patient's death. Therefore,
4 there was some choreography needed as to how the family
5 were to be made aware, if they didn't know. Now, they
6 did know in this case. So that's the reason why
7 I always telephoned the coroner to tell him about
8 a death that has been reported. He then asked me to put
9 our conversation in writing in a letter, and I have no
10 doubt that, although I haven't seen it as yet because
11 I haven't seen the coroner's file, no doubt there will
12 be a hand note by Mr Leckey of our telephone
13 conversation. But the coroner's file has not been made
14 available as yet.
15 Q. I know. Thank you for that, that's a useful addition.
16 The second paragraph:
17 "The circumstances are as follows: Claire had
18 a history of epileptic seizures since age 10 months and
19 had learning disability."
20 The point is taken that Claire had had her last
21 previous seizure some years before her admission to the
22 Royal and that therefore, to give a history of
23 "epileptic seizures since the age of 10 months", is
24 incorrect.
25 A. Well, it's incorrect on two counts, we now know. The

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1 A. It's not just so easy to see the 6 months. I agree it's
2 there. I would then have had to make a decision as to
3 which one I thought was correct. But I didn't make that
4 choice, I went with what I saw.
5 THE CHAIRMAN: In fairness to you, Mr Walby, on the basis
6 that you're reporting this to the coroner, you're not
7 purporting to give him the complete definition of
8 everything that happened and, when the notes and records
9 are going to be scrutinised, as you expect them to be
10 for the inquest, any inconsistencies or errors should be
11 picked up as part of that process.
12 A. Yes. I really expected this letter to take no further
13 part in affairs. It could have been a one-line letter
14 to ... "Further to yesterday's conversation, I'm
15 reporting Claire ..."
16 MR STEWART: It made no difference because, in any event, as
17 you know, Mr and Mrs Roberts wrote to the coroner to
18 correct what they took as an error and, indeed, Dr Steen
19 also availed herself of the opportunity to correct what
20 she saw as a mistake. So there was some, as it were,
21 oversight of that.
22 Can I ask, on the issue of the autopsy report, were
23 autopsies of that time generally unsigned or were they
24 generally signed?
25 A. I would have thought they were signed. I'm just

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1 thinking from my own clinical practice. I would have
2 thought they were signed. The particular layout of this
3 report and the paper, the heavily textured paper that
4 it's on, made me know immediately that this was one that
5 had emanated from the pathology department and wasn't
6 a photocopy. It was very typical of the autopsy reports
7 that come from the pathology department. So if it had
8 been issued in error as a draft in some way, I would
9 have thought that's most unlikely. And I've heard
10 further discussion during Dr Herron's evidence that his
11 explanation may well have been that he sent a covering
12 letter, which was stapled to it -- and the top left-hand
13 corner, I believe, has staple holes, which suggests that
14 a covering letter might have been taken off before the
15 autopsy report was filed in the notes and therefore
16 a signature of Dr Herron or Dr Mirakhur could have been
17 lost if the copy letter -- if the original letter
18 enclosing the autopsy report wasn't filed in the notes.
19 Q. Do you remember seeing any other unsigned autopsy report
20 turning up at about that time in medical notes and
21 records?
22 A. No, I don't, but I wouldn't have gone looking for it.
23 Q. Subsequently, Mr and Mrs Roberts -- in fact, maybe a bit
24 before -- after their meeting with Dr Rooney and
25 Professor Young and Doctors Steen and Sands,

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1 A. Could I take you, first of all, to 139-152-010?
2 Q. Thank you, yes.
3 A. The bottom e-mail, it's from Nichola Rooney and she's
4 saying:
5 "Michael would also like Dr Walby to get sight of
6 any responses made."
7 That does not say "would like Mr Walby to get
8 involved in the responses". But if you then go to
9 139-173-005, this draft letter is then forwarded to me
10 for my consideration.
11 Q. Yes.
12 A. So Dr Rooney has decided that she would like me to make
13 some comments on this letter.
14 Q. Does she say that or does she simply say it has been
15 forwarded for your consideration? She's, with respect,
16 asking that you become aware of it, consider it, but not
17 necessarily comment on it or suggest alterations to it.
18 A. Well, therein lies the reason for my comment. That is
19 a note where I have made some comments. They may not be
20 appropriate. Then if you then go to -- and if you put
21 it up beside it, the page that you have, 139-139-001.
22 If you put beside it 139-173-001.
23 That shows the secretary's translation of my
24 handwritten note. She's sending, by fax, my suggested
25 amendments to the letter to Dr Rooney, and there was an

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1 in December, wrote a letter setting out a series of
2 questions or queries and issues that they wanted
3 addressed. We find that at 089-006-012. It's a lengthy
4 letter that runs to three pages. A number of people
5 were involved in preparing and putting together a series
6 of responses to this letter.

7 If you see at 139-139-001, that's part of an e-mail
8 trail that has been copied to you because I've come to
9 recognise your handwriting.

10 A. Yes.

11 Q. This is where Professor Young and then Dr Steen indicate
12 they've made changes to the draft responses to be issued
13 by the hospital to Mr and Mrs Roberts, and it's coming
14 to Dr Rooney and it has reached a final, final, final
15 draft, and then you have annotated this e-mail at the
16 top right-hand:

17 "I have made some comments. They may not be
18 appropriate. Please ensure I get a copy of the final
19 letter. I will need to send it with the questions to
20 HMC."

21 And you have initialled that and dated it
22 11 January. We have a copy of what we believe to be the
23 draft on which you made comments. Can I ask you: what
24 did you mean by the phrase "they may not be
25 appropriate"?

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1 appreciation that this was wanted to be dealt with quite
2 quickly. If you look at some of the other e-mails,
3 you'll have seen that Dr Rooney was itching to get this
4 letter out.

5 Q. Yes.

6 A. In fact, the letter that's dated 12 January, sending my
7 comments, it enclosed my comments and asked them for
8 a copy, but it is not put into it "these may not be
9 appropriate". That indicates that I had a query about
10 my part in this. But I took it that the medical
11 director and Dr Rooney had wanted me to. They wouldn't
12 have sent me a draft if they hadn't wanted me to; they
13 would have sent me the final letter if it was just for
14 my file.

15 Q. I suppose they might have wanted you to give your
16 consent to it going out as opposed to your suggestions
17 for its alteration.

18 A. I wouldn't have taken that decision, I wouldn't have
19 consented or withheld consent.

20 Q. You see, there is a bit of a difference between
21 a tentative "I have made some comments, they may not be
22 appropriate", and:

23 "Find enclosed draft copy of your letter with my
24 comments as requested. Grateful if you could let me
25 have a final copy of the letter for my file."

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1 There's a little bit of a disconnect between those
2 two, isn't there?
3 A. I expect we're going to come on to looking at the
4 comments that I've made --
5 Q. Yes.
6 A. -- and you'll realise they're really rather of
7 a different nature than the comments that I make on
8 witness statement drafts.
9 Q. All right.
10 A. They are really margin notes in that I read the Roberts'
11 letter and, with each question, I looked at the answer
12 and I thought there were some disconnects between the
13 two. The purpose of my comments was not largely to
14 amend the drafts, they were to draw the attention of
15 the author, Dr Rooney, that to somebody who hadn't been
16 involved in this before, this answer didn't quite match
17 the question.
18 Q. This is not a major issue, but let's do just that.
19 Let's go to the draft at WS177/1, page 89 and page 90
20 beside it.
21 A. Just to help everybody, you see my written comments and
22 you see the crosses and the ticks. The crosses and the
23 ticks are made much later. When the final letter that
24 was sent was sent to me, I go through it and see which
25 of the comments that I made were taken on board and were

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1 "This suggests we ..."
2 A. I'll tell you what it says:
3 "This suggests we are critical of our failure to
4 move her. Maybe we are?"
5 Q. Yes. So that indicates to you that there's
6 self-criticism. In other words, an acceptance of
7 something perhaps or self-criticism and, of course,
8 having made that suggestion, that comment, of course
9 that leads to that phrase being expunged, taken out of
10 the letter.
11 A. Well, they amended it and they then amend it to the
12 wording that I had written below.
13 Q. Yes.
14 A. Because they ... If they indeed were critical, then
15 they could have said so. I thought that the problem
16 with this was -- the person who would have given an
17 answer to this was Dr Webb. Dr Webb was in Dublin and
18 wasn't involved in dealing with this. Therefore, they
19 have said it is difficult to give an opinion because
20 none of the people who were authors to this letter were
21 those who could give an opinion.
22 Q. You could have annotated it by saying, "Please refer
23 this to Dr Webb for his opinion", as opposed to, "This
24 looks like we're critical of what happened, let's take
25 it out".

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1 not taken on board, were accepted and acted on and which
2 ones weren't. So that gives you -- the first one there,
3 there was a reference in the Roberts' letter to 133
4 sodium and the reply refers to 132. I just have made
5 a note, "This disagrees with the Roberts' 133", yet no
6 comment.
7 THE CHAIRMAN: So you're picking up that, in this instance,
8 Mr and Mrs Roberts had made a small mistake about 133
9 and 132?
10 A. I really wasn't saying it was a mistake; it was just
11 saying: they have asked about the 133 and we're talking
12 about a 132.
13 MR STEWART: So you were highlighting an inconsistency --
14 A. Yes.
15 Q. It's really on the second of those two pages at
16 paragraph 6(b), which says:
17 "It is difficult to give an opinion on why Claire
18 was not moved to PICU."
19 That is a response to a question which asked:
20 "Why was Claire not admitted to intensive care if
21 her condition was so serious?"
22 Why was she not admitted to intensive care?
23 "It is difficult to give an opinion on why Claire
24 was not moved to PICU."
25 Your annotated remark is:

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1 A. You can see exactly -- there's certainly no disguising
2 what I do. I'm absolutely transparent about it and it's
3 up to them to look at it and say -- I mean, they could
4 have involved Dr Webb in it. I don't know whether there
5 was a decision to not do so or what.
6 THE CHAIRMAN: Or if it's pressing to get the response out,
7 going to Dr Webb might slow it down another day or two.
8 A. I'm sure that would have been an additional difficulty.
9 THE CHAIRMAN: Okay.
10 MR STEWART: I was merely going to suggest that because of
11 your work defending the Trust against claims, you might
12 have got into the habit of restricting information that
13 might have revealed vulnerabilities and that is why you
14 thought this was best taken out.
15 A. Absolutely not. I had two different hats, wearing my
16 litigation hat or my coroner's hat. I had to deal with
17 them in a completely different way.
18 Q. This letter is intended by you to go to the coroner as
19 well, isn't it?
20 A. Well, I can tell you from my experience that when
21 the coroner finds during an inquest that there has been
22 some correspondence and that the Trust has been in
23 possession of some information which he hasn't been made
24 aware of, he's not best pleased. So I'm aware that
25 under circumstances like this, the coroner would want to

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1 receive copies of such correspondence.
2 Q. Would you want the coroner to be informed that the
3 letter had received editorial rewriting from the
4 litigation management office?
5 A. Um ... I don't know that that would be necessary
6 because it would apply to all the inquest statements
7 that are received by his office and I am sure that
8 the coroner will have been aware that I was providing
9 assistance to and support to those providing witness
10 statements. So I would have thought that that would not
11 become as any sort of surprise to the coroner.
12 Q. Why do you think the coroner might have been aware that
13 you were involved in, in parts, the rewriting of
14 statements for inquests?
15 A. Well, the first part, you said was?
16 Q. Why do you think the coroner would have been aware that
17 you were involved in partial rewriting of statements?
18 A. He'd have been aware that staff who produce their own
19 attempt at a witness statement frequently do it rather
20 clumsily and in an inappropriate format. And he was
21 used to obtaining witness statements from the Trust
22 which followed the format that he required, in terms of
23 being in the first person and starting off in a manner
24 that the witness will be reading this in the witness box
25 and therefore third person is not appropriate. So I've

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1 know. But it means that that potential warning to
2 Dr Rooney that -- was this right, was maybe not ... It
3 was maybe not appropriate for me to comment, but the
4 fact is, Dr Rooney did want my comments.
5 I think you'll find that there's at least another
6 e-mail, which does refer to wanting comments from me.
7 I think she's in no doubt that she wanted me to make
8 comments.
9 Q. She's going to be with us tomorrow so I can ask her.
10 A. Indeed. And it may well be also that her conversations
11 between Dr McBride and Dr Rooney may have had some
12 implicit instruction that I should see the letter after
13 a final draft. And I did say to you yesterday that
14 there have been other occasions where I have been sent
15 draft letters maybe that the complaints department have
16 virtually got finalised for me to cast my eye over.
17 I think I used the words "proofreading". That's really
18 what this was intended to be.
19 Q. I see. Can we now just follow the trail of this to
20 140-062-001? I'm sorry. I have a completely different
21 document with exactly the same pagination.
22 THE CHAIRMAN: What is it you're looking for?
23 MR STEWART: It's a letter of 25 January 2005. It will
24 appear in the coroner's file from Mr Walby to Mr Leckey.
25 (Pause).

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1 no doubt that the coroner would have known that that was
2 part of my function.
3 Q. You say he would have known and you have no doubt he did
4 know, but did you ever tell him?
5 A. I can't think of telling him in those terms, no,
6 I can't.
7 Q. Did you think that this letter going out to Mr and
8 Mrs Roberts, in response to their questions about
9 Claire, do you think it should have indicated to them
10 that it also has received input from the litigation
11 management office?
12 A. Well, this goes back to the comment that I have made
13 about the appropriateness of it in that I was asked to
14 do it and I did it. I could have drawn the line and
15 gone to the medical director, Dr Rooney [sic], and said,
16 "Send me the final version, but don't let me get
17 involved in the drafting of it". And so I was alert to
18 it at the time, as you can see from my comment, "they
19 may not be appropriate".
20 Q. Yes.
21 A. "They may not be appropriate", unfortunately, did not
22 get translated into the typed letter and it may well be
23 that the secretarial and admin staff in my office
24 thought that everything I did was appropriate and
25 therefore they weren't going to put that in. I don't

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1 Perhaps I could read it to you. It's of no great
2 startling import. It simply says [inaudible]:
3 "I have now received the enclosed series of
4 questions posed by Mr Alan Roberts in his letter of
5 8 December 2004 following his meeting at the hospital on
6 7 December 2004 and a comprehensive reply from
7 Dr Nichola Rooney, on behalf of the hospital, dated
8 12 January 2005."
9 So you forward that to him and then you add:
10 "I will leave it to you whether you wish to forward
11 them to Dr Bingham to assist in compilation of his
12 report."
13 Dr Bingham was the independent expert that
14 the coroner had --
15 MR McALINDEN: Mr Chairman, the reference I have for that
16 letter is 139-135-001.
17 THE CHAIRMAN: Thank you.
18 MR STEWART: Yes. Dr Bingham was the independent expert
19 retained by the coroner from Great Ormond Street
20 Hospital; is that correct?
21 A. Yes.
22 Q. Why did you want these responses to go to the
23 independent expert?
24 A. Well, I didn't, I just said to the coroner "you may send
25 them to Dr Bingham".

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1 Q. Why did you need to suggest that?
2 A. I think I wanted it to be clear that because I had
3 previously written to Dr Bingham -- as you see the start
4 of that letter, "further to my letter to Dr Bingham" --
5 and I had sent copies of the ... The coroner had asked
6 me to send copies of the hospital notes to Dr Bingham.
7 Therefore, I was just marking the coroner's card that
8 I hadn't also forwarded this material on to Dr Bingham.
9 Q. The purpose of asking you these questions is to
10 determine whether or not the information supplied to
11 Mr and Mrs Roberts was substandard in quality and
12 whether poor information was also provided to the
13 coroner. That's the area we're interested in. Did you
14 yourself read Dr Rooney's final letter with any sort of
15 reference back to the medical notes and records or what
16 you knew of the case?
17 A. No.
18 Q. Had you looked at the death certificate or the medical
19 certificate of cause of death?
20 A. I did not do an analytical response to the Roberts'
21 letter. I was a final viewer of it when a lot of other
22 people who had been intimately involved in looking at
23 the case notes -- and therefore it wouldn't have been
24 appropriate for me to be doing that. So when the final
25 letter came, as I've told you, I read it because I went

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1 difficulties this afternoon.
2 MR QUINN: This letter is in a different file and I'd be
3 obliged if ... (Pause). I'll come back to the point.
4 THE CHAIRMAN: Sorry, let's stick with it because we are
5 looking at the issue of how the draft letter to Mr and
6 Mrs Roberts was knocked backwards and forwards a bit
7 within the Trust.
8 MR QUINN: It was. The final draft is referred to in my
9 opening, and when one looks at paragraphs 2(a) and 3(b)
10 of the letter ...
11 MR FORTUNE: 177/1, page 39.
12 MR QUINN: Thank you. This is a final version. It's the
13 second paragraph of 2(a):
14 "Practice now would involve approximately six-hourly
15 checks and use of the CT scanner. However, in 1996,
16 before there was such extensive knowledge about
17 hyponatraemia, it would have been normal practice to
18 monitor sodium level every 24 hours."
19 Then again it's mentioned at 3(b), the third
20 sentence:
21 "As already explained, common practice in 1996 would
22 have been to monitor sodium level approximately every
23 24 hours."
24 What the Roberts family want to know -- and this is
25 the question specifically highlighted by Mr Roberts

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1 X and tick to see, but it then was the Trust's letter,
2 which was a response to the Roberts', and if there were
3 errors in it -- at that stage, it would not have been
4 for me to be getting involved in that. This was what
5 the Trust had said to the Roberts in response to their
6 letter and I was sending it to the coroner for his
7 information.
8 MR QUINN: Mr Chairman, if I can just come in. I don't want
9 to come back on this point later on. I wonder,
10 Mr Chairman, if we could look at the transcript of
11 yesterday at page 165. It's day 67, page 165 of the
12 transcript. Sir, we're on the live transcript. I will
13 get back to this point when we find it in the live
14 transcript and marry it up. It's a quote that the
15 witness said yesterday. It's in relation to what he
16 said about the blood test and that is that the claim
17 would be settled on that point alone. It's in relation
18 to litigation and it is in the transcript.
19 Before we move off this point, what we want to know
20 is: when one looks at the letter, at the final draft of
21 the letter, which is at 196-018-113, you can see that
22 this point is referred to at paragraph 2 and paragraph 3
23 of the letter. Perhaps the letter could be brought up.
24 The letter is 196-018-113. (Pause).
25 THE CHAIRMAN: We are clearly having referencing

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1 yesterday after the evidence -- is if this witness was
2 aware that there was a problem with monitoring the blood
3 levels in 1996, that is that he would have advised
4 settlement of the case on the basis of the failure to
5 monitor the levels, then why weren't the parents simply
6 told that? Why wasn't the Trust at this stage open and
7 honest and told the parents that there was a problem and
8 that they've recognised this problem?
9 The question is: why did the clinicians tell the
10 parents through this letter that it was normal practice
11 when the witness seems to be saying: well, if it was
12 normal practice, I would still have settled the
13 litigation on the basis of what I know about it.
14 THE CHAIRMAN: And the difference in Claire's case was that
15 even if it was normal practice in 1996, the fact is that
16 she had come in with a slightly low level.
17 MR QUINN: 132.
18 THE CHAIRMAN: And that is the issue which should have
19 prompted a repeat of the blood test earlier?
20 MR QUINN: Yes.
21 THE CHAIRMAN: And your evidence yesterday, Mr Walby, was
22 simply on the failure to repeat the blood test, that
23 that would be enough for the Trust to be advised to
24 settle a medical negligence claim.
25 A. Yes.

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1 THE CHAIRMAN: You see, the contrast here is between the
2 information given to the Roberts in 2005, I think this
3 letter is, and what you said yesterday.
4 A. But what I said yesterday was with the benefit of all my
5 knowledge at the end of an inquest. I mean, I fully
6 accept that the doctors, the paediatricians, would have
7 been monitoring electrolytes once a day in children
8 where there wasn't any specific reason to do it more
9 often. I think we've heard evidence that indeed there
10 was reason to be doing it more often. And that will
11 have been the basis of -- was the basis of my answer
12 yesterday, that a claim would have been settled.
13 MR QUINN: I sort of used a bit of foresight and I expected
14 that that would be your answer. But that then leads on
15 to the question, Mr Chairman, and through you again: if
16 Mr Walby, as I suspected he would say, left the inquest
17 knowing that there were mistakes made by the Royal
18 Victoria Hospital, why was no action taken? That is an
19 even more pertinent point in relation to the governance
20 issues that we have here know because he knew precisely
21 then what he said yesterday to the inquiry, yet nothing
22 seems to have been done.
23 THE CHAIRMAN: In terms of internal audit or lessons
24 learned? I know we're jumping around a bit on this, but
25 do you see that point?

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1 earlier; right?
2 A. Yes.
3 THE CHAIRMAN: I've been told that repeatedly, that
4 governance was more advanced by 2006 and from what I've
5 been told, it's more advanced today.
6 A. Yes.
7 THE CHAIRMAN: By 2006, for instance, Dr Hicks, who gave
8 evidence yesterday -- she wasn't asked directly.
9 I didn't pick up any understanding from her that she had
10 learned anything from Claire's case. So is it really
11 safe -- let me ask you it in this general way -- to rely
12 on: there has been an inquest, it has been quite
13 high-profile, so everybody's heard about it?
14 A. Could I take you to my answer to question 8 of my first
15 witness statement? I am asked the question:
16 "What did [I] think about learning from these
17 cases."
18 My answer is that I felt the learning was on the
19 basis that you needed to do electrolyte testing as often
20 as required and you needed to look at the results and
21 you needed to act on the results. I have a feeling
22 that, if indeed Claire's case was discussed at an audit
23 meeting, that the learning that may well have come out
24 of it after a discussion with all the junior doctors who
25 were there would be to say that that is the important

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1 A. Yes, and I did say that the normal sequence of events,
2 which would occur following an inquest, didn't happen in
3 her case because there was knowledge by most parts of
4 the Trust about this issue. The medical director knew
5 about it and therefore it wasn't taken further.
6 THE CHAIRMAN: I know we're continuing to jump around, but
7 in Adam's case, as Dr Murnaghan has reminded us this
8 morning, a view was taken that the only lesson to be
9 learned in Adam's case was to be learned by paediatric
10 anaesthetists. And the consequence of that is that
11 nothing was learned from Adam's case beyond the
12 paediatric anaesthetists because the note which was
13 provided to the coroner in Adam's case towards the end
14 of the inquest was effectively drafted collectively by
15 the paediatric anaesthetists and circulated only to the
16 paediatric anaesthetists. So nothing was learned. If
17 it was a lesson at all, it was a minimal lesson. And
18 apparently on the basis -- well, they're the only people
19 who need to be concerned about this. In Claire's case,
20 as I understand it, what you're saying is that given the
21 outcome of the inquest, everybody who needed to know had
22 heard about it.
23 I'm curious about that, Mr Walby, because
24 I understand that, by 2006, governance had developed
25 considerably from the position it was in ten years

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1 point. The failure is -- it's a failure to monitor
2 blood levels at the right time and then act on the
3 results. And it would be just the same if the patient
4 had a drop in haemoglobin and it wasn't tested until the
5 patient had a collapse with a haemoglobin of 4. It's
6 exactly the same story that you need to get the doctors
7 to be aware of, that you need to monitor results often
8 and act -- monitor particular criteria often and act on
9 the results.
10 THE CHAIRMAN: Sorry, when I asked Dr McKaigue about this
11 this morning, about a lesson which might have been heard
12 from any mortality or audit review of Claire's death,
13 and I suggested to him a lesson that might be learned
14 from it, he said that that wasn't any lesson which he
15 remembered and he thinks he would have remembered it.
16 I think you were here and you'll have heard that
17 exchange.
18 A. Yes. As he was giving that answer, I thought to
19 myself: you would not remember now, at an audit meeting
20 in 1996, that the outcome of a case was that you need to
21 do the blood tests very often. It's a generic --
22 THE CHAIRMAN: Sorry, this is a more specific point, which
23 is what is, on the evidence, a possible but unusual side
24 effect of encephalitis is that it leads to SIADH and
25 that is the particular reason in that condition that you

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1 don't need just to worry about treating the
2 encephalitis, you also need to keep a particular eye on
3 the sodium level because that can unexpectedly
4 deteriorate very quickly. So this much more than doing
5 blood tests every 24 hours, this is stepping up blood
6 tests in a child who's suspected to have encephalitis
7 because it may not be the encephalitis which really
8 threatens her health or kills her, it might be the SIADH
9 leading on to hyponatraemia, leading to cerebral oedema,
10 leading to death: is that not the lesson?
11 A. I do accept that, but if you had just by rote done the
12 blood test sooner, then you'd have been on the ball to
13 be picking this up.
14 THE CHAIRMAN: Okay. Mr Fortune?
15 MR FORTUNE: Sir, we seem to have ranged far and wide.
16 THE CHAIRMAN: We do, a bit.
17 MR FORTUNE: It's very difficult when Mr Walby talks about
18 "clinicians", "most parts of the Trust", as to who he is
19 referring to. Perhaps we could --
20 THE CHAIRMAN: That's my concern about Mr Walby's suggestion
21 that the lesson would have been picked up from knowledge
22 of the inquest because that strikes me as being
23 questionable, about whether that's really an adequate
24 response in 2006 from a governance perspective.
25 MR FORTUNE: And also, sir, an expression that's been used,

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1 you were giving information to the coroner on behalf of
2 the hospital as though it was officially the hospital's
3 information.
4 A. Are you suggesting to me that the reply from
5 Nichola Rooney's wasn't the hospital's ...
6 THE CHAIRMAN: The reply from Dr Rooney, she is not
7 a medical director. I understand that her position
8 is that she relied at least to some extent in the
9 answers she gave to Mr and Mrs Roberts on information
10 provided to her by Dr Steen and Professor Young, and we
11 know she had some assistance from you. But let's focus
12 for the moment on Dr Steen and Professor Young.
13 Professor Young had not previously been involved in
14 Claire's case: he didn't know Claire at all, he had
15 never been involved in treating her. Dr Steen was the
16 named consultant and had been involved at least to the
17 extent that she was there on the morning of 23 October
18 when Claire was in intensive care. So if there is
19 an issue about care management, then the fact that
20 Dr Steen has contributed to the consideration of Mr and
21 Mrs Roberts' letter and the response to that letter
22 leaves open the possibility that a person who is making
23 a contribution of substance to the letter sent on behalf
24 of the Royal is a person who's also under some scrutiny
25 herself for her role in Claire's care. And I think

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1 I think for the first time, that this was a high-profile
2 inquest. Well, even if it was a high-profile inquest,
3 what does that actually mean in terms of people in the
4 hospital getting to know what the facts were?
5 THE CHAIRMAN: Knowing that it's on as opposed to knowing
6 the detail of it?
7 MR FORTUNE: Absolutely.
8 THE CHAIRMAN: Yes, I understand.
9 Mr Stewart, I'm not sure where I left you some time
10 ago.
11 MR STEWART: Let's go back to the document I was at, which
12 is the letter 140-062-001. I hope that was the one.
13 No, it wasn't, it was 25 January 2005, 139-135-001.
14 When you forwarded to the coroner Nichola Rooney's
15 comprehensive reply on behalf of the hospital, did you
16 intend the information contained therein to be given to
17 the coroner on behalf of the hospital?
18 A. Yes.
19 Q. This is a case that you knew at that time may have
20 raised a care management problem.
21 A. Yes.
22 Q. And by channelling this information to the coroner,
23 which included information from Dr Steen, who might have
24 been one of the clinicians involved in the care
25 management problem, without checking that information,

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1 you're being asked: is that satisfactory as a position?
2 A. I believe it is satisfactory in that the letter stands
3 aside from the clinical notes. It is to be ... There
4 is a disconnect between the medical records, which were
5 created in 1996, and this letter, which is going to the
6 coroner in 2005. I don't think I would have expected
7 there to be any risk of merging of these two in some
8 way.
9 MR STEWART: It's exactly because of, not just a disconnect
10 but a series of disconnects. Inconsistencies and
11 discrepancies between the medical notes and records and
12 the content of this letter means there's a problem.
13 That's a problem unless it's properly checked and
14 properly investigated. And a version should not be
15 given on behalf of the hospital unless it has been
16 properly investigated.
17 A. Well, you'll recollect that I'm not the director of this
18 letter to be going to the Roberts. That is a decision
19 that has been made by the Trust to reply to the letter.
20 THE CHAIRMAN: I have got that point, thank you.
21 MR FORTUNE: Sir, can I raise one matter in the light of how
22 this question-and-answer part of Mr Walby's evidence is
23 developing?
24 One matter that seems to be beginning to emerge is
25 whether at this stage, if there was, to use the

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1 expression, something of a disconnect, whether somebody
2 within the Trust -- and here is Mr Walby representing
3 the Trust for these purposes -- should have been asking
4 themselves whether the Trust could represent all the
5 interests or whether there was the beginning of
6 a conflict.

7 THE CHAIRMAN: It's an issue which you raised in Adam's case
8 as well.

9 MR FORTUNE: Absolutely because in Adam's case it caused
10 a problem leading up to the inquest and indeed at the
11 inquest.

12 THE CHAIRMAN: Yes.

13 MR STEWART: It's something I raised briefly, the
14 possibility, with Professor Young the other day.

15 Were you alive to that as a possibility?

16 A. Yes, and I presume we're going to be coming on to
17 talking about the witness statements, all four, and in
18 my letter to each of the four, which I can give you
19 references as we go along for -- who would you like to
20 start with?

21 THE CHAIRMAN: We'll pick that point up as we come to those
22 letters.

23 A. Well, I can tell you, I did it to all four. In my first
24 letter to each of the four, I referred to them obtaining
25 their own legal advice.

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1 their witness statement themselves, but yes. Can we
2 look at 129-007-001? It's from the coroner to
3 Dr Michael McBride and it's about the investigation of
4 hospital deaths:

5 "Last autumn, a senior detective expressed concern
6 to me about the present limited role of the police
7 in the investigation of hospital deaths. In particular,
8 concern was expressed at the system that has been in
9 operation for a number of years whereby the medical
10 director or clinical director of the hospital will
11 arrange to obtain statements from staff involved and
12 forward them to me without the statement makers having
13 been interviewed by a police officer. In many
14 instances, the individual concerned had consulted their
15 legal adviser prior to making a statement and the legal
16 adviser had input into how it was drafted. It was put
17 to me that this approach did not constitute 'best
18 practice' as the police should interview those concerned
19 as soon after the event as possible and, where
20 necessary, seize medical notes, any relevant equipment
21 and, if the circumstances of the death warranted it,
22 treat an area of the hospital as a potential crime
23 scene. I agreed that in future, I would agree to
24 a police officer interviewing those involved. The
25 present system would be discontinued."

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1 MR STEWART: Will you permit me to take us through the chain
2 of documents in a chronological fashion so we get there
3 having touched all bases along the way?

4 The first of the documents is the coroner writing to
5 you, 139-147-001. It's 21 December 2004:

6 "Dear Peter, please advise me if you would be able
7 to obtain for me statements from Dr David Webb,
8 Dr Heather Steen, Dr Sands and Professor Ian Young? If
9 you are not, please let me know and I would write to
10 each direct."

11 That gives you your basic instructions to go and
12 chase these people down and obtain statements. And at
13 that time, you had, as I understand it, a witness
14 statement protocol that had been circulated in 2002,
15 dealing with the issue of obtaining statements from
16 witnesses. That's available at 133-003-003.

17 A. That's correct.

18 Q. Presumably that was what guided you in this operation.

19 A. Yes. If you look at that document and marry it up to
20 any one of the four witness statement requests, you'll
21 see the various features of that protocol being
22 reflected in my letter.

23 Q. Yes. With one or two minor variations, yes. Some of
24 them aren't dated and perhaps one could quibble about
25 whether or not each witness decides on the content of

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1 I appreciate that that is a letter and not a formal
2 protocol, but it seems to express a view as to what best
3 practice might be.

4 A. I agree, and ... You extracted this correspondence from
5 one of the Brangam Bagnall files?

6 Q. Yes.

7 A. When it was brought to my attention and there was
8 concern that I had left things in the air because
9 I hadn't taken it to its final conclusion with the Trust
10 solicitors at the time ... But in actual fact, it came
11 away from the legal aspect and was dealt with directly
12 between the medical director and the coroner and the
13 Department of Health. I produced a lot of other
14 correspondence, which -- senior counsel for the Trust
15 gave details of in an e-mail he provided to senior
16 counsel to the inquiry, which gave the paper trail as to
17 how indeed it wasn't that I did nothing. I followed
18 things along and although I wasn't involved in it, I was
19 disappointed to discover that the memorandum of
20 understanding which was developed, which it seemed to
21 have been thought at the outset was going to deal with
22 how hospital deaths are investigated, really only dealt
23 with the complex situation where the health and safety
24 executive, the police, the coroner and the Trust need to
25 form a system for these organisations all to interact.

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1 It left out completely how a simple, straightforward
2 death should be dealt with between the hospital and
3 the coroner. And you have that correspondence.
4 Q. Yes, we have that correspondence. Did you at any time
5 revert to the coroner, with whom you had very regular
6 contact, to ask him what he would like you to do
7 in relation to this communication of best practice?
8 A. Well, when I received this, I thought to myself: I'm not
9 going to hear from the coroner any more. The
10 consequential effect of him putting this letter into
11 operation was that I would cease to get requests from
12 the coroner's office to collect witness statements.
13 When a death occurred that was reported to the coroner,
14 the coroner would report it to the police, the police
15 would get an investigating officer appointed, and this
16 investigating officer would start dealing with the case,
17 assuming it was a murder, and he would downgrade it in
18 the various levels of police investigation as quickly as
19 they could, and that would be the way it would be
20 handled. And that would involve my office ceasing
21 communication with the coroner.
22 THE CHAIRMAN: So that you would not again receive a letter
23 from the coroner, asking you if you could help to get
24 statements from Dr Webb, Dr Steen and so on?
25 A. That's right.

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1 the correspondence. Do you have the e-mail from my
2 secretary of 3 November to Dr McBride?
3 THE CHAIRMAN: 3 November?
4 A. 3 November 2005.
5 THE CHAIRMAN: If it's a short document, would you read it
6 out for us?
7 A. The memorandum of understanding has been issued and it
8 says:
9 "I would have no issue with this. The Health and
10 Safety Executive (Northern Ireland) have clearly taken
11 control of this and most of it is not relevant to us.
12 The issue of how the police manage things once
13 the coroner decides to get involved in a straightforward
14 hospital death gets no mention and that was what started
15 this off, you'll remember, from our perspective."
16 The medical director then e-mails the Chief Medical
17 Officer in giving a comprehensive response to the
18 memorandum of understanding, and that is a letter from
19 the medical director to Dr Ian Carson on
20 4 November 2005. He makes a large number of points
21 in the letter, but the penultimate paragraph says:
22 "On a final note, the memorandum makes no reference
23 to the manner in which the police service will manage
24 processes once the coroner becomes involved in
25 a straightforward hospital death. I would suggest that

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1 THE CHAIRMAN: That would be the logical follow up to this
2 letter of 30 January 2004.
3 A. Yes. And actually, I thought there'll be a bit of
4 a tail-off. There are some letters in the post -- it'll
5 go on for a week or two, but it's going to stop.
6 Nothing changed.
7 THE CHAIRMAN: Okay.
8 MR FORTUNE: Sir, that seems to be the effect of the letter
9 at 129-004-001, when Gary Daly for Brangam Bagnall wrote
10 to Mr Walby by a letter of 14 March 2005. That seems to
11 be the last letter in that chain of correspondence.
12 Certainly, it's the last letter I've seen.
13 MR STEWART: There is a further one at 129-003-001 where Mr
14 Walby responds to Gary Daly to say:
15 "This matter remains in abeyance and, as you know,
16 we still operate the old system."
17 MR FORTUNE: 003?
18 MR STEWART: 129-003-001.
19 MR FORTUNE: I've not got that copied in my file.
20 A. May I say, that is where the inquiry -- as I said in the
21 start of my answer to this -- the Trust solicitors
22 dropped out of this matter. It was taken up by the
23 medical director with the coroner and the department, so
24 the Trust solicitors weren't required. That's why the
25 Brangam Bagnall file ends there. You say you do have

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1 more specific guidance with regard to such processes
2 would be helpful."
3 So my point gets taken to the medical director, gets
4 taken to the deputy Chief Medical Officer.
5 MR STEWART: Yes, but the point remains that you took
6 statements from the witnesses in this case before that
7 memorandum came into existence and you received a note
8 of the coroner's view of what might amount to best
9 practice and you did not revert to him for advice as to
10 how you should implement it.
11 A. That's correct.
12 Q. And that is notwithstanding your general duty to the
13 coroner. It's also notwithstanding what is described as
14 your main duty in your job description:
15 "Assisting the coroner in the preparation of
16 statements."
17 A. Yes. So my method of assisting him --
18 Q. Was to ignore his letter.
19 A. -- would have been to stop co-operating with him --
20 MR McALINDEN: Just in relation to that, perhaps Mr Walby
21 could be asked: the letter that has been referred to, if
22 after that letter had been sent by the coroner to the
23 Trust, did the coroner persist in sending written
24 requests for statements?
25 THE CHAIRMAN: I agree. I think the problem here is that

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1 there is some confusion and uncertainty caused by the
2 fact that the coroner has written to say: I want to move
3 away from the old system because the police have
4 suggested to me that it is unsatisfactory, and he did
5 not then move away from the old system, at least in some
6 areas, and Claire's case is an example of one in which,
7 if you relied on what the coroner had written to
8 Dr McBride on 30 January 2004, he would not have been
9 coming back to you a couple of years later, asking you
10 if you can help to get witness statements from various
11 people. That letter would have gone to the police,
12 saying: please obtain witness statements from the
13 following four doctors.
14 A. Yes.
15 THE CHAIRMAN: Okay. It's a bit unsatisfactory, it's not
16 what the coroner said he wanted to do, it's not what the
17 police said that they wanted the coroner to do, but it's
18 what happened.
19 A. But attached to that letter was Mr Leckey's letter to
20 the Chief Constable, dated 22 September 2003.
21 THE CHAIRMAN: Right.
22 A. And you'll remember that Mr Leckey is writing to Mr Orde,
23 saying that what was being suggested -- there are
24 a number of reasons:
25 "I think it is fair to say that investigating

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1 Professor Young, Dr Steen and Dr Webb.
2 A. Yes.
3 Q. Which order shall we deal with them? Do you want to
4 deal with them all?
5 A. I think the best thing is to deal with them in
6 chronological order, and that's Dr Steen.
7 THE CHAIRMAN: Mr Walby, I'm not going to stop you doing
8 this at all. I already have a specific example which
9 was raised with Dr Webb about his statement, and I think
10 if we can take a few of them as examples and then decide
11 whether I need to go through every single one. I'm not
12 going to cut you off if you think it's important for you
13 to go through every single one, but let's take a few as
14 examples because I suspect that your examples will
15 illustrate the point which you want to make to the
16 inquiry.
17 A. I would like to go through enough of them that the
18 inquiry is reassured that the process that I was
19 undertaking, I could stand over it. Then and today.
20 THE CHAIRMAN: I'm not going to cut you off from doing that.
21 Similarly, I'm not going to cut off the Trust
22 representatives or the family representatives or anyone
23 else from asking any further questions. You were going
24 to suggest starting with Dr Steen.
25 MR STEWART: Could I, sir, suggest Dr Webb because we have

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1 a hospital death may well prove more difficult than the
2 investigation of many other categories of deaths. There
3 a number of reasons for this: identifying all the
4 medical staff involved, locating them and taking their
5 statements, a difficulty in comprehending medical
6 procedures and medical language."
7 And then:
8 "In the past, a number of police officers have
9 stated that they meet with obstruction when attempting
10 to take statements from medical staff and some feel
11 intimidated by having to approach medical consultants."
12 But I must say that I take number 4 -- I would hope
13 the member of medical staff would be arrested if he
14 obstructed a police officer. So I think that one is
15 a bit light, but the others --
16 THE CHAIRMAN: It's a different -- it depends on what ...
17 Obstruction can be active obstruction or a degree of
18 lack of helpfulness. In any event, thank you, Mr Walby.
19 Let's move on from this point. I've got the point
20 that the procedure which was followed for Claire's
21 inquest isn't what the coroner had indicated two years
22 earlier it would be.
23 MR STEWART: I know, Mr Walby, that you'd like to go through
24 the process by which you did take the statements from
25 the various witnesses. There's Dr Sands and

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1 already covered some of this territory. You read the
2 transcript and produced a separate witness statement
3 request in relation to some of the evidence given.
4 A. Let's do that. Could I say one thing beforehand?
5 I felt that it was very important that witnesses should
6 have access to the original hospital notes when making
7 their statements.
8 Q. Yes.
9 A. That's because, as a practising clinician, I was well
10 aware that I would come into the ward, look at the
11 notes, and find a circumstance like you had with
12 Dr Volprecht, where there are blood results written in
13 and you mightn't be sure who wrote it in. Therefore,
14 the colour of the ink and the type of handwriting -- and
15 you could often tell that they were two different people
16 from looking at the originals. The trouble with
17 photocopying the note is that you lose all this. Let's
18 just take Dr Webb.
19 Dr Webb wrote in green ink. He was unique. He
20 wrote in green ink, but unless he looked at the
21 originals, you wouldn't realise that. He wrote in
22 Adam Strain's notes in green ink. He writes in
23 Claire Roberts' in green ink. But when you go to his
24 first note that he makes when he sees Claire, he writes
25 the note in green ink, but the "4 pm" is in blue ink.

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1 That immediately begs the question as to was it written
2 by the same person, did he change his pens? But when
3 you only have a photocopy that you send to Dr Webb,
4 which is of course what happens because you might ask
5 me: why didn't I photocopy four sets of photocopies and
6 send them to the four clinicians on the first day? The
7 day I wrote to Dr Steen, why didn't I send copies? It's
8 because I know that it takes each individual when
9 they're making their own witness statement to look at --
10 focus in on their part and they will want to see ...
11 I'm sure it would have been of interest to Dr Webb to
12 realise that that time was written in a different
13 coloured ink. He may have a good explanation for it,
14 but unfortunately, I wasn't going to pick up the
15 significance of this.

16 So although the other three got their notes to make
17 their witness statement, Dr Webb had photocopies, which
18 was sent to Dublin.

19 Q. And there was no such thing as a colour photocopier at
20 that time in the Royal, was there?

21 A. There are colour photocopiers. I'm not aware of the
22 inquiry having been using photocopies --

23 Q. I wish we had.

24 A. And so I must apologise because I was very much part of
25 the process by which the inquiry obtained Adam Strain's

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1 Thank you."

2 You were still operating the old system whereby
3 individuals were advised to go to their professional
4 body or legal adviser.

5 Then Dr Webb returns to you on 16 May at
6 139-112-001:

7 "I received your letters 22 March and 30 April."

8 Presumably you sent a reminder on 30 April regarding
9 Claire Roberts:

10 "I have produced my report and have sent this to the
11 MDU --

12 Is that the Medical Defence Union?

13 A. Yes.

14 Q. "-- for their comments. As soon as I hear back from
15 them, I will forward my report to yourself at the Royal
16 Belfast Hospital."

17 And you have noted "noted".

18 Moving on to 139-098-001. David Webb writes again
19 on 16 June to enclose his report for the coroner on
20 Claire Roberts:

21 "I hope this is in order. I will be away until
22 10 July."

23 139-098-002 is in fact the statement, I think, that
24 he forwarded to you; is that correct?

25 A. It is.

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1 notes at the end of 2004/2005. Apart from the colour,
2 different coloured inks, laboratory reports have got
3 different colours: haematology uses pink, radiology uses
4 green, and you would now know that text merged into the
5 background when they were photocopied. Therefore, it
6 caused the inquiry a lot of difficulty and I apologise
7 for that. But it would have taken an expert to look at
8 the tone that I set the photocopier on every page as
9 they did it and --

10 THE CHAIRMAN: I understand. Don't worry.

11 A. So it's very difficult. Let's go on to Dr Webb.

12 MR STEWART: The trail starts at 139-124-004 when you write
13 to Dr Webb asking him for the statement:

14 "I should be grateful if you would provide a draft
15 statement outlining your part in the care of the late
16 Claire Roberts."

17 And you say:

18 "Your statement should commence with 'I am
19 a registered medical practitioner ..."

20 And you go on to give the formal warning, I think,
21 that:

22 "This is a legally significant statement and you may
23 wish to consult your professional body or legal adviser
24 before submitting your draft to this office. A booklet
25 explaining the function of the coroner is available.

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1 Q. It's quite a lengthy document for a statement. And
2 you have gone through this, through the succeeding
3 pages, correcting typographical errors, making very
4 minor spelling suggestions and so forth. Until you come
5 to the one with which we are principally interested,
6 which is many pages further on at 139-098-021.

7 There, Dr Webb had written:

8 "I made the mistake of not seeking an intensive care
9 placement for Claire before I left the hospital."

10 And you have put a line through that and written in:
11 "Although I did not seek ..."

12 It seems as though Dr Webb was making an acceptance
13 or an admission of error there and you thought that was
14 inappropriate and decided to excise it. Can you explain
15 why that was?

16 A. Well, "decided to excise it" is not the way I would put
17 it. You've got my witness statement number 3.

18 Q. Yes.

19 A. And to save the inquiry's time, would you like me to
20 amplify any parts of it rather than starting from
21 scratch?

22 Q. Please?

23 THE CHAIRMAN: WS176/3, page 2. (Pause). Do you have it to
24 hand yourself?

25 A. Yes.

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1 THE CHAIRMAN: Okay.
2 A. My belief was and still is that a witness statement for
3 the coroner should be a factual statement and should not
4 contain opinion or comment.
5 MR STEWART: Can I ask where that derives from? On what
6 basis do you understand that a witness statement should
7 not contain comment or opinion?
8 A. I can't quote you chapter and verse, but I understand
9 that that indeed is what's supposed to occur.
10 Q. Does that mean that an individual cannot accept error?
11 A. It doesn't mean that an individual cannot accept error,
12 but in the position of an inquest I have listened to the
13 opening of many inquests by Mr Brian Sherrard, one of
14 the Belfast City coroners, and he always opens it with
15 how the purpose of an inquest is to determine who the
16 person was, where they died and how they died, it's not
17 to apportion blame, and if that's what's being looked
18 for, it's not going to be obtained in his court. I am
19 conscious that witnesses who are being required to
20 provide statements to the coroner are providing factual
21 information to allow the coroner to make whatever
22 decision he wishes to make.
23 Q. But you'll also be aware, having sat through many
24 inquests, that in determining the cause of death, many
25 separate opinions are advanced.

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1 A. No.
2 Q. You think not?
3 A. No.
4 Q. Okay. Secondly, do you think it appropriate that you,
5 as litigation management officer, try to use your
6 general medical knowledge to sway clinicians who were
7 involved in a particular case?
8 A. In this particular circumstance, I did feel that.
9 I mean, as you'll have read, I had a position in which
10 I ... Somewhat analogous, frequently -- whereas it had
11 only happened to Dr Webb once in Allen Ward, comes along
12 as a visiting clinician and has a child in the ward
13 who ... There has to be an issue, could they have been
14 in intensive care or not? I had that in my clinical --
15 I was a practising ENT surgeon, my on-call commitments
16 were to the Children's Hospital and the regional service
17 in Northern Ireland, to provide airway management for
18 paediatric airway emergencies. Therefore, during the
19 winter months, children with croup and epiglottitis
20 would be admitted and they tended to go to Allen Ward.
21 And I had many a child in the four-bedded bay that
22 Claire was in. They would be put in a steam tent, they
23 would be stridorous, and they would be given antibiotics
24 and steroids and I would sit by the bedside for a long
25 period of time and to see was the child going to start

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1 A. Yes, I accept that.
2 Q. Would you also accept that if opinion comment is
3 excluded from a witness statement, it means, for
4 example, that a whistle-blower would be precluded from
5 making comment? That can hardly be the purpose of the
6 system.
7 A. Well, if you take this example, if I was wanting this
8 subject not to be raised, would I not have suggested
9 expunging this sentence and saying, "We're not going to
10 go there"? I wanted the subject to be live, to remain
11 alive in Dr Webb's witness statement, but that it
12 should -- I felt that he was being overly harsh with
13 himself. And here, I have to admit that I was using my
14 extensive clinical knowledge and I was able to appraise
15 him of why I thought use of the word "mistake" was
16 really quite inappropriate here. And you see my long
17 explanation --
18 Q. Can I stop you there? There are a number of things you
19 said there. First of all, you said you did not want to
20 stifle the debate. I'm not quite sure how you phrased
21 it. But if you actually exclude the reference to the
22 mistake in not referring to intensive care, don't you
23 remove from the agenda the very possibility of a debate
24 or reduce the possibility of a debate that it might have
25 been a mistake?

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1 breathe more easily or was the airway going to cause
2 trouble and the patient would then need to be intensive
3 care, me having taken him to theatre on the way there.
4 It's in my statement. That's why I know that because
5 the intensive care bay only has four beds and two HDU
6 beds, that obtaining placement of an intensive care for
7 Claire just would not have been --
8 Q. It doesn't say that. It says:
9 "[He] made a mistake seeking [not obtaining,
10 seeking]."
11 It's a slightly different thing. There are two
12 points from what you just said. First of all, the
13 winter months. This was October, not the middle of the
14 flu season in January or February.
15 A. Oh, by October you're getting admissions to the
16 intensive care unit, it starts to be full of children.
17 Q. Did you in fact check up on the occupancy figures for
18 PICU on that night before you actually gave your advices
19 to Dr Webb?
20 A. No. But my point is that seeking placement of a child
21 who doesn't need airway protection -- we now have
22 a paediatric intensive care which has 12 beds in it.
23 The population of Northern Ireland hasn't increased
24 three times. They're not all funded, but the fact is
25 you do now, with relative ease, get a child like Claire

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1 into an intensive care unit bed. But in 1996, for
2 Claire to be moved to intensive care unit at a stage
3 when she didn't need airway protection, there's every
4 likelihood that an acute emergency will have come in
5 during the night and Claire could have been displaced
6 out of intensive care, without having had any airway
7 preservation.

8 So all I can say is that I spoke to Dr Webb and took
9 him through that scenario and I said, "You're being very
10 harsh on yourself here", as clinicians and nurses tend
11 to be on themselves when things go wrong. And I felt it
12 was appropriate for me to point out to this doctor. But
13 it's his -- and, as I've said at the bottom of this
14 statement, I absolutely would say to every witness that
15 I was advising about the witness statement, it was their
16 witness statement and theirs alone. They had to sign
17 it. And we will come on to Dr Sands', which will
18 demonstrate -- in fact, I can hardly think of a case
19 file that wouldn't be a better example of the way
20 I tried to do my job. And you'll see that in Dr Sands'.
21 Q. We'll follow that up. We might have a short break
22 first, but we'll certainly follow it up. Dr Webb has
23 told this inquiry that he still believes that he made
24 a mistake in not seeking a placement for Claire that
25 afternoon in PICU. In other words, he was trying in his

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1 through what I've just been through with you, and
2 I followed it up with a letter, you'll see then, which
3 is dated --
4 Q. There's no note there by your secretary of any telephone
5 conversation between you and Dr Webb, is there?
6 A. There isn't. But that's what happened.
7 Q. So we move on then, I think, 28 July, to 139-097-001.
8 A. And I think I explained that, that the reason that --
9 I'm pretty good on making file notes about what happens,
10 as you'll have discovered from this file. But the
11 particular circumstance was that the telephone call was
12 taken -- the secretary's office is several rooms away.
13 Therefore, I suspect that the telephone call was
14 transferred down to my office after my secretary had got
15 the administrative details of his e-mail address, and
16 I then had a conversation with him without the file
17 being in my hands. But the letter that goes to him --
18 THE CHAIRMAN: 139-096-001, dated 31 July.
19 A. Yes. If you just read that letter, you might not be
20 aware that it had arisen out of a telephone conversation
21 because it is really making clear that the change that
22 we have made in an e-mail version that it doesn't slip
23 through the net. His witness statement, as you know,
24 was a very long witness statement, and Dr Webb's manner
25 of dealing with correspondence, you'll have become aware

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1 statement to be transparent and honest, and you were
2 trying to stop that information getting through and to
3 shield the Trust from any criticism, even
4 self-criticism.
5 A. Well, I wouldn't accept that.
6 Q. All right. Very well. The trail continues at
7 139-100-001. This is just for the sake of completeness.
8 This is the steps by which the statement then came back
9 up. Your office rings Dr Webb to ask him to e-mail the
10 statement up. His secretary has said they are not
11 allowed to do that because of patient details:
12 "Even though I pointed out Claire was our patient."
13 She needed to check with Dr Webb, and then it goes
14 on to a page of scribbles at 139-099-001.
15 A. The is vital page of scribbles. Could we show that,
16 please? Here we are, 28 July 2005. He phones up to
17 have a conversation with my secretary about putting his
18 statement in e-mail form. And as you see I've
19 mentioned, I was concerned about some embarrassment to
20 Dr Webb if he referred to "Dr Stein" throughout his
21 witness statement. So that in fact was a major reason
22 why we needed to have it redrafted. So I'm in the
23 office at the time that Dr Webb and my secretary have
24 a telephone conversation and I'm asked, do I want to
25 speak to him, and I did want to speak to him, and I went

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1 that it's ... He doesn't deal with correspondence the
2 way I deal correspondence. Let's put it just like that.
3 THE CHAIRMAN: Okay.
4 A. So I wanted to be jolly sure that he didn't print off
5 a copy of his long statement and sign it and send it
6 back to Walby. I needed to make sure that he took on
7 board that our conversation had meant that he was happy
8 that the use of the word "mistake" was not appropriate
9 in a coroner's witness statement. And I would have
10 expected him to return to his defence organisation again
11 and say, "What do you think of this?". I don't know
12 whether he did and it wasn't for me to prompt him
13 further.
14 MR STEWART: Yes. A couple of questions here. You say
15 in the second paragraph:
16 "Statements are usually first-hand accounts of your
17 own actions leaving others to fill in their proportion
18 of the patient management. But in this case, I felt
19 your more comprehensive style of statement is
20 appropriate in this particular case."
21 So you would say that normally you wouldn't have
22 comment and opinion, but in this case your comprehensive
23 style of statement is appropriate; is that what you
24 meant?
25 A. Well, Dr Steen also took that route of providing a very

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1 long witness statement. That was the way -- I certainly
2 wouldn't have tried to constrain somebody in terms of
3 the length of their statement.

4 THE CHAIRMAN: It makes it a bit harder to understand how,
5 given the length of statements they've provided, that
6 some issues were still missed at the inquest. If
7 Dr Webb goes to the trouble of providing a longer than
8 usual witness statement and Dr Steen goes to the trouble
9 of providing a longer than usual witness statement, and
10 in doing so they scrutinise the notes and records,
11 because that is the basis for doing it, it does make it
12 rather difficult to understand how things were still
13 missed.

14 A. Could I put an almost contrary view?

15 THE CHAIRMAN: Go on.

16 A. If Dr Steen had provided a witness statement which took
17 up matters at 3 am and went from there onwards, I think
18 what would have happened would have been that
19 the coroner would have asked for statements from other
20 members of staff and he wouldn't have maybe gone by
21 name, but I think that what would have happened would be
22 that I would have written to Dr Stevenson, Dr Roger
23 Stevenson, and I think that if Dr Roger Stevenson at
24 that time had been asked to make a witness statement, he
25 would have spotted within the hour, as Professor Young

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1 are not very many.

2 THE CHAIRMAN: You see, I don't understand how Dr Stevenson
3 would pick up on the wrong drug administrations because
4 he was a very junior house officer in paediatrics, he
5 didn't know what the administration should be. The
6 person to pick up on the wrong drug administration is
7 the prescribing doctor.

8 A. Well, he would pick up on the calculations.

9 THE CHAIRMAN: Yes, that's one element. There are two
10 different issues. One is the wrong calculation of the
11 phenytoin. The other issue is the wrong -- not the
12 wrong calculation of midazolam, but the wrong
13 administration of midazolam.

14 A. Yes. I think that would have opened up in that if
15 a witness statement went in from Dr Stevenson that just
16 dealt with the error in the dosage, that would have
17 opened up the -- the coroner would have got an
18 independent report from a clinical pharmacologist and it
19 would have taken a different route. But the fact is you
20 sir, needed to get 28 witness statements from witnesses
21 across the world on this, and therefore, in hindsight,
22 I now see what would have got to the nub of it much
23 quicker. But it is with hindsight now and I was acting
24 on the instructions of the coroner, who asked for four
25 witness statements, and at the end of the day received

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1 referred to, that he had made major mistakes in his drug
2 calculations. And I think he would have gone to his
3 defence organisation and said, "Will you look after me
4 while we prepare statements?". I think his statement
5 probably would then, Dr Stevenson's, would not have come
6 through the Trust because those were major drug errors,
7 which I think he and his defence organisation would have
8 considered would have been important that they're
9 reported in a correct way.

10 THE CHAIRMAN: But that's curious because, to use
11 Professor Young's term, if you expected Dr Stevenson to
12 spot the wrong drug administration within the hour, how
13 would you not expect Dr Webb to spot the wrong drug
14 administration within the hour because he was the doctor
15 who had decided which drugs were to be given, and he's
16 also the doctor who Dr Stevenson depended on for
17 advising him of what the rate of administration should
18 be?

19 A. Well, it is curious, but there's no doubt that it
20 concentrates the mind if you're being asked to comment
21 on your own actions. And Dr Webb, in the same way, if
22 he had only concentrated in his witness statement on his
23 own actions, it would have meant that we maybe would
24 have ended up with a broader range of statements, and
25 I feel if Dr Stevenson -- because Dr Stevenson's entries

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1 four and wrote back to me saying, "I don't need any
2 more".

3 MR FORTUNE: Sir, I'm reluctant to enter this debate and I'm
4 certainly reluctant to give evidence. The procedure for
5 obtaining statements depends very much on individual
6 coroners because some coroners, in my experience, want
7 a report from a consultant as to his or her hands-on
8 care, not a report saying, "And this is what happened",
9 referring to many other hands. I cannot speak for
10 Mr Leckey, but certainly the practice does vary from
11 coroner to coroner.

12 THE CHAIRMAN: Thank you very much. Mr Stewart, is there
13 anything further on this letter or not?

14 MR STEWART: Just a couple of points, which will only take
15 a moment.

16 Why was it that you wanted to redraft onto a police
17 witness pre-printed pro forma statement page?

18 A. Well, if I take you to the document that you had up
19 before, 133-003-003, number 5 asks that the final
20 version of the statement must then be presented in
21 standard format for signature by the witness. So
22 that is where I believe it comes from. All I can say
23 is that when I started doing this work in 1999, witness
24 statements were being made out by this system and they
25 were being put on to these forms and there was a police

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1 constable from Grosvenor Road Police Station -- and it
2 was the same police officer over a number of years, so
3 it's not as if it changed -- it was a duty of his to
4 call into the Royal every 10 days or so and collect the
5 bunch of witness statements that we had collected in all
6 the various cases. And I have to say, I had on average
7 65 cases a year that I was collecting witness statements
8 for. So there were quite a number of witness statements
9 being collected. So this police officer was collecting
10 these witness statements and taking them away and he had
11 obviously some method of processing them in order that
12 they get to the coroner's office.
13 Q. And he didn't complain to you?
14 A. No.
15 Q. The coroner normally put those statements and redrafted
16 them on to separate paper, which was the coroner's own
17 paper. Dr Webb's accepting all other statements went on
18 to that coroner's paper. That seems to be the standard
19 paper. Why didn't you get hold of some of that?
20 A. Well, what happened was that I started to get complaints
21 from the coroner that I was lagging behind in providing
22 the witness statements, which he'd requested months ago.
23 When I would go to the file, I would find a photocopy of
24 the witness statement and a note that it had been
25 collected by the Grosvenor Road police, and therefore

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1 (3.55 pm)
2 THE CHAIRMAN: I think you're going to move on from Dr Webb
3 now.
4 MR STEWART: Yes --
5 A. May I just make one short point?
6 THE CHAIRMAN: Please do, and then I have a point I want to
7 ask you about.
8 A. My third witness statement, the fourth paragraph, which
9 we didn't touch upon, but I wanted to just say that
10 I wasn't working in a vacuum, and therefore I'm just
11 going to read:
12 "When Dr Webb made his witness statement in 2005,
13 I had been dealing with Trust witness statements for six
14 years. Many had been sent to the Trust's solicitors for
15 approval, and I had become aware that the type of
16 comment that Dr Webb was making could expect to be
17 queried if legal advice was obtained."
18 And I hadn't made that point earlier.
19 THE CHAIRMAN: Thank you. Let me ask you about my point.
20 It's not specifically about the statement, but it's
21 about Dr Webb, because we received a document yesterday,
22 which is 139-166-001 going into 002. This was the
23 letter which was one of the ones for which privilege was
24 waived yesterday by the Trust. It's to you from
25 Mr Daly of Brangam Bagnall.

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1 there was an issue as to where these statements were
2 going. And on some occasions, they were found and then
3 on occasions they couldn't be found. This could be very
4 unfortunate because the doctor by that stage is likely
5 to have moved to Australia in a registrar training year,
6 the coroner requires a signed -- an original, signed
7 witness statement, and therefore these witness
8 statements being produced in this standard format were
9 able to be e-mailed again to the witness, wherever they
10 were, and they could print it off and sign a version,
11 sign it, and then send it back to us when they were
12 lost.

13 So this was the method that made collecting witness
14 statements for the coroner easily doable in the time
15 frame that was required. I am not aware of the coroner
16 ever having said that he didn't like this standard
17 format. The standard format, which is referred to in
18 this document, I had assumed was the standard format
19 that he was happy with.

20 MR STEWART: I see. That's very helpful. Thank you.

21 THE CHAIRMAN: Okay. We'll take a break for 10 minutes for
22 the stenographer and resume at 3.45. Thank you very
23 much.

24 (3.35 pm)

25 (A short break)

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1 A. Yes.
2 THE CHAIRMAN: The point I am interested in particular is on
3 the second page on the right-hand side. If you go to
4 the two-line paragraph:
5 "Dr Webb is also of the view that the family were
6 fully aware of the extent of Claire's illness."
7 How do you read that? What do you think that
8 Mr Daly was telling you about Dr Webb's view of what
9 Mr and Mrs Roberts understood?
10 A. Well, I have listened to the views of the doctors and
11 nurses who seem to have thought that Claire was ill, and
12 he doesn't really say at what stage he and Dr Webb ...
13 Was she seriously ill, does he mean, or she was
14 moderately ill? Because it ... He must be surely only
15 referring to the period between lunchtime and 5 pm. He
16 can't be referring -- because he would have no knowledge
17 after 5 pm because he'd left the hospital.
18 THE CHAIRMAN: Yes, but the reason that he left the hospital
19 at the time when he did and the fact that he left the
20 hospital at all was because he thought that Claire,
21 while ill, was going to recover. That was his evidence.
22 His evidence was that's what he expected to happen. In
23 fact, his note said:
24 "CT scan in the morning if she doesn't wake up."
25 Also, beyond that, if he thought she was going to

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1 deteriorate in the devastating way that she did, he
2 would not have left.
3 Mr and Mrs Roberts, as you know from following this
4 segment of the inquiry, were also of the view that while
5 Claire was ill, there was no threat to her life. So
6 when Mr Daly writes to you and says:
7 "The family were fully aware of the extent of
8 Claire's illness."
9 It's a curious way of describing Mr and Mrs Roberts
10 being fully aware that Claire was ill, but likely to
11 recover. First of all, do you agree with that?
12 A. Yes. But the issue is that a diagnosis of viral
13 encephalitis is a devastating diagnosis to be made if it
14 was your child. Because I have medical knowledge, maybe
15 I take it seriously, but there may be mild viral
16 encephalitis and major, serious ones, and so Dr Webb,
17 I suppose, in the range of work that he does, will have
18 known that a possible viral encephalitis diagnosis is
19 serious, as indeed must be the status epilepticus.
20 THE CHAIRMAN: You see, the trouble, and I'm sure you're
21 ahead of me on this, is this: two of the indicators that
22 Claire was not expected to die were, firstly, that
23 Dr Webb left the hospital at about 5 or 6 o'clock on the
24 Tuesday evening in the expectation that she was going to
25 recover and, secondly, Mr and Mrs Roberts then left the

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1 that sits with the description given by Mr Daly. I'm
2 asking you because --
3 A. Of course --
4 THE CHAIRMAN: You weren't there [OVERSPEAKING] but this
5 letter went to you.
6 A. It did.
7 THE CHAIRMAN: When you read this letter or when you read it
8 now, does it not look to you as if Dr Webb is saying
9 immediately before the inquest that the family knew very
10 well that Claire was very gravely ill and that her life
11 was at risk?
12 A. You would take that out of that.
13 THE CHAIRMAN: You would? But isn't it curious that that's
14 not what Dr Webb has said to the inquiry and isn't it
15 curious that that's not what Mr and Mrs Roberts were
16 given to understand?
17 A. You would need to remind me ... Would I have been fully
18 aware of ... This didn't just come out at the inquest
19 in Mr and Mrs Roberts' statements, it would have been in
20 their earlier letters and meetings with the clinicians
21 in 2004.
22 THE CHAIRMAN: I think, if it wasn't spelt out, it was
23 implicit. I can't say off the top of my head that it
24 was spelt out, but I'm sure it was implicit in their
25 queries.

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1 hospital with their sons at 9 o'clock that night with
2 the same expectation. Dr Webb has said: if I thought
3 that she was at real risk of deteriorating and dying in
4 the way she did, I would not have left. And I accept
5 that from Dr Webb. He doesn't look to me to be the sort
6 of guy who just clears off home because he wants to see
7 something on television. He looks to me to be the sort
8 of doctor who will stay around if he thinks that there
9 is a real risk that one of his patients is going to
10 deteriorate and die.
11 A. Yes.
12 THE CHAIRMAN: Similarly, Mr and Mrs Roberts, having kept at
13 their daughter's bedside with their in-laws and between
14 each other and their sons all day, are highly unlikely
15 to have left at 9 o'clock that night if anybody had
16 indicated to them that Claire was at risk of dying.
17 Right? So when Dr Webb is reported by Mr Daly as saying
18 in this note that:
19 "The family were fully aware of the extent of the
20 deceased's illness."
21 It seems to me that it must mean that they were
22 aware of the illness to the extent that she was likely
23 to recover because that was Dr Webb's view when he left
24 the Royal on the Tuesday evening and it was the Roberts'
25 view when they left the Royal, and I'm wondering how

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1 A. The difficulty is, it would have been nice if Mr Daly
2 had written another sentence to -- it almost could be
3 read either way, that the extent of the deceased's
4 illness was not too great. Just using the word
5 "extent" --
6 THE CHAIRMAN: The problem is if they were fully aware that
7 the extent of Claire's illness wasn't very great, then
8 that doesn't make sense because the extent of her
9 illness was so great that she died overnight.
10 A. Yes.
11 THE CHAIRMAN: I understand why you're trying to make some
12 sense of this, but that suggestion doesn't really fit.
13 Anyway, it might be -- I'm raising it with you because
14 this was a letter to you. I understand that you were
15 not part of any discussion or part of that discussion
16 between Dr Webb and Mr Daly and what I just have to
17 consider at the moment is whether I need to recall
18 Dr Webb on that issue. But we'll leave it.
19 Mr McAlinden?
20 MR McALINDEN: You do have the consultation note, which
21 I presume preceded that letter. That's at 140-046-001.
22 You'll see that the consultation note doesn't make any
23 reference to this particular issue.
24 THE CHAIRMAN: Yes. That's one of the consultation notes
25 with Dr Webb, isn't that right?

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1 MR McALINDEN: Yes.
2 THE CHAIRMAN: There's a second consultation note when
3 Dr Webb was present with others.
4 MR McALINDEN: That was the morning of the inquest hearing,
5 which would have been the 25th.
6 THE CHAIRMAN: That post-dates the letter.
7 MR McALINDEN: Yes.
8 THE CHAIRMAN: So it cannot be that.
9 MR McALINDEN: This is the only documentation that would
10 seem to pre-date this letter.
11 THE CHAIRMAN: Thank you very much. I'm not sure we can
12 pursue it much further at the moment. It's a bit of
13 a loose end. We'll see how to tidy it up. Thank you.
14 Mr Stewart.
15 MR STEWART: Thank you, sir.
16 Mr Walby, you said you'd like to go through the
17 process of obtaining the statement from Dr Sands.
18 I think you said that you'd like to highlight issues
19 in relation to that procedure.
20 A. Yes, please.
21 Q. I have put together a series of the documents which
22 constitute the trail. There may be one or two pieces
23 missing and you've got the pieces. We'll work through
24 it together.
25 A. Yes.

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1 around and said:
2 "May I first express my sympathy with
3 Claire Roberts' parents and wider family."
4 It was just an example of how Dr Sands had never
5 attended an inquest and wasn't really aware that he
6 would be standing up and being asked to read his
7 statement. And it was purely a format issue.
8 Q. Yes. Then your e-mail continues:
9 "Regarding your comments at the end of paragraph 3:
10 'This was standard fluid therapy at that time.
11 Although I did not prescribe the fluids, I was not aware
12 of contraindication to their use in this type of
13 situation.'"
14 If we go across to paragraph 3, at the very bottom:
15 "This was standard fluid therapy at the time, yes,
16 although I did not prescribe the fluids, I was not aware
17 of a contraindication to their use in this type of
18 situation."
19 A. Yes.
20 Q. So you're referring to this, regarding your comments:
21 "Could I suggest we leave this out? The issue of
22 what was and is fluid practice remains under debate and
23 0.18 N-saline remains 'standard fluid therapy' when
24 monitored adequately. I think that the fact that you
25 did not prescribe the fluids is alluded to in the

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1 Q. 139-124-002. Your request on 14 March to Dr Sands to
2 provide a draft statement outlining his part in the care
3 of Claire Roberts. It otherwise proceeds in identical
4 terms to that letter that you sent to Dr Webb.
5 A. Yes.
6 Q. I think, some time later, it occurs to you that nothing
7 has come back from Dr Sands because at 139-108-001,
8 a reminder goes to your office. There has been an
9 intervening reminder:
10 "I look forward to receiving your statement
11 outlining your part ..."
12 5 June. Then there is a message from you to
13 Andrew Sands on 7 June at 139-106-001 and accompanied by
14 the draft statement at 139-103-005, if that could be
15 placed beside it. That's the first page of it. 7 June,
16 you write:
17 "Andrew, I have combined your first two sentences
18 into one with which I hope you will agree."
19 So you have made a suggestion that the initial
20 paragraph of, "I am a registered medical practitioner",
21 be joined on to the second paragraph with --
22 A. Well, the issue was I felt it was inappropriate for
23 Dr Sands to be standing up at the inquest and starting:
24 "Concerning the case of Claire Roberts deceased."
25 That seemed to me an inappropriate way, so I jiggled

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1 previous sentence of your statement. The issue of
2 contraindication remains debatable and you're probably
3 not saying that if you had been the prescribing doctor
4 you would not have used such fluid. All in all, it
5 sounds very defensive and at this stage, if you leave
6 comments out, it's probably better."
7 That seemed to me to be you suggesting quite clearly
8 that he amend his statement provided to take out a bit
9 on the basis you don't like the way it sounds because it
10 is a bit defensive.
11 A. He's being defensive, that's what I am saying. These
12 fluids were prescribed, but they weren't prescribed by
13 me, they were prescribed by Dr O'Hare, in parenthesis,
14 the night before. I thought that that really was --
15 that that was sounding like him defending himself
16 against something he hadn't been charged with and that
17 it should be left out.
18 Q. But it's still nonetheless a validly-made comment of his
19 knowledge at the time and not irrelevant to the issue
20 being described.
21 A. Well, again, this falls into the realms of comment in
22 a first-hand witness statement.
23 Q. No, with respect, it's what he knew.
24 A. Well, he's fleshing it out further than I thought he
25 needed to. To me, it made it sound as if he was

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1 defending himself over the prescription of the fluids,
2 which, as we have heard others say, was perfectly
3 acceptable by many from the night of 11 pm on the night
4 of the 21st onwards.
5 Q. I mean, let's suppose that he thought that was relevant
6 and obviously he did think it was relevant, otherwise he
7 wouldn't have said it in the first place, and --
8 A. That's the point, he didn't say it in the first place.
9 Q. Well, he did. He said this was standard fluid therapy
10 at the time --
11 A. No. But he didn't say that in his -- if you look at my
12 note, I then talked to him the following day and he's --
13 we were discussing his witness statement. And he said
14 he was happy with my change to the first sentence. His
15 defence organisation inserted the two sentences
16 I referred to and he was going back to them.
17 Q. Thank you. There it is, you're absolutely right:
18 "Happy with the change to the first sentence."
19 In paragraph 2:
20 "His defence organisation inserted the two sentences
21 I referred to and he ..."
22 A. And he is going back to them.
23 Q. Thank you.
24 A. That reinforced my view that I had been right, that
25 these were defensive sentences put in by his defence

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1 sentence, I want the first one out. I made my comment,
2 he went back to his defence organisation and I don't
3 know anything about that conversation, but it ended up
4 with a witness statement which had the first sentence in
5 and the second sentence out, and that's what then went
6 to the coroner without further discussion.
7 Q. Yes. We can find that coming back to you at
8 139-103-002. And there's it the third paragraph, which
9 ends:
10 "This was standard fluid therapy at that time."
11 With the final sentence there deleted.
12 The next step after that is you transcribe that on
13 to the police witness paper and you send it off to
14 the coroner. That is under cover of letter 139-101-001.
15 Here we are.
16 A. Yes.
17 Q. And it is to Mr Leckey:
18 "Dear John, I refer to previous correspondence
19 regarding the above named and now enclose an original
20 signed statement obtained from Andrew Sands."
21 And you send him then the police statement, or a
22 statement that looks as though it's from the police.
23 What we've described so far is the production of
24 a statement which was written by Dr Sands and it was
25 amended by the Medical Protection Society, then it was

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1 organisation. And he went back to them.
2 Q. Yes. I can see that you think and can say that shows
3 that I have a good nose for that type of slightly
4 jarring comment, but the point remains whether or
5 whether not you should have suggested that it be taken
6 out, whether that was truly your correct response if you
7 were assisting the coroner.
8 A. If you go on to the final version of his statement, he
9 does go back to his defence --
10 Q. Can we, before we get to the final version, go through
11 the steps that take us there?
12 A. Yes.
13 Q. The next step is indeed that he comes back to you at
14 139-103-001. This is from Andrew to you, 4 July:
15 "Please find attached modified draft statement,
16 which has been approved by MPS."
17 The Medical Protection Society. So after your
18 discussion, I take it he then goes back to them. Do
19 they allow him to retain it or do they consent to its
20 omission?
21 A. They leave the first sentence and take out the second.
22 Q. So it's taken out?
23 A. So it makes the point that I make suggestions and I only
24 do it once. You don't find a follow-up e-mail from me,
25 saying: hey, you have only taken out the second

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1 modified by the litigation management office, then it's
2 approved by the Medical Protection Society, and then
3 it's transcribed by you on to police paper and presented
4 to the coroner as an original signed statement obtained.
5 Is that really a transparent way of doing it?
6 A. I would have used the word "original" to make sure that
7 it's not a photocopy of it. Occasionally, I had to --
8 because the coroner wanted to get on with things and for
9 some reason, as I suggested to you, the witness
10 statements that went adrift in Grosvenor Road police
11 station, sometimes the coroner would say, "Look, I need
12 to get on with things, send me down your photocopy. It
13 won't do for the inquest, but it'll help me make
14 progress in my enquiries". So my use of the word
15 "original" there was referring to it being originally
16 signed, an original signature on the paper, and not the
17 fact that it had gone through --
18 THE CHAIRMAN: Not that it was the --
19 A. Not that it was the first version, yes. In fact,
20 I believe Dr Sands says, "This is the second ..." --
21 I think he had maybe two drafts and the second one,
22 which dealt with his defence organisation, which
23 I didn't see.
24 THE CHAIRMAN: Okay.
25 MR STEWART: Do you have it there?

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1 A. No, we don't have it. The e-mail talks -- you see if
2 you go to, I think it's 139-171-001, you see that's what
3 comes back to me. The lower is the e-mail that you were
4 talking about before. Then we have him thanking me for
5 my comments:
6 "This is the second draft I have written on the
7 subject."
8 So he's telling me that, in effect, his defence
9 organisation have previously modified an original one,
10 which I didn't catch sight of.
11 Q. So by the time this statement gets to the coroner, it
12 has been well and truly vetted.
13 A. Correct.
14 MR QUINN: I was just about to raise this point. What goes
15 on in the next e-mail below that, same page, I think
16 Mr Stewart should perhaps read that and make sure he's
17 aware of --
18 MR STEWART: Read it for me.
19 MR QUINN: 139-171-001. It's what Mr Walby says about the
20 defensive position. I'll let you read it yourself, then
21 the questions are evident from it.
22 MR STEWART: Shall I read it out for the record?
23 A. It's the same e-mail that you've just dealt with.
24 THE CHAIRMAN: That's what we went through a few minutes
25 ago. It appears twice in the same file, but it is --

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1 if I have been able to satisfy you with these two,
2 I don't think we need to go on to the others.
3 THE CHAIRMAN: I understand that. Mr Fortune, to the extent
4 that Mr Walby was involved in Dr Steen's statement,
5 do you require any issue to be raised about that?
6 MR FORTUNE: No, sir. I anticipate that the procedure would
7 have been much the same.
8 THE CHAIRMAN: Yes. And just in general terms, Mr Walby, is
9 that correct?
10 A. Yes.
11 THE CHAIRMAN: Thank you very much. Okay.
12 MR STEWART: Perhaps now we've mentioned Dr Steen, perhaps
13 I could ask you to go through some of your contact with
14 Dr Steen in relation to a slightly different issue.
15 That is at 140-092-001. That's where, Mr Walby, you
16 have forwarded to you by the coroner a copy of
17 Mr Roberts' further statement. This is prior to the
18 inquest. And he asks you in the second paragraph to
19 circulate the Roberts' statement amongst the involved
20 staff and "written responses would be useful at this
21 stage".
22 So you in compliance with that request send it off
23 to the various witnesses and you send it off, I think,
24 to Dr Steen at 139-086-004. There we are,
25 6 October 2005. The trail of further e-mails I was

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1 A. That is a printing of it with my follow -- with his
2 follow-up back to me, so it is the same as --
3 Q. Can we go to 090-051-157? To look at:
4 "This is the original signed statement obtained from
5 Andrew Sands as delivered to the coroner."
6 Then he in turn transcribes it on to separate paper,
7 091-009-055. So you see the issue is really whether
8 it's appropriate for you and the Medical Protection
9 Society and everybody else, maybe even solicitors, to
10 get involved in the writing, rewriting, editing and
11 amending of statements without revealing that that has
12 been done.
13 A. Well, I would be surprised if the coroner thought that
14 this hadn't happened to some degree in every case.
15 THE CHAIRMAN: That's taken us through two statements,
16 Dr Webb and Dr Sands. I think it certainly covers
17 generically the issues that you would want it cover. Is
18 there another particular statement you want to go
19 through?
20 A. No. If you've got the message, I am happy to stand over
21 what I did with the witness statements. These are the
22 two which contain material -- the others are, I think,
23 minor typographical ... I had got the sense from senior
24 counsel's opening statement that there was a generic
25 concern about everything I was doing and, therefore,

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1 going to take you through, and I can go through five of
2 them, are successive reminders from you to Dr Steen for
3 her to respond to this. Do you remember that?
4 A. I do.
5 Q. And various discussions along the way, it seems, where
6 you're trying to persuade her to respond.
7 A. Well, the situation was that the coroner had invited
8 comments. It has been my experience that sometimes
9 doctors don't wish to comment and they are not under any
10 compunction to comment. Dr Sands and Professor Young
11 did. Dr Webb let it be known that he wasn't going to be
12 making a comment. But I didn't get a yea or nay from
13 Dr Steen, and that's the reason for my note to her. It
14 continues right up until a consultation prior to the
15 inquest, which the Trust solicitor had with Dr Steen,
16 and at which I make a note in the file, you'll see,
17 where I raised it with the Trust solicitor: what do we
18 do about not having got a response from Dr Steen? And
19 his recommendation, you can see, that we don't now do
20 it.
21 Q. And on what basis was it decided to go ahead without
22 asking her to respond?
23 MR FORTUNE: Sir, can I interrupt at this stage? Because
24 I'm not sure where this line of questioning is going to
25 take us. Here is Mr Walby doing his best to chase up

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1 a witness who, on the face of it, has been slow in
2 returning a statement requested by Her Majesty's
3 Coroner. Is there anything more sinister to it than
4 a series of "Where is the statement?".
5 THE CHAIRMAN: Yes, this is not the original statement; this
6 is the response to Mr and Mrs Roberts' statement.
7 MR FORTUNE: Or indeed just that, sir.
8 THE CHAIRMAN: In the scale of things, it may not be a very
9 important point, but Professor Young and Dr Sands did
10 have some comments to make. Dr Webb said he didn't have
11 any comments to make and your client simply didn't
12 respond, repeatedly didn't respond, and that's just what
13 Mr Stewart is asking about: what was happening? And
14 I think Mr Walby has now said that -- I think Mr Stewart
15 said it was followed up five times with an absence of
16 response from Dr Steen. I think that might be the
17 point; is it?
18 MR STEWART: It is. We can go through all the e-mail trail
19 if you'd like, but it's in relation to the professional
20 duty owed by Dr Steen under the GMC regulations to offer
21 all relevant information and to assist the coroner.
22 MR FORTUNE: Sir, I'm not inviting my learned friend to go
23 through the e-mail traffic. My learned friend can make
24 the point certainly when Dr Steen gives evidence: you
25 were slow in returning a document containing your

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1 inquiry.
2 I was present at the inquiry's hearing
3 in February 2005 where the chairman had referred to, in
4 response to Mr Coyle, that he wasn't going to get into
5 the situation of dealing with five, 10 or 15 cases for
6 the inquiry because it would take far too long and he
7 wanted the salient points to be heard. He wanted the
8 salient cases to be heard at the inquiry.
9 I was of the knowledge at that stage that there were
10 three other deaths. Mr Coyle came back and said when he
11 felt that he had other cases, there were other cases of
12 living hyponatraemia, they weren't deaths, so he
13 retracted what he had started -- the chairman making his
14 comment. But although Mr Coyle may not have been aware
15 of any deaths, I was aware of three deaths which the
16 inquiry chairman was considering as to whether he should
17 add them to the inquiry. And none of the three deaths
18 are ones that you've heard mentioned here. The chairman
19 will know of those. I take it you don't want me to
20 mention their names.
21 THE CHAIRMAN: No, thank you.
22 A. There were presumably others which I was not aware of,
23 and therefore the chairman was going to have to make
24 a decision as to which cases he thought would be most
25 appropriate to conduct a full inquiry, which I'm fully

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1 comments, if any, in relation to the letter of
2 Mr Roberts of 29 September 2005.
3 THE CHAIRMAN: Thank you.
4 MR STEWART: The inquest took place, and a verdict was
5 given, you had a reason to be dissatisfied with the
6 finding of the coroner and you weren't entirely certain
7 that the coroner had got the right end of the stick and
8 you wanted to make sure this point was corrected.
9 A. Yes.
10 Q. Would that be a fair summary of what you were concerned
11 about?
12 A. Well, it wasn't so much the right end of the stick, it
13 was that he had failed to record in his verdict that
14 there had been a reduction of the fifth-normal saline on
15 the evening of 22 October, whereas Dr Steen's witness
16 statement clearly said that that had occurred. His
17 recording of her answers to the question didn't say
18 that, and therefore his verdict, when it appeared,
19 suggested to me that it was looking as if the Trust, the
20 hospital, had not initiated even what it thought was the
21 correct thing to be doing if you find this condition.
22 And therefore, I wanted that to be corrected for an
23 additional reason than getting the verdict right, that
24 the chairman was going to be having to consider whether
25 or not he should add this case to his list for the

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1 supportive of and I think was the right thing to happen.
2 I felt that if all Mr O'Hara got was the verdict on
3 Claire Roberts, that he might add it to the inquiry on
4 the basis of it being a -- as we heard Professor Young
5 refer to it as, and I hadn't heard this -- this
6 hypernatraemic as opposed to euvolemic. Euvolemic
7 hyponatraemia. I hadn't really taken on board that
8 there were three types of hyponatraemia -- hypervolemic,
9 euvolemic and hypovolemic -- and that this case was
10 falling into the case of euvolemic hyponatraemia. And
11 I suspect, Mr Chairman, at that stage that you weren't
12 aware your inquiry would be moving into an area to deal
13 with other than the situation where far too much
14 fifth-normal saline had been given to a child. And
15 that is the basis of me wanting to make sure that the
16 verdict properly reflected that, that there had been
17 a reduction of the ...
18 THE CHAIRMAN: To ensure, in effect, that whatever decision
19 I made was based on the correct information?
20 A. Yes.
21 THE CHAIRMAN: And the line which you were concerned about
22 in the coroner's verdict was: that blood test, referring
23 to the 121 blood test, should have been repeated and, at
24 the same time, there should have been a reduction in
25 fluids.

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1 A. Yes.
2 THE CHAIRMAN: And your concern was that there was
3 a reduction -- there's a bit of a debate about that
4 issue -- but --
5 A. I agree.
6 THE CHAIRMAN: -- there should have been a reduction in
7 fluids at about 11.30. Dr Stewart's note says that
8 there was to be a reduction in fluids to two-thirds, you
9 weren't sure whether Mr Leckey had in fact picked that
10 up and conveyed it accurately in the sentence towards
11 the end of his verdict.
12 A. Yes.
13 THE CHAIRMAN: Thank you.
14 MR STEWART: Had you ever, before this, sought to persuade
15 the coroner to amend his finding?
16 A. No.
17 Q. Have you since?
18 A. I don't think he's made a mistake since.
19 Q. And have you had other deaths referred to inquiries
20 since?
21 A. No.
22 MR STEWART: Thank you very much. I have no further
23 questions.
24 THE CHAIRMAN: Can I just raise one point with you,
25 Mr Walby? I'm just curious about it. Maybe in the way

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1 than one measure of 121, I was asked to make sure all
2 the doctors were aware of all the results, and therefore
3 those are my personal annotations on Dr Webb's table
4 because it was the quickest way to do it, given that
5 we were in the middle of the inquest. Dr Webb in fact
6 has a 122, which is incorrect there.
7 THE CHAIRMAN: Yes.
8 A. So that lists the two series of -- and those were
9 distributed to the doctors so they were aware of those.
10 THE CHAIRMAN: And the handwritten sequence of figures
11 between the 22nd and the 23rd, that's your handwriting?
12 A. That's all my writing.
13 THE CHAIRMAN: That's adding in the results which were
14 obtained on the 23rd; is that correct?
15 A. Yes. Dr Webb had not got -- I suspect the last column
16 of results was maybe from a PICU sheet. You'll remember
17 that there's a set on the 22nd, a set of results written
18 in the notes and then there's a margin note beside
19 Dr Steen. So that demonstrates that the two 121s had to
20 be from different blood tests.
21 THE CHAIRMAN: And that was almost certainly taken after
22 Claire was moved to PICU?
23 A. No, I think not. No, no, because she wasn't moved to
24 PICU until the 23rd. So there seems to have been -- and
25 there has been evidence on it before -- and I don't want

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1 we've handled the evidence, it hasn't emerged.
2 Yesterday or the afternoon before we were told that the
3 reason privilege was being waived by the Trust for some
4 documents was that there was a particular document which
5 you might want to refer to in your evidence. It's
6 139-164-001. Mr McAlinden will correct me if I'm wrong,
7 but I understand that -- sorry, could you bring the
8 second page as well, please?
9 A. That's it.
10 THE CHAIRMAN: In case we've overlooked or skipped past
11 something too quickly, what I understand is that you
12 wanted to be able to refer to this document for which
13 privilege has been claimed and, in particular, you
14 wanted to refer to what I think is your handwritten note
15 in the bottom right of the first page; is that correct?
16 A. That's part of it, but there are ... This letter
17 appears in two versions. There's one without my
18 handwriting on it and sometimes it's e-mailed and ...
19 I thought that the issue of the 121 on the two separate
20 occasions would come up.
21 You heard evidence yesterday that discussed that.
22 Initially it was thought -- but you're now clear.
23 There's a page in the file, 139-167-001. This page
24 is a single page out of Dr Webb's witness statement, in
25 which, once the issue had come up about there being more

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1 to give evidence about it -- but I am pretty sure
2 you have evidence that Dr Sands has made comment about
3 the two sets of blood tests.
4 THE CHAIRMAN: Let's just look at this quickly. If you look
5 at 090-022-056, in the top left of that page, on the
6 right-hand page on the screen, the 121 is the reading
7 which came back at about 11 or 11.30, and it's in the
8 notes of 11.30. That's the first reading of 121.
9 A. Yes.
10 THE CHAIRMAN: The second entry -- if you could take down,
11 please, the page on the left-hand side of the screen,
12 page 55, and put up 57 alongside page 56. Down on the
13 right-hand side of the screen, that is the second
14 reading of 121.
15 A. Yes.
16 THE CHAIRMAN: That page starts with the 4 am entry, which
17 is after she's in PICU.
18 A. Yes. But the blood test results are coming. But the
19 time the blood was taken, we don't know.
20 THE CHAIRMAN: Okay. We'll agree it's later than 11.30.
21 It's most probably at around the time of her collapse
22 because it doesn't appear that any other doctor saw her
23 between Dr Stewart seeing her and her collapse.
24 A. No.
25 THE CHAIRMAN: So whatever the precise time, it's at about

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1 the time that her condition had deteriorated with the
2 result that she went to PICU, whether the test was
3 actually taken in PICU is --
4 A. So if you go back to the letter that I had wanted to be
5 referred to then.
6 THE CHAIRMAN: 139-164-001. That's the point you're making
7 in the last paragraph on the first page?
8 A. Yes, that I made sure that the doctors each had a copy
9 of that page so they knew what was being talked about --
10 if you go to the second page of this letter --
11 THE CHAIRMAN: Yes, the two together, please. Thank you.
12 A. -- in case there was any doubt about it from Mr Daly's
13 letter to me:
14 "This death does not appear to fit within the terms
15 of reference to that inquiry and counsel will make
16 a point to the coroner in due course."
17 It's just to highlight the fact that I wasn't going
18 out to a flyer to suggest that this case was absolutely
19 at one with the terms of reference of your inquiry, sir.
20 THE CHAIRMAN: Okay. I understand.
21 A. I'm well aware it's turned out to be appropriate to be
22 in the inquiry.
23 THE CHAIRMAN: Is there some point about your handwritten
24 note at the bottom of the first page or does that not
25 matter?

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1 THE CHAIRMAN: I can understand how Mr and Mrs Roberts must
2 feel a bit sore about this, to put it gently, that they
3 see what might appear to them to be a fairly cosy
4 relationship between the Trust and the coroner to the
5 extent that their statement goes to the Trust for the
6 comments of the doctors, but they do not have
7 a reciprocal position in seeing the Trust statements for
8 their comments to go to the coroner. But to the extent
9 that that is appropriate or inappropriate, I think it's
10 a matter which, if need be, you can raise or I can raise
11 with the coronial service.
12 MR QUINN: It's something Mr Roberts wanted on the record.
13 We realise we can't ask this witness to answer that. It
14 was a comment and I made sure it was a comment when
15 I first approached it.
16 The second point I have is in relation to document
17 139-161-001, if that could be brought up. The question
18 I want to ask, Mr Chairman, is this. The first line of
19 that document states:
20 "This inquest ended on 4 May 2006 with no criticism
21 of the Trust's care of this patient."
22 In light of what has been said in relation to the
23 settlement of any clinical negligence claim brought
24 because of the blood test issue, how does that sit with
25 the evidence that we have? So what we have here is

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1 A. It doesn't matter. It was really just that I was
2 concerned that matters may come up that you might have
3 asked where this copy -- how this copy page appeared,
4 and I needed to be able to demonstrate because there was
5 every likelihood that it might have done.
6 THE CHAIRMAN: Okay, thank you very much.
7 Mr Quinn, have you any questions?
8 MR QUINN: I have a number of questions. One of them I can
9 deal with very quickly. That is the comment about
10 the coroner sending Mr Roberts' statement to the Trust.
11 I want, through you, sir, to ask the question: was
12 there any mention of the clinician's statement being
13 sent to Mr Roberts for comment by the coroner or the
14 Trust? Because it would seem very unfair if not. What
15 happens here is the coroner, after receiving the
16 statement from Mr Roberts, sends it to the Trust for
17 comment: here is what Mr Roberts is going to say. Yet
18 there's no reciprocal agreement in relation to the
19 statements by the clinicians. Why would that be? Why
20 would that be fair?
21 MR McALINDEN: Mr Chairman, that's an issue, if it is
22 an issue in this case, for the coroner to address. It's
23 certainly not an issue for Mr Walby to address.
24 MR FORTUNE: That would be my submission as well, so far as
25 Dr Steen is concerned.

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1 Mr Peter Walby writing this letter on 12 May 2006, yet
2 still having the mind that after the inquest, had any
3 negligence claim been brought, the Trust were at fault.
4 So how do those two things sit together?
5 A. They sit together in that, as I said earlier, an
6 inquest -- the purpose of an inquest is not to apportion
7 blame. Therefore, I think if you want to bring up --
8 I was there as the coroner read out his verdict. So
9 although when it says -- it appears shortly ... When he
10 read it out, I heard it, and if you go to it, does it
11 indeed contain criticism of the Trust's care of the
12 patient? I'm not sure I have a reference to the
13 verdict.
14 MR QUINN: That's not the point, Mr Walby, about whether or
15 not the coroner criticises the trust. It's what you do
16 in relation to what's in your mind. You're writing in
17 one e-mail that there was no criticism by the coroner of
18 the Trust, yet you know the Trust are at fault. So how
19 does that sit together?
20 A. They're different things.
21 MR QUINN: In your mind.
22 THE CHAIRMAN: Are you suggesting that: well, thankfully
23 there was no criticism of the Trust, even though any
24 medical negligence case is open and shut?
25 A. That indeed was the case, but on the other hand

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1 that's ... That's just a factual statement of what
2 occurred.
3 MR QUINN: I take it no further, sir. The last point I have
4 is this: could two documents be put up together?
5 139-149-001 and, beside it, 139-135-001. You will see,
6 Mr Walby, on the second paragraph, the last few lines,
7 where it says:
8 "... under the care of consultant paediatrician
9 Dr Heather Steen with the provisional diagnosis of viral
10 illness."
11 It's the second paragraph, the last three lines, if
12 they could be highlighted. When one looks at the other
13 letter, you will see that you have written to the
14 coroner again after Christmas and, in the last,
15 paragraph it reads:
16 "It has also been pointed out to me that in my
17 original letter to you of 16 December 2004, I referred
18 to Claire Roberts' provisional diagnosis as simply being
19 that of a viral illness, whereas the admitting registrar
20 had gone further and considered it to be possibly
21 encephalitis."
22 We know that the registrar Dr O'Hare stroked out
23 encephalitis, so where did you get that information from
24 to provide to the coroner if it is wrong?
25 A. If you go to the A&E entry, you'll see that's what her

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1 A. Is that not the same doctor?
2 MR QUINN: It's the SHO, yes. So are you saying that
3 that -- and could I ask then to put up, just to
4 complete --
5 THE CHAIRMAN: Sorry, the point is Mr Walby says the
6 admitting registrar had gone further and considered it
7 to be possibly encephalitis. It's Dr O'Hare who had
8 written encephalitis, which she then deleted, and she's
9 the registrar.
10 MR QUINN: That's correct, that's the point I'm making.
11 THE CHAIRMAN: And she's the only registrar.
12 MR QUINN: Because the other doctor was a SHO.
13 A. Can you go back to that ... Back to the A&E page?
14 THE CHAIRMAN: If you take down the right-hand page and
15 bring up 090-012-014, I think. You'll see that the name
16 of the doctor is Dr Puthuachery, it's on the top line,
17 the doctor's name.
18 A. Yes. Are you telling me that after Dr O'Hare writes
19 "admit", Dr Puthuachery then comes back and writes
20 "query encephalitis"? I must admit -- I stand to be
21 corrected and would like to look at the original chart
22 if it's material, but that's where it has come from.
23 I have taken it that that was also Dr O'Hare writing
24 "query encephalitis", because normally you would expect
25 the registrar who has been called by an SHO to put

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1 diagnosis is.
2 THE CHAIRMAN: But she had encephalitis and then she deleted
3 it, didn't she?
4 A. Not on that page she didn't. This is a child arriving
5 into casualty. That's the ward note that you're talking
6 about. This is the ...
7 MR STEWART: It's at 090-012-014.
8 A. You see the primary diagnosis: "query encephalitis".
9 She may well have changed her mind, but that is the
10 patient arriving in the A&E department with a diagnosis
11 of query encephalitis.
12 MR STEWART: For the sake of completeness, she was admitted
13 to hospital and the same doctor makes a note on
14 page 090-022-052, if that might be placed side by side.
15 You can see at the top:
16 "1. Viral illness. 2. Encephalitis."
17 And the same doctor then crosses "encephalitis" out.
18 A. Yes.
19 MR QUINN: So was there a possibility of encephalitis when
20 that same doctor, Dr O'Hare, has crossed it out?
21 A. The wording of -- can you put up beside that what I have
22 said in the second letter?
23 MR QUINN: That's the letter at 139-135-001.
24 MR STEWART: It's not the same doctor who crossed it out,
25 it's a separate doctor.

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1 a query diagnosis so that the ward knows what to expect.
2 THE CHAIRMAN: Let me put it this way: even if that is
3 Dr O'Hare's "query encephalitis" at the bottom of the
4 left-hand page, since you know from the records that she
5 then deleted that, deleted encephalitis on her detailed
6 examination of Claire, why do you alert the coroner to
7 the fact or to the point that the admitting registrar
8 had gone further and considered it to be possibly
9 encephalitis when she had originally contemplated
10 encephalitis and then dismissed it?
11 A. Well, I wrote to the coroner my two-page letter and
12 I copied it to the medical director. I didn't have any
13 expectation that it would go any further than that.
14 You'll see that there's a handwritten note on the bottom
15 of 139-148-007.
16 MR QUINN: 001. It's Dr Steen's handwritten note.
17 A. Yes. That is me:
18 "I hear you have ..."
19 So then some time -- when I met Dr McBride, he said
20 to me, "Dr Steen thinks you've got some mistakes or
21 errors in your letter". So I then, as you can see,
22 a couple of days later, was writing to Dr Steen asking
23 her for her witness statement, and I put a handwritten
24 note at the bottom asking her to identify these errors.
25 Because don't forget, under normal circumstances the

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1 consultant responsible for the patient would be
2 referring the death to the coroner, so I don't think it
3 would have been at all inappropriate for Dr Steen to be
4 making additions or corrections to me because, as we now
5 know, it maybe should have been reported in 1996 by
6 Dr Steen.

7 THE CHAIRMAN: With all due respect, she's eight years late.

8 A. Yes, you saw where I was going with that. So I wanted
9 to know what the errors were.

10 THE CHAIRMAN: But I think the point is that there's a real
11 question mark about whether in fact it is an error.
12 Because what your letter ends up doing, even if it's
13 something you're not fully alert to, it ends up
14 inserting possibly what Dr O'Hare might have thought at
15 one point, but omitting that Dr O'Hare did not think
16 that within an hour or so. So it's not correcting an
17 error; in fact, if anything, it's potentially
18 misleading. That's the point.

19 A. Well, that certainly was not my intention.

20 THE CHAIRMAN: I'm more concerned with the result than with
21 intention, Mr Walby, and I'm not accusing you of
22 deliberately misleading the coroner. But I'm concerned
23 that before you write to the coroner to correct
24 something of which the coroner has been advised of
25 before, the person who's pointing it out to you in order

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1 MR QUINN: Lastly, why did Dr Steen have a copy of the
2 letter to Mr Leckey when you told us earlier that it
3 went to the medical director?

4 A. Exactly.

5 MR QUINN: Was she the medical director?

6 A. No. You'll need to ask the medical director.

7 MR QUINN: So that was then distributed amongst the
8 clinicians for comment?

9 A. I think if you go back to the transcript you will see
10 that I was surprised. I sent a copy to the medical
11 director and I had no expectation that it would go
12 anywhere else.

13 MR QUINN: Thank you.

14 MR STEWART: May I, for the sake of completeness, and for
15 accuracy and for the record, indicate that Mr Reid has
16 informed me that the entry "query encephalitis" was made
17 by Dr Puthuchear, and this is confirmed in the witness
18 statement WS134/1 at page 7. And also he refers to:

19 "Identify [in 15(a)] who made the primary diagnosis
20 of 'query encephalitis' and state when this diagnosis
21 was made and the basis thereof."

22 The answer is:

23 "I wrote the diagnosis of encephalitis."

24 A. That's my mistake then. I should have written "the SHO
25 in casualty" rather than "the admitting registrar".

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1 for you to give that information and you yourself, in
2 providing that information, really need to be quite sure
3 that you are correcting an error in the first place.

4 And my concern is, whether you are in fact doing that,
5 to the extent you rely on "query encephalitis" on
6 page 14 on the screen, is that not very quickly
7 superseded by Dr O'Hare deleting encephalitis after
8 Claire's admission?

9 A. Well, I think that the wording of my letter is ... It's
10 now gone from the screen again, but the wording of my
11 letter, I thought, talks about her initial ... I mean,
12 lots of diagnoses changed over the --

13 THE CHAIRMAN: Okay. It may be we can take it no further.

14 MR QUINN: Sir, there are just two other points.

15 One, does that mean then that the error identified
16 by Dr Steen is that particular error, ie that Dr Steen
17 has identified that you've missed out a provisional
18 diagnosis of the other part of the diagnosis, possibly
19 encephalitis? Was that Dr Steen's prompting to cause
20 you to change it?

21 A. Yes, I met Dr Steen in the Children's Hospital in the
22 course, I think, of my clinical duties and I said to her
23 as well that -- there wasn't a written response to this,
24 I don't think you'll find, and that was what I then put
25 into the second letter.

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1 THE CHAIRMAN: Any other questions before I come to

2 Mr McAlinden? No? Mr McAlinden, have you anything?

3 Mr Walby, there were a number of things you wanted
4 to tell us and I hope we have given you a chance to say
5 everything. Unless there is anything you want to add,
6 your evidence is complete.

7 A. Well, I've covered everything, but I would just like to
8 say that my task here has been made an awful lot easier
9 by the work of the litigation management office staff in
10 keeping the files so that I was able to go through
11 everything -- and it's all there -- as opposed to
12 hospital notes, which tend to be a bit patchy. So I'd
13 like to thank them for having maintained the files the
14 way they have done.

15 THE CHAIRMAN: Thank you very much. You're now free to
16 leave. Thank you for your time.

17 (The witness withdrew)

18 Tomorrow, we've got Dr Rooney and then Mr and
19 Mrs Roberts. I've been asked if it's possible to sit
20 tomorrow morning at 9.30.

21 MR McALINDEN: I have checked with Dr Rooney this afternoon
22 and she will be here tomorrow morning at 9 with a view
23 to commencing her evidence at 9.30.

24 THE CHAIRMAN: Unless that causes any great difficulties,
25 we'll sit at 9.30 tomorrow morning. Thank you very

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1 much.
2 (5.00 pm)
3 (The hearing adjourned until 9.30 am the following day)
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