

1  
2 (10.30 am)

3 Governance opening by MS ANYADIKE-DANES

4 MS ANYADIKE-DANES: Good morning.

5 If I just take the opportunity to do one matter of  
6 housekeeping before I start with the opening. There are  
7 two documents that the inquiry legal team prepared to  
8 try and assist. They mirror documents of a similar type  
9 that you'd have seen in the opening case, which was  
10 Adam's.

11 The first concerns the list of persons. You would  
12 have seen that there was a schedule of persons that was  
13 provided in relation to clinical matters in Claire's  
14 case. There has been a schedule of persons that relates  
15 primarily to the governance aspect of the case, and  
16 that's a schedule that you will be able to pull up and  
17 check what the involvement of the person was, what  
18 statements or reports they've previously provided and  
19 whether it's intended that they should be called as  
20 a witness. In due course, we will provide a schedule  
21 that indicates, on the clinical side, all those  
22 witnesses on whose written evidence we relied solely and  
23 in due course we will do that for governance, indicate  
24 those witnesses on whose written evidence we are solely  
25 relying.

1 to 21 March 1997, which is when the limited autopsy  
2 results were in. And you can see there on the bottom  
3 one for 10 January 1997, there is at that stage a letter  
4 from the Chief Medical Officer to the chief executives  
5 of the Trust, and it is asking them to put into effect  
6 the agreement in the letter of 13 November 1996 to  
7 Sir Kenneth Calman, which you would have seen earlier.

8 So what is happening is not only are you seeing the  
9 events as they relate to Claire and, in due course,  
10 other children -- because other children, unfortunately,  
11 were admitted and died before we got to the next part of  
12 Claire's case -- but it also has this running list on  
13 the far right as to what was happening for generally.

14 If we can go to 006, for example, that's the third  
15 schedule and that's the main events in the period  
16 between the notification of the results of the limited  
17 autopsy and the UTV broadcast on 21 October 2004. Here  
18 you see, if we go down through it, what exactly was  
19 going on and we identify when other children die. For  
20 example, you'll see that at 010: there is the  
21 14 April 2000, when Lucy dies; 19 June 2001, Raychel has  
22 died, and so on.

23 You are increasingly seeing more activity, if I can  
24 put it that way, on the far right, as higher up in the  
25 structure there are events or publications being

1 So that is one document. The other document is  
2 a chronology. I just pull that up very quickly now to  
3 show you how it works. It's at 310-021-001. There you  
4 see it, and because Claire's case spanned quite a period  
5 of time, so it's divided into a number of schedules.  
6 That's the first schedule. You can see that it actually  
7 pre-dates -- an attempt to set what the position was  
8 from the governance and hospital management point of  
9 view at the time Claire was admitted.

10 So in place were a number of protocols, guidance,  
11 circulars and practices and so forth, and also  
12 publications. So you can see those running down with  
13 the date on the far left-hand side.

14 If one moves through -- I'm not going to take you  
15 through this, this is just to indicate how it works --  
16 you will get to a second schedule, which is from  
17 Claire's death until the notification of the results of  
18 the limited autopsy on 21 March. It is a similar thing,  
19 except in this case it sets out -- if I take you to  
20 that, 003. There you see that form has changed now so  
21 you now have the events in relation to children and  
22 you've got the reference and then "Any other  
23 developments".

24 For example, another development, if we turn the  
25 page to 004, if you bear in mind that this is taking you

1 produced. And on it goes until one gets to the fourth  
2 schedule, which is at 015, and that's just the title of.  
3 One then moves from the UTV broadcast on 21 October 2004  
4 to the inclusion of Claire's case in the work of the  
5 inquiry, which was announced on 30 May 2008.

6 That goes through in a similar way, showing you what  
7 was happening, on the left-hand column, which was more  
8 directly pertinent to Claire's case and those of the  
9 other children, whereas on the far right you have  
10 what was happening at a broader level and, very often,  
11 a departmental level.

12 So that is a schedule that we hope will assist as  
13 you try and get some sense of what was happening that  
14 particularly bears on Claire and how her parents were  
15 being informed or not informed as to events relating to  
16 her from the span of her death up until the time her  
17 case became part of this inquiry.

18 Mr Chairman and everyone else, you have heard the  
19 evidence on the clinical aspects of the case and the  
20 first of the post-death events, if I can call it that,  
21 which is the autopsy. Because that is really the first  
22 investigation into what happened to Claire. And that  
23 evidence has been heard over a period of very nearly  
24 eight weeks from 15 October through to 5 December.  
25 In the course of that, I am sure that those in here,

1 certainly you, Mr Chairman, from your interventions,  
2 have begun to see certain themes arising out of that  
3 clinical evidence. One of which -- and I'm not seeking  
4 to put these in orders of importance -- is the  
5 consultant responsibility, and I don't mean identifying  
6 who the consultant was. I mean who was the consultant  
7 who should have had the overall charge of Claire's care  
8 and should have been seeing if there was going to be any  
9 specialist intervention, seeing how that fitted into an  
10 overall plan for her care. Who was the person who had  
11 that responsibility?

12 That is a theme that has arisen because it has  
13 considerable ramifications. It also leads into the role  
14 of the consultant. One will recall that Dr Steen  
15 described the paediatric service at the Children's  
16 Hospital as being consultant-led, meaning that the  
17 consultants were not based on the ward. And in Claire's  
18 case, her consultant would not only have not been based  
19 on the ward, but her contract required her to be working  
20 in the community and, in fact, only to be in the  
21 Children's Hospital -- I believe it was for two days,  
22 which might have been two mornings.

23 So that itself raised issues to do with: if you are  
24 going to have such a system, how do you ensure that  
25 there is continuity of care, that there is appropriate

1 have to attend. And that paperwork, Mr Chairman, the  
2 deficiencies in it have been exposed during the course  
3 of the clinical part of this case and I will say  
4 a little more about that later on, but I'm just drawing  
5 out some of the themes from the clinical hearing.

6 That also moves into another area, apart from just  
7 the communications between the clinicians and the basic  
8 material that they have to update the consultants, it  
9 also moves into an area to do with cover. So if you are  
10 going to have the consultants who are in charge of the  
11 children who have responsibility for their care and  
12 treatment, and not based in the ward, and may not, for  
13 that matter, be based in the hospital full-time, then  
14 one needs to think about how is appropriate cover being  
15 provided, particularly, as it happened in this case,  
16 when the consultant -- even on the day or the morning  
17 when they're supposed to be in the hospital -- may have  
18 other calls upon their time, and it seemed that that may  
19 well have been the case with Dr Steen. So what was the  
20 arrangement in those circumstances?

21 And as it happened, on that particular day, it  
22 happened that the registrar, who is based on the ward,  
23 and therefore is the most senior person -- and an awful  
24 lot, therefore, rides on the registrar in a system like  
25 that. In that case, the registrar was conducting

1 cover, that there are effective communications between  
2 that consultant and the junior doctors and the nursing  
3 staff and any specialist who should be brought in to  
4 assist with the case. We will be trying to explore with  
5 the witnesses the extent to which any consideration was  
6 being given that if you are going to have a system like  
7 that, how do you put in place measures that will ensure  
8 that that system produces the correct level of care for  
9 the children.

10 And that then itself moves into theme that has  
11 arisen, which is, it may be that if you are going to  
12 operate a system like that, it puts quite a bit of  
13 emphasis on the quality and adequacy of the paperwork.  
14 Because it may be that's what the junior doctors have  
15 available to them when they're updating the consultant  
16 who's not based on the ward, and to some extent it may  
17 be that that paperwork and the observations recorded in  
18 it of the junior team and nurses are a substitute for  
19 the consultant being able to actually look at the  
20 patient, which is what happens periodically if  
21 a consultant is on the ward. If the consultant's not  
22 going to be based on the ward, they're going to need  
23 a way to be updated as to what is happening about the  
24 patient, so they can make decisions as to when they feel  
25 intervention is necessary or they particularly perhaps

1 a clinic in the afternoon. So the question is now: what  
2 are the arrangements for cover in those circumstances?  
3 Because it seems that for Claire's case, in the  
4 afternoon, which turned out to be a significant period  
5 during her admission, perhaps the most senior person  
6 there was a senior house officer, whose experience in  
7 paediatric matters was not considerable. And also, as  
8 it happened, the ward sister was not there either, and  
9 there may be very good reasons why she wasn't there, but  
10 if you're running that sort of system and you don't have  
11 your consultant there because that's not your system,  
12 you don't have your registrar there and you are missing  
13 your experienced nurse, then that calls into question  
14 how a system like that has the potential to break down  
15 if not very much changes in the personnel that are  
16 available.

17 That itself leads on to the cover over the evening,  
18 and the evidence was there about the registrar and their  
19 access to the consultants, and also the calls on their  
20 time, literally the number of beds that the registrars  
21 were required to provide service and cover for over the  
22 evening.

23 Then on the final point, which is really what one is  
24 talking about, is resources, is the services, and  
25 throughout this one has been very much aware that this

1 is the Children's Hospital, this is the place where the  
2 paediatric expertise resides, it services the whole of  
3 Northern Ireland, and yet issues were raised as to the  
4 extent to which it provides services when they might be  
5 required in the interests of the child's care. In this  
6 particular case, one was talking about CT scans and  
7 EEGs. Not only is the Children's Hospital there, but so  
8 also is the neurological unit, also serving the whole of  
9 the region, and it'll be a matter in due course when  
10 you, Mr Chairman, consider and determine on the clinical  
11 matters, the extent to which the availability of the  
12 CT scan and EEG in any way affected the way Claire's  
13 treatment progressed.

14 Then finally, before I start to open matters proper  
15 and move from these preliminary thoughts, there is the  
16 question of the communications with the parents, which  
17 is an issue that runs through the entire period of time,  
18 not just when Claire was admitted, but after she had  
19 suffered her respiratory arrest and her collapse: who  
20 were the people who were supposed to be informing them,  
21 how they went about that, and how a situation could  
22 arise in those circumstances when it would appear,  
23 according to the nurses and the clinicians, although  
24 they were aware of how ill Claire was, significantly,  
25 the parents were not.

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1 Doctors McKaigue and Crean appear in both and the  
2 clinical governance structures applicable to both were  
3 the same and most of the senior personnel in the  
4 clinical management structure were still in post.

5 So there was a real opportunity, if it had been  
6 taken, to learn from Adam's case and to use that to  
7 either ensure that Claire's case didn't happen in the  
8 way that it did or, should it happen for any reason,  
9 that they had a structure there to evaluate what was  
10 happening and to try and improve matters for the future.

11 Hyponatraemia, which is at the heart of this public  
12 inquiry, was an issue which had been considered by  
13 Doctors Taylor, McKaigue and Crean in their preparation  
14 for Adam's inquest, just four months before Claire's  
15 death. They had referenced the Arieff article, as we've  
16 come to call it, on hyponatraemia in their formalised  
17 recommendations for the coroner, and the content of the  
18 Arieff paper was relevant to Claire's condition when one  
19 considers its full title, "Hyponatraemia and death or  
20 permanent brain damage in healthy children".

21 Dr Taylor considered that this paper had wider  
22 significance in terms of alerting the profession to the  
23 potential risks of dilutional hyponatraemia and  
24 Dr Bartholome has recalled how the events surrounding  
25 this inquest, that is Adam's inquest, had been known to

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1 So Mr Chairman, those are the themes that have come  
2 out of the clinical phase of Claire's case, and the task  
3 in this governance hospital management phase is to look  
4 at those issues from the perspective of the practices,  
5 systems and protocols in place that were either there to  
6 ensure that the difficulties of the kind that I have  
7 alluded to did not arise or, if they did arise, that  
8 there was a system for considering them, identifying why  
9 that had happened in that way, what might need to be put  
10 in place to ensure that the risk of such a thing  
11 happening again was minimised and how the trust that  
12 families have in their health system could be restored  
13 by the quality of the information that is given to them  
14 once the issues and problems are recognised and properly  
15 analysed.

16 Mr Chairman, I turn now to the governance issues  
17 proper. To some extent, Mr Chairman, they share a time  
18 and a place and a context with Adam's case, and the  
19 issues which foreshadow the future work of the inquiry  
20 in relation to the deaths of Raychel Ferguson and  
21 Conor Mitchell. Both Claire and Adam died in the same  
22 ward of the same hospital within 11 months of each  
23 other, and when Claire died some of the doctors working  
24 in intensive care had been there for Adam: Doctors Webb  
25 and Taylor were involved with both and the names of

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1 her and to most of the doctors in the Children's  
2 Hospital. Dr McBride, who was then the medical  
3 director, has emphasised to the inquiry how Claire's  
4 death did, however:

5 "Reinforce for me the critical importance of  
6 ensuring that clinical practice continually evolved in  
7 line with emerging evidence."

8 And the poignancy about this part of the inquiry's  
9 work is that exactly the same thing might have been said  
10 about Adam's death and, during the course of the  
11 governance hearing in Adam's case, you heard evidence  
12 relating to the extent to which such a sentiment had  
13 actually informed action following Adam's death. No new  
14 governance initiatives of significance appear to have  
15 occurred in the period between November 1995  
16 and October 1996. The Children's Hospital continued as  
17 the regional paediatric teaching hospital.

18 However, and as is evident from the inquiry witness  
19 statements of Dr Shields and Ms Chambers, at the very  
20 time of Claire's admission to the Children's Hospital,  
21 as part of the Royal Group of Hospitals, it was actively  
22 pursuing accreditation from the King's Fund  
23 Organisational Audit. Indeed, Dr Steen, Claire's  
24 consultant paediatrician, may herself have been involved  
25 in arrangements for a mock survey as part of the

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1 preparation for the King's Fund survey on the very  
2 Tuesday afternoon that she might otherwise have been  
3 involved in the ward round examining Claire and  
4 directing her treatment.

5 Nevertheless, the work of the audit committee,  
6 medical records committee and the clinical risk  
7 management committee seemingly continued as before. The  
8 Trust board deliberated its business, but seems to have  
9 been more concerned with corporate matters than patient  
10 matters, and a review of the board minutes from the  
11 Royal Hospitals Trust for the period of December 1995  
12 to December 1996 reveals only three references to  
13 specific clinical incidents, and there is no reference  
14 to the death of Adam Strain. And notwithstanding such  
15 elements of clinical governance as may have been in  
16 place during that period, it is now clear that in  
17 Claire's case, just as in Adam's, there was no formal  
18 report of the death at the time of the death to the  
19 clinical lead of the paediatric directorate, nor to the  
20 director of nursing or the medical director. There was  
21 no reporting of Claire's death to the chief executive or  
22 to the board. And it will be a matter for you,  
23 Mr Chairman, to determine the extent to which her death  
24 was actually noted within the structures of governance.

25 In Claire's case, just as in Adam's, there was no

1 opportunity of learning about hyponatraemia in Adam's  
2 case because Dr Murnaghan's plans for a seminar were not  
3 communicated to her, apparently, and in any event those  
4 plans were subsequently abandoned or they were just  
5 simply forgotten about.

6 The medical negligence case concerning Adam's  
7 treatment and care was still alive and ongoing at the  
8 time Claire was admitted and it had become clear after  
9 Adam's inquest that there was no real likelihood of  
10 successfully defending the legal action. Yet there is  
11 no evidence to suggest that the Director of Risk and  
12 Litigation Management took any steps to draw clinical  
13 lessons from the litigation, nor were any steps taken to  
14 ensure that performance failings or care management  
15 problems or adverse clinical incidents were reported.  
16 The convention simply seems to have been that clinicians  
17 were left to themselves to determine whether a medical  
18 error had arisen or an adverse clinical incident had  
19 occurred and perhaps, if so, what to do about it.

20 It will be a question for you to determine,  
21 Mr Chairman, whether such self-regulation was consonant  
22 with clinical governance, best practice and the  
23 interests of healthcare standards.

24 By the time the role of hyponatraemia in Claire's  
25 death was being questioned in 2004 and 2006, clinical

1 internal hospital investigation into the death. In  
2 neither case is there conclusive evidence of the death  
3 being reviewed at audit or mortality meetings. In  
4 neither case is there any documentation to suggest that  
5 any learning was extracted from what was known, whether  
6 to be shared by way of continuous professional  
7 development or otherwise incorporated into teaching.

8 The evidence that has been given of the neurological  
9 grand rounds and the debate they apparently engender, it  
10 was there, and it's claimed that there was such a grand  
11 round for Claire's case. However, since they're not  
12 recorded in any way, the only evidence of such a debate  
13 leading to actual learning is what happens afterwards,  
14 and it'll be a matter to be determined whether the  
15 subsequent events indicate that there was any real  
16 learning from any grand round there might have been into  
17 Claire's case.

18 And by reason of the failure to report the deaths to  
19 the directorate clinical lead in the Children's  
20 Hospital, there was no opportunity for an overview to be  
21 taken and the relevance of the Arieff paper to general  
22 paediatric practice to have been appreciated.

23 Dr Mulholland was clinical lead at the time of  
24 Adam's death. He was told nothing and he didn't seek to  
25 find out. Dr Hicks, who succeeded him, was denied the

1 governance had developed. Clear protocols on adverse  
2 incident reporting and root-cause analysis investigation  
3 was available, mechanisms had seemingly been put in  
4 place in order that lessons learnt from clinical audit,  
5 from adverse event monitoring, near miss monitoring,  
6 patient complaints and clinical negligence claims were  
7 routinely translated into better practice. The  
8 information and the systems were there and yet even then  
9 there still was no investigation into Claire's case.  
10 And so again, it will be a matter for you, Mr Chairman,  
11 to determine whether misinformation was given to both  
12 Claire's parents and the coroner and whether there was  
13 a culture of defensiveness to criticism amongst the  
14 medical community and, if so, its likely significance.

15 And in particular, the point of having guidance and  
16 protocols and paper practices, if they don't get  
17 translated into actual systems whose effectiveness is  
18 monitored and evaluated, and for which people can be  
19 held accountable, and the extent to which that actually  
20 happened in relation to these children's cases lies  
21 at the heart of this part of the investigation.

22 If I turn now to the specifics of Claire's case and  
23 start with staffing levels. Broader responsibility for  
24 the provision of 24-hour cover to patients rests with  
25 the paediatric clinical directorate. Dr MacFaul, the

1 inquiry's expert on governance matters, expresses some  
2 reservations about the levels of staffing and workload  
3 in that the resident medical staffing out of hours  
4 in the clinical hospital was thought by him to be low,  
5 given the range of responsibilities undertaken, and he  
6 referred in his oral evidence particularly to  
7 Dr Bartholome, who was the registrar in the night of  
8 22 October and into the morning of 23 October 1996,  
9 which proved to be a critical time for Claire.

10 He refers to that as being clearly an unreasonable  
11 workload, thus early consultant involvement in complex  
12 or unusual cases was rendered all the more relevant  
13 given the limited level of medical staffing otherwise  
14 available in the evening. And Dr Steen advises that  
15 consultants only have a small amount of time allocated  
16 to ward round and have fixed commitments at other times,  
17 often off site, for example at clinics, which is the  
18 earlier theme that I had drawn attention to.

19 Some discussion of workload pressures appears in the  
20 Royal Group of Hospitals' strategy for Children's  
21 Services, "Getting it together", so termed, and that was  
22 published in 1996. This policy document received broad  
23 input from Doctors Mulholland, Hicks and Crean, in  
24 conjunction with Mr Clarke, the paediatric directorate  
25 manager.

17

1 Children's Hospital between 5 o'clock on 22 October,  
2 that's the Tuesday, and 4 am on the Wednesday, 23rd.  
3 And she was responsible for 114 inpatients in 12 wards,  
4 in addition to covering the A&E department, which dealt  
5 with about 100 patients per day, half of whom were seen  
6 after 5 o'clock. So that is Dr O'Hare when Claire first  
7 comes in and Dr Bartholome over the evening when Claire  
8 deteriorated and into the early morning when she  
9 suffered her collapse. Dr Sands, her registrar, agrees  
10 in relation to there being a single registrar in charge  
11 of the Children's Hospital overnight, that that was an  
12 onerous job, a big responsibility.

13 Furthermore, as I've already pointed out, one  
14 Tuesday afternoon in four, he was engaged with the  
15 clinic of Dr Nan Hill, and we still are exploring the  
16 cover arrangements for that. Dr Bartholome gives her  
17 view that the relative inexperience of SHOs on duty was  
18 a worry because you had to depend on junior staff who  
19 were very inexperienced:

20 "As a safety issue, it was always a big concern  
21 because children can become sick very quickly and  
22 I would have to keep an eye on every junior doctor, and  
23 this is part of the role of the registrar."

24 There was no night sister on Allen Ward, rather the  
25 night sister would have covered the entire hospital.

19

1 It recognised that workload pressures were becoming  
2 evident and I quote from it:

3 "It was acknowledged that nursing and medical staff  
4 are under considerable pressure of work and there were  
5 cases where mothers felt that standards of care were  
6 inadequate or insensitive. The first phase of the  
7 redevelopment of the Royal Belfast Hospital for Sick  
8 Children will alleviate some of these problems, but the  
9 Trust is concerned that the pressure on staff has  
10 continued to intensify."

11 And it concluded that there was:

12 "A shortfall in staffing across the range of  
13 clinical professions, which continues to inhibit the  
14 provision of comprehensive assessment, treatment and  
15 rehabilitation services in a number of specialties."

16 And Dr Bartholome has confirmed in her evidence to  
17 the inquiry that this was an issue that had been raised  
18 with management.

19 So in relation to staffing levels, it will be  
20 recalled, if one recites the bare facts as they emerged  
21 in the clinical part of Claire's case, Dr O'Hare says  
22 that there was one registrar covering, I think, about  
23 120 patients, which included four intensive care unit  
24 beds, and she worked a 36-hour shift between the 21st to  
25 22 October. She was the sole registrar on duty in the

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1 The ward sister, Sister Pollock, stated that when she  
2 could not cover Allen Ward, an F-grade sister would act  
3 as back-up. However, because there would not seem to be  
4 any F-grade sisters in post until November 1996, she  
5 conceded it was a fairly common event to have an E-grade  
6 sister take charge. So in October 1996 it would appear  
7 that Allen Ward would fall under the responsibility of  
8 an E-grade sister during the day and under a ward sister  
9 at night who was also charged with covering the rest of  
10 the Children's Hospital.

11 Further, and in addition, there was no permanent  
12 nurse manager in post in the paediatric directorate in  
13 1996. Three of the sisters in the Children's Hospital  
14 were acting into this position and had the  
15 responsibility for different wards and departments of  
16 the Children's Hospital.

17 The effect of that, at a purely governance level,  
18 not so much the clinical level, is something that we are  
19 hoping to understand better and explore further in the  
20 oral hearings. I move now to communications with  
21 parents.

22 The department's charter for patients and  
23 clients, March 1992, accords a right:

24 "... to be kept informed about your progress. Your  
25 relatives and friends are also entitled to be informed."

20

1 Accordingly, if it is accepted that the patient has  
2 a right to information about his condition, it follows  
3 that the professional practitioners involved in his care  
4 have a duty to provide such information.

5 During the oral hearings on clinical matters you  
6 heard evidence, Mr Chairman, from the clinicians in  
7 respect of their impressions of the seriousness of  
8 Claire's condition; I won't take you to it. In  
9 particular, you heard from Dr Steen. She referred to  
10 the picture over the night:

11 "She's getting more and more complex, a sicker and  
12 sicker child with more complications."

13 Dr Sands, you heard, considered her to be "very  
14 neurologically unwell". Dr Bartholome also accepts  
15 there is no doubt she was the sickest patient on the  
16 ward at that time.

17 The issue is the extent to which any of that was  
18 adequately communicated to Claire's parents. The  
19 addition of the paediatric prescriber refers to  
20 status epilepticus, which was the condition that Claire  
21 was thought to have throughout her admission:

22 "Once seizures controlled, institute maintenance  
23 therapy, keep patients informed and supported."

24 That's what they were directed to do.

25 Dr Stevenson has acknowledged in his evidence that

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1 what they told the parents, there seems to have been no  
2 comprehensive record made of that. And the GMC "Good  
3 medical practice guidelines" direct that:

4 "Doctors, in providing care, must keep clear,  
5 accurate and contemporaneous patient records, which  
6 report information given to parents."

7 The nursing expert for the inquiry, Ms Ramsay, has  
8 said that in her opinion, as a minimum, there should  
9 have been a record of the information given to Claire's  
10 parents, their understanding and concerns. If that is  
11 so, then what might have warranted review is, if the  
12 clinicians thought they were communicating to the  
13 parents, but the parents failed to understand, how could  
14 that be? How could their ability to communicate  
15 important information to parents be so lacking that the  
16 parents have failed to understand the most fundamental  
17 thing, which is: how sick is my child? That is  
18 something that might have been worthy of a review. Not  
19 everybody's ability to communicate such sensitive  
20 information is perfect and that is something that might  
21 have been worth considering along with how to improve  
22 that.

23 Allied with that is to improve the system for  
24 recording it so at least there's some way of knowing  
25 what they think they're telling the parents, and that

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1 he was ward based and he would have been the point of  
2 contact, and the issue is if he was the point of  
3 contact, what was the level of his understanding so that  
4 he could provide an effective channel for the parents  
5 for communication? That is a clinical question, but  
6 it's also a governance question. If that's the system  
7 you're going to put in place so that it is possible to  
8 have a doctor at that level of inexperience there, then  
9 what is that doctor's support in order to ensure that  
10 your obligations to the parents to keep them informed is  
11 being discharged?

12 It is quite clear from the evidence of the parents  
13 that if the clinicians did understand the seriousness of  
14 Claire's condition, then they simply failed to  
15 communicate that properly to her parents. I won't go  
16 through the aspects of their evidence which makes that  
17 absolutely clear because, Mr Chairman, you heard it.  
18 And in fact, Dr Steen in her own evidence on 15 October  
19 2012 said:

20 "I think we failed the parents completely around  
21 communication. I failed to and the team failed to get  
22 through to the Roberts just how sick Claire was."

23 That might be the first time that Claire's parents  
24 were able to hear that acknowledgment.

25 Whatever the recollection of the clinicians is as to

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1 might be a starting place for understanding why it is  
2 that the parents did not grasp how ill their child was.  
3 Seemingly, the only internal review touching upon  
4 communication with Claire's family was conducted by  
5 Professor Young in 2004, and he formed the conclusion:

6 "The communication with the family at the time of  
7 Claire's death seemed to have been reasonably good.  
8 However, some aspects of Claire's condition may not have  
9 been disclosed at the time, such as hyponatraemia."

10 There is no evidence that the records of Claire's  
11 case were ever subjected to audit scrutiny and there is  
12 little evidence of the impact, if any, that the  
13 multidisciplinary medical records committee, which the  
14 chief executive states was in place, had upon the  
15 quality of the records in this significant respect. And  
16 there is no evidence that the system for medical records  
17 scrutiny was functioning efficiently.

18 The GMC "Good Medical Practice" code provides  
19 a reminder that:

20 "To establish a successful relationship between  
21 doctor and patient, the doctor must listen to patients."

22 It's axiomatic that listening is essential to oral  
23 communication, and the evidence from Claire's parents  
24 is, if they were listening, then they didn't hear them  
25 accurately about a number of aspects of Claire's history

24

1 that they were seeking to identify to them. You will  
2 have heard, Mr Chairman, about the issues to do with the  
3 seizures. Dr Webb had formed the view that he was being  
4 told that Claire had suffered a seizure on the Monday.  
5 Mrs Roberts is of the view that she told him no such  
6 thing.

7 That miscommunication, that misunderstanding, that's  
8 an important question, because it allowed Dr Webb to  
9 feed that kind of information into part of the  
10 formulation of his differential diagnosis. There are  
11 other issues on accuracy. Perhaps the most telling of  
12 them for the family, anyway, can be seen in the autopsy  
13 request form, I won't take you to the details of all of  
14 that because you have heard about it, and you have heard  
15 about that in the clinical context. But from the  
16 governance context, what is the significance of that?  
17 The significance of that is that the evidence from the  
18 pathologists is that their time is so constrained in  
19 terms of being able to conduct these autopsies that they  
20 must necessarily rely to a large extent on the autopsy  
21 request form and the clinical history provided in it.  
22 And that clinical history is providing the context in  
23 which they are going to view their investigation during  
24 the course of autopsy. So it is significant for them  
25 and it was significant for Dr Herron because he formed

25

1 patients depends on trust, to establish and maintain  
2 that trust you must give patients information they ask  
3 for or need about their condition, its treatment and  
4 prognosis."

5 It may therefore be inferred that withholding  
6 information is potentially damaging to public trust and  
7 confidence in the medical profession.

8 You may wish to consider, Mr Chairman, the extent to  
9 which the damage to the public trust done by failures in  
10 communication with the parents is something that should  
11 have been a concern to the clinicians and administrators  
12 involved in the Children's Hospital and evident in its  
13 procedures. It was certainly a matter of concern to the  
14 department as it was part of the reasons for the  
15 establishment of this inquiry. The minister stated:

16 "I believe it is of the highest importance that the  
17 general public has confidence in the quality and  
18 standards of care provided by our Health and Social  
19 Services. This is why I recently announced that I had  
20 appointed John O'Hara QC to conduct an independent  
21 inquiry."

22 And it's also reflected in the terms of reference  
23 for this inquiry:

24 "The communications with and explanations given to  
25 the respective families and others by the relevant

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1 the view that Claire had actually had diarrhoea, which  
2 was part of his thinking as to the likelihood of certain  
3 differential diagnoses when he went to try and conduct  
4 a clinicopathological correlation.

5 But she hadn't had diarrhoea. But that's what he  
6 thought because that was how he interpreted that form.  
7 So what's on the paper can prove to be important, and  
8 Mr Chairman, you have heard throughout how some of the  
9 errors get consolidated as they move on and are relied  
10 upon by others later on in the system of either Claire's  
11 care or the evaluation as to what happened to her.

12 The final issue in relation to communications  
13 concerns trust. The preamble to the GMC "Good Medical  
14 Practice" guidance for doctors proceeds from the central  
15 premise that:

16 "Patients must be able to trust doctors with their  
17 lives and well-being, and to justify that trust, we as  
18 a profession, have a duty to maintain a good standard of  
19 practice and care and to show respect for human life  
20 and, in particular, as a doctor you must listen to  
21 patients and respect their view and give patients  
22 information in a way they can understand."

23 And in emphasis of this concept of trust,  
24 paragraph 11 of that guidance continues:

25 "The successful relationship between doctors and

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1 authorities."

2 That is a specific issue that is to be the subject  
3 matter of this inquiry.

4 Mr Chairman, how that was reflected in the  
5 interactions with Claire's parents, even then, even  
6 at the time that the inquiry was established, that is  
7 once Claire's case became known, that's something to be  
8 considered.

9 Communication, of course, as I have indicated  
10 extends on to the communications between clinicians and  
11 communications between the nurses and between the  
12 clinicians and the nurses. And I have said something  
13 about that already.

14 Where does one get the source of that? Well, part  
15 of the source of effective communications is medical  
16 records and record keeping. And high quality healthcare  
17 records are the foundation which allows high quality  
18 evidence-based healthcare to be provided. And  
19 information has most value, of course, when it is  
20 accurate, comprehensive, up-to-date, accessible and  
21 targeted at clinical need. It is also necessary for  
22 clinical and other types of audit review and research.

23 Mr Chairman, there are a number of guidelines that  
24 were referred to during the course of the clinical  
25 hearing relating to the need to keep clear, accurate,

28

1 contemporaneous patient records. For example, that  
2 comes from "Good Medical Practice", that's 1995. Nurses  
3 were also subject to standards for records and  
4 record-keeping in 1993. Miss Duffin, who was Director  
5 of Nursing Services, has stated that the Trust medical  
6 records committee had produced a policy procedure, which  
7 used the UKCC guidelines as its base. Well, one will  
8 see how that informed action.

9 A number of issues arose in relation to the records  
10 relating to Claire's case. Amongst them, worthy of note  
11 for the governance perspective, is the nursing  
12 evaluation on Monday the 21st, which omits to record the  
13 results of an urine test, although both "urine direct"  
14 and "O+S" are ticked. The serum sodium of 132 is  
15 entered into Claire's clinical notes at midnight without  
16 any reference to the time the sample was taken or the  
17 time the result was actually received. Mr Chairman,  
18 you will know from the evidence that Dr Webb gave, the  
19 confusion that arose for him in terms of guiding  
20 Claire's treatment and formulating her differential  
21 diagnosis in thinking that that result, rightly or  
22 wrongly, whether he should or he shouldn't, but his  
23 evidence was that he did think that that result emanated  
24 from the morning as opposed to the previous evening.

25 Then there are the numerous errors, if one calls

29

1 improving clinical guidelines.

2 The Royal Hospital's annual audit report of  
3 1993/1994 announced its medical audit programme with the  
4 assertion that it had developed an effective  
5 organisational framework for medical audit, which:

6 "... supports and encourages changes in clinical  
7 practice as a natural part of organisation-wide quality  
8 assurance."

9 And the management executive stressed the need for  
10 programmes of audit in its management plan for 1995/1996  
11 to 1997/1998 with reference to better practice. It  
12 required that:

13 "Specifically, units should ensure that there is  
14 a clear policy on clinical audit as part of a programme  
15 to improve all aspects of service quality -- not just  
16 clinical outcomes -- support and evaluation of quality  
17 improved programmes, multidisciplinary approaches to the  
18 development of best practice in service delivery."

19 And the introduction of clinical audit implied that  
20 practice would be evaluated against some sort of agreed  
21 standard to establish better practice. The presence of  
22 agreed clinical guidelines, therefore, becomes  
23 fundamental and, in the opinion of Mr MacFaul, if audit  
24 is examining, as it was to do, quality, the extent of  
25 clinical records, availability, the appropriateness of

31

1 them that way, or mistakes made in the recording of the  
2 medication that was prescribed or administered to  
3 Claire. And leaving aside whether dosages were  
4 incorrectly recorded, there is also the issue of not  
5 being entirely sure when the clinicians are actually  
6 signing off for things, when it's intended they should  
7 be administering. Some of that information you have  
8 heard during the course of the clinical hearing and  
9 I don't wish to go into it now because some of it is  
10 a clinical matter. But the extent to which there were  
11 systems in place that should have avoided that sort of  
12 thing or, if it happened, were there to review it,  
13 understand why it happened and put in place steps to  
14 ensure that the chances of it happening again were  
15 minimised, that's the work of this part of the hearing,  
16 Mr Chairman.

17 So if I then move on to the issue of audit.  
18 Consensus guidelines, which are the guidelines  
19 essentially that operated, provide an agreed standard  
20 against which practice can be measured. And in order to  
21 audit the processes of care readily, reference to such  
22 guidelines or agreed standards is critical, and the  
23 absence of guidelines may, therefore, lead to  
24 substandard audit. And the sharing of experience and  
25 results from audit or review is a powerful mechanism for

30

1 facilities for diagnosis and treatment,  
2 communications -- and he goes on to observe that:

3 "Given the focus in the 1990s on clinical audit with  
4 its implicit requirements for standards against which to  
5 judge practice, it is noteworthy and a shortcoming that  
6 a range of guidance was not available in print for the  
7 staff from early 1990s. And thus the absence of  
8 guidelines leads to less good quality and substandard  
9 clinical audit. This again constitutes shortcomings  
10 in the quality of clinical governance at that time  
11 within the Children's Hospital and, indeed, within the  
12 Trust generally."

13 And linked to the targets set by the Children's  
14 Services Strategy for the introduction of guidelines is  
15 the target that it set for the adoption of a clinical  
16 audit programme oriented towards the development of  
17 clinical guidelines, monitoring variance in the use of  
18 guidelines and assessing the clinical effectiveness of  
19 services with an effective clinical information system,  
20 which would facilitate the introduction and  
21 implementation of clinical guidelines.

22 The responsibility for any failings in the  
23 introduction of clinical guidelines can be traced  
24 through the hierarchies of accountability within the  
25 Trust, and it will be a matter for you, Mr Chairman, to

32



1 determine the reason for any delay in the introduction  
2 of clinical guidelines and whether this may have been  
3 linked to shortcomings in the Trust's programme of  
4 audit.

5 It is not at all certain that Claire's death was  
6 presented at any audit review or mortality meeting. The  
7 systems in operation for both audit and review were  
8 developing in the mid-1990s and were described in the  
9 evidence received by the inquiry in respect of the  
10 governance issues arising in Adam's case.

11 These processes did not, however, engage the nursing  
12 staff. Staff Nurse McRandal gave evidence that no one  
13 spoke to her about Claire's case after her death and  
14 Nurse Jordan denied any recollection of any discussion  
15 after Claire's death about what happened or about  
16 lessons that could have been learned and stated that she  
17 was never asked to be part of any investigation or  
18 audit, nor did any nursing manager or any senior nurses  
19 ever speak to her about Claire Roberts' death.

20 Notwithstanding that, Mr Clarke, the directorate  
21 manager within the paediatric directorate of the  
22 Children's Hospital, confirms that in 1996 there was  
23 a site-wide clinical audit process in operation and the  
24 paediatric clinicians would have participated in this  
25 process. This process included mortality meetings,

33

1 presented at a mortality meeting once the post-mortem  
2 result was complete. The audit minutes were taken in  
3 such a manner as to preclude any possibility of patient  
4 identification and the DLS has informed the inquiry that  
5 the Trust's understanding is that Claire's case was not  
6 discussed at any paediatric morbidity meetings and it is  
7 therefore not possible to know whether Claire Roberts'  
8 death was discussed at any particular meeting and the  
9 attendance register has not been retained.

10 Dr McKaigue believes that the case was discussed and  
11 he claims to have been present. But if it was  
12 discussed, then the consequences, the result, the  
13 product of the discussion don't seem to be evident in  
14 what happened thereafter. Mr Chairman, you may wish to  
15 consider that the likelihood of any learning emerging  
16 from processes that are designed to leave no paper trail  
17 to be questionable.

18 THE CHAIRMAN: Yes, but the fundamental point is that  
19 we have yet to hear a single witness give any evidence  
20 of anything that changed as a result of any audit, and  
21 we look forward to seeing whether any of the witnesses  
22 who return for governance or who come fresh for  
23 governance can identify a single point which was learned  
24 from Claire's death.

25 MS ANYADIKE-DANES: Thank you, Mr Chairman, that is exactly

35

1 discussed within the context of paediatric clinical  
2 audit meetings, together with the  
3 neurological/neuroscience grand rounds.

4 Dr Herron has found evidence to suggest that the  
5 case was prepared for a neuroscience grand round, but  
6 there's no record of the meetings and, Mr Chairman, you  
7 would have heard, so far as Dr Herron and Dr Mirakhur  
8 have stated, the benefit of those grand rounds is that  
9 apparently it engenders a rather spirited debate amongst  
10 clinicians, aimed at trying to understand what happens  
11 in the child's case, and ordinarily one would think that  
12 that was a very positive development that such a thing  
13 happened. But you also heard there's absolutely no  
14 record of what happens in there and the reason for that,  
15 it is said, is because that might be inimicable to free  
16 debate.

17 But a consequence of that is that it's not possible  
18 to correlate what action is actually taken after that to  
19 any deficiencies that were discussed during the course  
20 of the grand round, nor is there a way for the parents  
21 to have access to any of what was discussed there,  
22 including any criticisms that might have been made there  
23 in relation to their child's care.

24 If we pass on to audit, Dr Steen has no recollection  
25 of audit, but would have expected Claire's case to be

34

1 it.

2 If all those procedures and processes were in place  
3 in the way some suggest they were, it's absolutely  
4 difficult to understand how Claire's death and the  
5 presence in relation to it of hyponatraemia would not  
6 have featured at any meeting, could not have emerged,  
7 and how her parents could have been allowed to stay for  
8 so long without recognising that her case, like the  
9 others, involved this particular condition.

10 If we then to go to adverse incident reporting.  
11 That's another tool in the management governance toolkit  
12 that should assist. Dr Steen has informed the inquiry  
13 that she would not have expected that she would have  
14 reported Claire's death to other members of staff as at  
15 that time it was felt that the sequence of events  
16 leading to her death was known and there were no areas  
17 of concern around her care.

18 Dr Hicks, her clinical lead, would not have expected  
19 the death to have been brought to her attention unless  
20 it was thought that there had been an untoward event,  
21 but who are the people to have formed the view that  
22 there is an untoward event? If the treating clinicians  
23 don't, then it's very unlikely to find its way up to the  
24 clinical lead.

25 Staff Nurse Pollock would certainly have expected to

36

1 have been informed if there was going to be an adverse  
2 incidence report, but anyway, she wasn't informed and  
3 she made no report herself. So Claire's death goes  
4 unreported in 1996 and there is no investigation into  
5 her death prior to December 2004. No report in respect  
6 of the death was furnished to the clinical lead, who was  
7 responsible for the services of the Children's Hospital.  
8 It would have been the responsibility of the clinicians  
9 involved to advise their clinical director or  
10 directorate management team in the first instance, but  
11 as I have just cited from Dr Steen's evidence, she  
12 didn't see there was that sort of problem, so presumably  
13 there's going to be no such reporting.

14 As Dr MacFaul observes, significant clinical  
15 incidents and adverse outcomes should be reported within  
16 a Trust structure. The first stage of any such process,  
17 however, is recognition of the event in the first place.  
18 In respect of the management of Claire, this recognition  
19 simply doesn't seem to have happened.

20 Guidance on the reporting of untoward incidents was  
21 available from as early as June 1991, and that was in  
22 a circular, and this covered the reporting by hospitals  
23 of untoward incidents to the Health and Social Services  
24 board where there was a suggestion of a failure in  
25 professional standards of care and treatment. And the

37

1 2000, adverse clinical events were reported using  
2 a statement book held in the respective clinical area  
3 and details of such incidents as recorded were forwarded  
4 to the Director of Nursing and the Director of Medical  
5 Administration and these were reviewed and followed up  
6 to ensure that appropriate actions were taken.

7 Well, had Claire's death been reported, then an  
8 immediate investigation could have been followed in  
9 order to provide the Director of Medical Administration  
10 and the Director of Nursing with a detailed written  
11 report. Knowledge of the case and the implications of  
12 hyponatraemia would thereby have been circulated at the  
13 highest levels of governance and it's a matter for  
14 speculation as to what difference that could have made  
15 to the growing medical consciousness of hyponatraemia  
16 and the risks attaching to Solution No. 18 and fluid  
17 management. But as we await to hear, it doesn't seem to  
18 have happened.

19 Had Claire's death been subject to scrutiny in 1996  
20 as an adverse incident, it is likely that it would have  
21 been referred to the coroner and that would have  
22 provided an additional forum for discussion and learning  
23 and could have served as a driver for dissemination,  
24 particularly as that coroner would only recently have  
25 conducted the inquest into Adam's case and would have

39

1 Royal Group of Hospitals would have had procedures in  
2 place to enable this reporting. The system appears to  
3 have operated until at least April 1993, when the Royal  
4 Hospital became a Trust, but was perhaps thereafter  
5 abandoned in line with the intention that the Trust be  
6 able to operate within maximum operational freedom and  
7 autonomy, and the system for gathering reports within  
8 the Children's Hospital seems to have lapsed and there  
9 is no evidence that any steps were taken to encourage  
10 the reporting of untoward incidents involving a failure  
11 in standards other than relying upon clinicians to  
12 report their own mistakes or the mistakes of each other.

13 The medical risk management group chaired by the  
14 medical director with high level representation from  
15 Dr Murnaghan and the Director of Nursing had  
16 responsibility for clinical risk management and  
17 undertook specific responsibility for the reporting of  
18 untoward incidents, clinical ones. Dr Murnaghan was  
19 also the Director of Risk and Litigation Management, and  
20 as such had a very particular knowledge of hyponatraemia  
21 derived from Adam Strain's case and it's unclear how the  
22 medical risk management group discharged its  
23 responsibilities. Indeed, it is not at all clear that  
24 it did anything in relation to the reporting of untoward  
25 clinical incidents. Mr McKee recalls that, prior to

38

1 heard what they said they were going to do in relation  
2 to his case in terms of spreading the message about  
3 hyponatraemia.

4 That Adam and Claire should have died within a year  
5 of each other in the same intensive care ward of the  
6 same children's hospital without prompting medical  
7 comment on the broader lessons of fluid management and  
8 the prevention of hyponatraemia is striking and an  
9 apparent failure of clinical governance, which will be  
10 more fully explored in the oral hearing.

11 So, Mr Chairman, if I come now to the final phase of  
12 this, which is the incidence and events of 2004 to 2006.  
13 We start with the UTV broadcast. It's a documentary  
14 called "When Hospitals Kill". And that went out on  
15 21 October. The investigative focus was on the role of  
16 hyponatraemia, the role that it had played in the deaths  
17 of Lucy Crawford, Adam Strain and Raychel Ferguson, and  
18 whether there was any cause to suspect a cover-up. The  
19 programme was the product of many months of work and had  
20 involved contact and correspondence with the Royal Group  
21 of Hospitals. And it is to be assumed that the Royal  
22 Group of Hospitals was aware in advance of the date of  
23 the broadcast and the general content of the programme.  
24 Indeed, correspondence was directed, on 7 October 2004,  
25 by the Trust's solicitor, Mr George Brangam, to the UTV

40

1 producer of the programme to express:  
2 "In the light of the programme makers' unacceptable  
3 behaviour, it is with the utmost regret that the Trust  
4 cannot participate in the programme or co-operate."  
5 And to suggest legal proceedings unless certain  
6 allegations be retracted. So it's to be supposed that  
7 matters were being followed at the highest levels of  
8 governance.  
9 Claire's parents watched the programme. Mr Roberts  
10 described that the circumstances and the unfortunate  
11 outcomes of the three children detailed in the programme  
12 were so similar to Claire's outcome. An extraordinary  
13 thing you might think, Mr Chairman, that a person  
14 without any medical training whatsoever on something as  
15 technical and complex as hyponatraemia can watch  
16 a programme and recognise in that something that related  
17 to his own child's condition, who had died many years  
18 before then.  
19 So the following day, Mr Roberts telephones the  
20 Royal Victoria Hospital's press office and he speaks to  
21 a lady he thought was Dympna, who stated the Royal  
22 Victoria Hospital were expecting calls following the  
23 Insight programme:  
24 "She advised me that she would arrange a meeting  
25 with a Dr Nichola Rooney. And Dr Rooney contacted me

41

1 fluid management. She contacted me by telephone on  
2 Wednesday 24 November to inform me that Dr Steen had  
3 prepared a document, detailing Claire's treatment.  
4 "Dr Rooney advised me that she would like the  
5 medical director, Dr McBride, and a professor from  
6 Queen's, Professor Young, to look at the document. She  
7 informed me that she would then arrange a meeting on  
8 7 November with my wife and I, together with Dr Steen,  
9 Dr McBride, Professor Young and Dr Sands."  
10 The inquiry has sought, but has not received, a copy  
11 of the document prepared by Dr Steen in relation to  
12 Claire's treatment, unless it's the undated, untitled  
13 synopsis of the case records, provided to the inquiry by  
14 Dr Rooney. It would seem that contingency planning had  
15 resulted in the re-deployment of Dr Nichola Rooney, the  
16 psychology service manager, to deal with the Royal Group  
17 of Hospitals' response to enquiries related to the UTV  
18 programme. The extent to which contingency planning  
19 also encompassed the review of other cases in which  
20 hyponatraemia was implicated or might have been  
21 implicated is as yet unknown, but we will pursue it.  
22 It is however clear that, by October 2004,  
23 two-and-a-half years had passed since the department had  
24 published its guidance on the prevention of  
25 hyponatraemia and a level of general knowledge of

43

1 later on Friday the 22nd and arranged a meeting for  
2 Monday the 25th."  
3 And Mr Roberts continues in a statement he made for  
4 the inquiry:  
5 "My wife and I met with Dr Rooney on Monday  
6 25 October at the Royal Victoria Hospital. Dr Rooney  
7 informed my wife and I that she would organise a review  
8 of Claire's medical notes with regard to fluid  
9 management, fluid type and the amount of fluid given and  
10 she would also arrange for a review of Claire's  
11 treatment from Monday 21 October to Tuesday 22 October.  
12 Dr Rooney contacted me by telephone on Monday  
13 1 November 2004 to say that Claire's notes had been  
14 passed on to medical staff for review."  
15 Mr Roberts further states in his inquiry witness  
16 statement that -- and this is worth reciting in full:  
17 "Dr Rooney informed me that Dr Steen, Dr Webb,  
18 Dr Hicks and Dr Sands would carry out the review and  
19 a meeting would be arranged in two to three weeks' time.  
20 I contacted Dr Rooney by telephone on Monday 22nd for an  
21 update on the review of Claire's medical notes and  
22 a meeting date. Dr Rooney informed me that Dr Steen had  
23 all Claire's notes and Dr Steen would be able to chart  
24 Claire's treatment. Dr Rooney also advised me that  
25 another senior consultant would be reviewing Claire's

42

1 hyponatraemia within the medical profession may be  
2 assumed from the general circulation of information by  
3 the department and the Ulster Medical Society. So that  
4 should have informed any comprehensive review that you  
5 might have hoped the Children's Hospital would have  
6 undertaken in relation to past cases.  
7 Such was the public disquiet provoked by that UTV  
8 programme that, as you know, Mr Chairman, this public  
9 inquiry was instituted. Dr McBride, the medical  
10 director of the Royal Hospitals, directed the handling  
11 of Mr and Mrs Roberts' complaint. To that end, he  
12 personally asked Claire's medical records be recovered  
13 from files. He reviewed the notes and felt it  
14 appropriate to request Professor Young, a consultant in  
15 clinical biochemistry, to review the medical and nursing  
16 records, to ascertain whether hyponatraemia could  
17 possibly have been a contributing factor to Claire's  
18 death. He did not otherwise consider the "Complaints:  
19 listening, acting, improving" guidance on the  
20 implementation of the HPSS complaints procedure of 1996,  
21 which defines a complaint as:  
22 "An expression of dissatisfaction requiring  
23 a response' because whereas [and this is him] Mr and  
24 Mrs Roberts have raised significant concerns in respect  
25 of their daughter Claire and her subsequent death, I am

44

1 not aware at this stage or at any time subsequently that  
2 Mr and Mrs Roberts made a formal complaint to the  
3 Trust."

4 Unfortunately the fact that that wasn't considered  
5 to be a formal complaint appears to have had  
6 implications for how it was actually treated. That's  
7 another matter to be pursued, whether one looks to the  
8 sense of what's happening or the label that's put on top  
9 of it.

10 The permanent secretary of the department wrote to  
11 the Chair of the Royal Group of Hospitals on  
12 28 October 2004 to formally require that:

13 "All documentation relating to the cases of Lucy  
14 Crawford, Raychel Ferguson and Adam Strain be secured  
15 and kept safe and, if necessary, be made available for  
16 independent examination."

17 And it's to be hoped that the Trust applied the same  
18 rigorous approach to all the documentation relating to  
19 Claire Roberts. I suspect we'll find out when we pursue  
20 matters further in the oral hearing.

21 Professor Young did not provide a written opinion,  
22 but rather his advice was given verbally by telephone.  
23 Dr McBride was to write to Mr and Mrs Roberts:

24 "Our medical case note review has suggested that  
25 there may have been a care management problem

45

1 systematically ascertain what happened, how it happened  
2 and why, so that we can do all that is possible to  
3 ensure lessons are learned to prevent a recurrence."

4 The report further states:

5 "We have introduced root-cause analysis, which  
6 ensures that the learning from adverse events is  
7 included in the process and systems of patient care to  
8 ensure that we do our reasonable best to prevent further  
9 adverse incidents or harm to those in our care, and this  
10 procedure is the current model recommended by the  
11 National Patient Safety Agency in England and is  
12 currently being deployed in the 'Department of Health  
13 and Social Services: Public safety in Northern Ireland',  
14 through the work of the clinical governance support  
15 team."

16 So let's look at the investigation into Claire's  
17 death. Dr McBride was alert to the possibility that the  
18 acts and omissions of the Royal Group of Hospitals'  
19 staff in the Children's Hospital may have contributed to  
20 Claire's death. In those circumstances, it is  
21 noteworthy that he chose not to initiate an  
22 investigation. It is to be noted that, as Dr McBride  
23 himself does, the Trust had introduced, from 2003,  
24 training in root-cause analysis of serious untoward  
25 clinical incidents. Indeed, the work of this inquiry

47

1 in relation to hyponatraemia and this may have  
2 significantly contributed to Claire's deterioration and  
3 death."

4 In this context, "care management problem" is  
5 defined by the procedure for investigation and review of  
6 adverse incidents as:

7 "Actions or omissions by staff in the process of  
8 care."

9 The intervening years between Claire's death in 1996  
10 and the review of her case in 2004 witness a sea change  
11 in clinical governance and the approach to adverse  
12 clinical incidents. Dr Carson, the medical director,  
13 was responsible for a series of governance initiatives,  
14 or, most notably: clinical excellence, 1997; clinical  
15 governance 1999; clinical governance report, 1999 to  
16 2000; clinical governance action plan, 2000 to 2001.  
17 These mark the increasing importance of a culture of  
18 accountability, or at least the increasing stated  
19 importance of developing a culture of accountability.

20 The Royal Hospitals' annual report 2004 to 2005  
21 emphasised, at page 5:

22 "A framework for learning in line with good  
23 governance and our commitment to openness and  
24 transparency. The Royal Hospital will acknowledge to  
25 patients and the public when things go wrong and to

46

1 might have been assisted if there had been such an  
2 investigation. And Dr McBride had noted:

3 "With hindsight and experience, root-cause analysis  
4 may have identified different learning over and above  
5 that identified in the case note review and coroner's  
6 inquest and may also have provided further answers for  
7 Mr and Mrs Roberts into the circumstances of Claire's  
8 death. This may have been the case even though eight  
9 years had passed since Claire's tragic death, during  
10 which time practice had changed and formal guidance on  
11 the prevention and management of hyponatraemia had been  
12 issued. However, at the time, taking into account the  
13 changes in practice in the intervening years, I was  
14 concerned that any further Trust investigation could  
15 potentially compromise or prejudice statutory  
16 investigations."

17 The department's interim guidance on reporting and  
18 follow-up on serious adverse incidents, which was  
19 published in July 2004, advises that:

20 "In those situations, where a body considers that an  
21 independent review is appropriate, it is important that  
22 those who will be conducting it are seen to be  
23 completely independent. In addition, such reviews  
24 should normally be conducted by a multi-professional  
25 team rather than by one individual. It is also

48

1 important that the department is made aware of the  
2 review at the outset."

3 Dr McBride recalls that:

4 "Given the context of Mr Roberts contacting the  
5 Trust and the level of public concern, it would have  
6 been my practice to advise the Chief Executive and  
7 Chair, particularly as Claire's death was subsequently  
8 referred to the coroner. Further, and at my direction,  
9 a serious adverse incident report was forwarded to the  
10 department in March 2006 following the notification of  
11 the date of the coroner's inquest in accordance with the  
12 departmental circular."

13 And that circular is "Reporting and follow-up on  
14 serious adverse incidents":

15 "It's my understanding [he goes on to say] that the  
16 former Eastern Health and Social Care board was also  
17 informed at this time as was required under guidance.  
18 A serious adverse incident report was forwarded to the  
19 department and [dated 28 March 2006] summarised Claire's  
20 history and stated, in October 2004, after reviewing  
21 notes, it was considered in retrospect that the known  
22 hyponatraemia, which was treated, may have had a part to  
23 play in the medical condition leading to death. It is  
24 for the inquiry to assess the accuracy of this report."

25 And Dr McBride further notes on 31 August 2006:

49

1 Claire's treatment or death was pursued at that time,  
2 and in a letter to the inquiry, the DLS advised that:

3 "There were no investigations into Claire's death  
4 prior to December 2004. Nor is it clear that the Royal  
5 Group of Hospitals conducted any investigation  
6 after December 2004 and it is to be regretted that this  
7 opportunity to assist the work of both the coroner and  
8 this inquiry was not taken."

9 So then if I pass on to the meetings with the  
10 Roberts. The e-mail correspondence passing between  
11 Dr McBride, Professor Young and Mr Peter Walby, who was  
12 the Associate Medical Director of the Litigation and  
13 Management office of the Royal Group of Hospitals Trust,  
14 on the day before the meeting scheduled with Mr and  
15 Mrs Roberts for 7 December 2004 reveals some of the  
16 preparation for that meeting.

17 Professor Young was then employed as a consultant by  
18 the Royal Group of Hospitals and was based at the Royal  
19 Victoria Hospital site. He had discussed the case with  
20 Dr Steen and had exposed areas of disagreement with her  
21 in relation to the case. These are his words:

22 "Heather has definite views about the significance  
23 of the fluid management, which are not quite the same as  
24 mine."

25 Additionally, Dr McBride clearly recalls that he met

51

1 "The department has been informed as per the  
2 circular and have requested a further background  
3 briefing, which I will provide."

4 That briefing document, Mr Chairman, has not yet  
5 been provided to the inquiry, although it has been  
6 sought.

7 It is unclear why Dr McBride chose not to make the  
8 reports pursuant to the interim guidance of the 2004  
9 circular immediately after the matter was brought to his  
10 attention. This guidance is couched in similar terms to  
11 the later 2006 circular and states at paragraph 15:

12 "The department will expect urgent local action to  
13 be taken to investigate and manage adverse incidents.  
14 In addition, it requires that where a serious adverse  
15 incident occurs and the senior manager considers that  
16 the incident is likely to be of public concern, he  
17 should provide the department with a brief report within  
18 72 hours of the incident being discovered."

19 Unless the 2004 guidance had gone unnoted in some  
20 way, the department issued an additional circular in  
21 2005 to restate the guidance previously given and to:

22 "Underline the need for HPSS organisations to report  
23 serious adverse incidents in line with the 2004  
24 circular."

25 It's not apparent that any investigation into

50

1 with Professor Young and Dr Steen in or about 6 December  
2 2004. This meeting was not formally minuted, but  
3 Dr McBride recounts:

4 "The outcome was that I was advised by  
5 Professor Young that hyponatraemia may have contributed  
6 to Claire's death. I asked that Professor Young's  
7 opinion be communicated to Mr and Mrs Roberts.  
8 I indicated that I wished Dr Nichola Rooney to be  
9 present at the meeting to support the family. It was  
10 confirmed that Professor Young, Dr Steen and  
11 Dr Nichola Rooney would attend the meeting with Mr and  
12 Mrs Roberts and communicate Professor Young's opinion  
13 that hyponatraemia may have contributed to Claire's  
14 deterioration and death. I determined that in the light  
15 of Professor Young's opinion, the Trust would now refer  
16 the case to the coroner and I asked that Mr and  
17 Mrs Roberts should be informed of this decision at the  
18 meeting."

19 On the morning of Tuesday 7 December, Mr and  
20 Mrs Roberts, Dr Rooney, Dr Sands, Dr Steen and  
21 Professor Young all met at the clinical psychology  
22 department of the Children's Hospital to discuss and  
23 address the unanswered questions and concerns regarding  
24 Claire. Dr Rooney opened the meeting, she outlined the  
25 issues and her secretary prepared a detailed four-page

52

1 typewritten minute of the discussions. And Dr Steen  
2 charted Claire's progress with reference to the medical  
3 notes and allowed Professor Young to field the questions  
4 relating to the fluid administration. Dr Rooney  
5 summarised the issues discussed and then left it to Mr  
6 and Mrs Roberts to decide whether they would seek  
7 further information or meetings or if they wished the  
8 matter to be referred to the coroner.

9 The content of Dr Rooney's minute of this meeting is  
10 noteworthy in a number of respects. Despite the fact  
11 that reassurance was given to Mr and Mrs Roberts that  
12 questions they feel still remain unanswered regarding  
13 Claire's death will be addressed, that the Trust would  
14 meet with them at any time to help them in any way  
15 possible, and that the Trust wants to be completely open  
16 in this case and will be happy to meet with Mr and  
17 Mrs Roberts again, Dr MacFaul believes that the approach  
18 to and the conduct of the meeting and the minute could  
19 be open to criticism. In particular, he says that  
20 consideration should have been given to the  
21 commissioning of an independent written report from  
22 a paediatric neurologist in these circumstances and that  
23 Professor Young may not have been recorded as  
24 independent, as he was employed by the Trust at the  
25 time.

53

1 were under discussion and it's not clear whether it had  
2 actually been made available to Professor Young or  
3 Dr Rooney at the time, and if it hadn't been, it's  
4 certainly not clear were it wouldn't have been.

5 Dr Steen appears, at least in the record of the  
6 minute, to have remained silent as to the post-mortem  
7 conclusions and seemingly didn't share the document  
8 prepared by her in respect of the care and treatment  
9 given to Claire. Or if she did, again, it's not  
10 something that's recorded.

11 Claire's medical notes and records were available  
12 and they might have been shared with Mr and Mrs Roberts  
13 to help them in understanding what was being described  
14 to them as the passage of Claire's admission and the  
15 diagnoses that were made and the treatment that was  
16 given to her.

17 Dr Steen is recorded as providing an explanation to  
18 Mr and Mrs Roberts as to how an illness such as Claire's  
19 can arise: viruses known as enteroviruses can enter the  
20 body via the stomach and can then cause swelling of the  
21 brain and it's not always a case that children with low  
22 sodium levels will result in swelling of the brain and  
23 that it's very difficult to evaluate how much the fluids  
24 contributed to the situation. The word "hyponatraemia"  
25 doesn't appear in Dr Rooney's minute and no reference

55

1 The clinical paediatric lead within the Children's  
2 Hospital, Dr Hicks, was not there, and in his view she  
3 should have been a part of the general governance  
4 management. She should have reviewed the death and it's  
5 to be regretted that Dr Hicks was not there as she seems  
6 to have been particularly qualified to assist in the  
7 understanding of Claire's case, because not only was she  
8 the clinical lead, she was a consultant paediatric  
9 neurologist who had previously treated Claire when she  
10 was a baby and was the lead at the time when Dr Webb was  
11 providing his specialist assistance. She was qualified  
12 in medico-legal ethical issues and had been selected by  
13 Dr Murnaghan for inclusion in the seminar group that  
14 he was seeking to set up to review the lessons to be  
15 learned from Adam Strain's case which is, of course, as  
16 you know, the inquest for which was just four months  
17 before Claire's death.

18 There are also a number of inaccuracies and  
19 omissions contained in that minute in relation to the  
20 information given to Mr and Mrs Roberts and those  
21 seemingly went uncorrected. It's also to be noted that  
22 there's actually no reference to the autopsy report  
23 in the discussions, or at least if there was, there's no  
24 reference to them in the actual minute. The content of  
25 that autopsy report was relevant to all the issues that

54

1 was made in the minute to the drug errors in relation to  
2 the midazolam and phenytoin, and you will have heard all  
3 the evidence in relation to the extent of the overdose  
4 of those particular drugs.

5 So it will be a matter for you, Mr Chairman, to  
6 consider and determine whether that constituted  
7 a failing in clinical governance review. That was the  
8 new era of 2004, that was an attempt to provide an open  
9 explanation to the family. That's what the Trust or the  
10 clinicians were seeking to do. Whether they succeeded  
11 in that is a matter to be determined ultimately by you.

12 But this is what, after that, the Roberts still  
13 wanted to know. They wrote a letter on 8 December 2004,  
14 raising a number of questions, and some of them, perhaps  
15 the most significant, are these:

16 "Does the full post-mortem report make any reference  
17 to hyponatraemia? Will the cause of Claire's death be  
18 reviewed by the Children's Hospital? Given that  
19 Claire's death was sudden, unexpected and without  
20 a clear diagnosis, why was the coroner not informed or  
21 an inquest held?"

22 And, Mr Chairman, it is perhaps noteworthy that at  
23 least two of those issues are matters that we are still  
24 having to consider in this inquiry. So if it was, if  
25 those questions were considered and answers were

56

1 provided to the Roberts, then it may be that there is  
2 a question mark as to the sufficiency of that.

3 Then Dr McBride directed Mr Walby to coordinate the  
4 notes of meetings and report to date so that:

5 "You are in a position to share this information  
6 with the coroner."

7 And on 16 December 2004, Mr Walby wrote to report  
8 the matter to the coroner formally. He described how  
9 having been examined by paediatric neurologist,  
10 Dr David Webb, Claire was considered to have a postictal  
11 acute encephalopathy and she was treated as such. She  
12 developed hyponatraemia and consideration was given to  
13 whether this was from the fluid overload with low-sodium  
14 fluids or a stress-induced antidiuretic hormone effect  
15 and her fluid management was altered.

16 You have heard the clinical evidence, Mr Chairman,  
17 and it will be a matter for you to determine whether  
18 indeed consideration was given as to whether the  
19 hyponatraemia she developed was from the fluid overload  
20 and, if it was, whether that consideration is  
21 effectively confined to the note of a very junior doctor  
22 at 11.30 on the Tuesday evening.

23 Dr Walby recounts how:

24 "Dr Steen also considered that there were errors in  
25 my letter and I requested her to provide corrections for

57

1 involved in Claire's case, such as were envisaged by  
2 Professor Young when he advised Dr McBride.

3 The process for taking witness statements to be used  
4 in a coroner's inquest and other court proceedings is  
5 covered by a departmental protocol published in 2002. A  
6 different view of best practice was, however, expressed  
7 by the coroner in his letter dated 30 January 2004 to  
8 the medical director, Michael McBride, and this is that  
9 he says in "The investigation of hospital deaths":

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

59

1 me to forward to the coroner."

2 So Dr Steen was given the opportunity to edit the  
3 information being given to the coroner and she took that  
4 and emphasised as part of doing that that the admitting  
5 registrar had formed a provisional diagnosis of possible  
6 encephalitis. And while that is the case, what she  
7 didn't also provide by way of information to the coroner  
8 in her review of that letter was that the admitting  
9 registrar had subsequently deleted that as a possible  
10 diagnosis.

11 If we move now on to the issues to do with  
12 the coroner and the inquest. It was Mr Walby's task to  
13 liaise with the coroner's office and to obtain  
14 statements from the staff involved in Claire's case.  
15 It is to be assumed that these statements were intended  
16 to form the basis of the inquest depositions and they  
17 appear to have been typed on pro forma PSNI witness  
18 statement sheets. This was apparently on the basis that  
19 this was the historical format preferred by the coroner.  
20 So Dr Steen's statement is dated March 2005 and that  
21 pre-dates the PSNI investigation. Dr Steen seems to  
22 have been reminded several times during the course of  
23 the five months it took her to furnish her statement to  
24 Mr Walby to produce it. The inquiry has not been  
25 provided with copies of statements from all the staff

58

1 and, if the circumstances of the death warranted it,  
2 treat an area of the hospital as a potential crime  
3 scene. I agree that in future I would agree to a police  
4 officer interviewing those involved and the present  
5 system would be discontinued."

6 This prompted Mr Walby to seek advice from the  
7 solicitor, Mr Brangam, on the basis that:

8 "The coroner's approach would seem to me to be  
9 a backward step."

10 No advices were forthcoming from the solicitor and  
11 Mr Walby took no steps, apparently, to follow  
12 the coroner's advices. He wrote to Mr Brangam on  
13 21 March 2005 to advise:

14 "As you know, we are still operating the old  
15 system."

16 In respect of the preparation for Claire's inquest,  
17 the PSNI were not involved. Mr Walby simply arranged  
18 for witness statements to be written on PSNI paper  
19 without the involvement of the PSNI. Mr Walby also  
20 arranged for legal advisers to approve the statements  
21 prior to release, corrected and redrafted statements,  
22 permitted professional indemnity insurers to comment on  
23 and approve doctors' statements. As to whether this  
24 approach would have constituted best practice by  
25 anybody's standards is a matter for the inquiry and

60

1 certainly whether it complied with what the coroner had  
2 in mind is a matter to be considered. And Mr Chairman,  
3 you have already heard evidence in relation to Dr Webb's  
4 evidence here in the inquiry as to how he had provided  
5 his detailed witness statement, informed by the clinical  
6 notes and records, signed the witness statement and  
7 nonetheless that was amended for him, sent back, and he  
8 incorporated that amendment and presumably re-signed it  
9 and sent it on as his statement to the coroner. Why?  
10 Well, we don't know, but one of the changes that was  
11 made is his concession that he believed he had made  
12 a mistake.

13 Mr Walby's job description specifies his duty:

14 "To assist the coroner with enquiries and the  
15 preparation of statements prior to inquest."

16 And his job description also requires him:

17 "To give advice and support to staff involved in  
18 coroner's cases."

19 So on one hand, he is tasked to assist the coroner;  
20 on the other hand, he's giving advice and support to  
21 staff who may themselves -- their conduct, in any  
22 event -- be called into question in a coroner's case.  
23 It is a matter for you, Mr Chairman, to determine the  
24 possible impact on good governance of any tension that  
25 there may have been to those two obligations and the

61

1 consultations on 3 April 2006 with Dr Steen, Dr Sands  
2 and Dr Webb together with the trust solicitor and, on  
3 7 April 2006, with Professor Young. The inquest into  
4 Claire's death was opened on 4 May 2006 by the coroner.  
5 Dr Bingham gave his evidence. He considered that the  
6 admission diagnosis was reasonable and that acute  
7 encephalopathy was a likely cause of her presenting  
8 illness. He did not consider the serum sodium  
9 concentration of 132 to be a likely cause. He  
10 considered it reasonable to have given Claire IV fluid  
11 and noted that she was given the fluid used as  
12 a standard in 1996 within the recommended volume for  
13 full maintenance fluid therapy. He believed that there  
14 were, however, reasons why Claire might have required  
15 fluid restrictions:

16 "Namely a lower level of her metabolism and possibly  
17 reduced urinary output due to secretion of ADH, which  
18 may accompany encephalopathy and nausea and vomiting."

19 And he concluded:

20 "If the reported sodium level of 121 was accurate,  
21 then it was the likely cause of her deterioration and  
22 death."

23 Dr Maconochie, who was also engaged as an expert,  
24 considered:

25 "A diagnosis of encephalitis/encephalopathy and/or

63

1 requirement that Mr Walby discharge them both and wear  
2 his two hats.

3 Indeed, it is for you also to determine,  
4 Mr Chairman, whether it was appropriate for the Royal  
5 Group of Hospitals to transfer sole responsibility for  
6 proper investigation to the coroner rather than  
7 conducting a simultaneous analysis itself, which might  
8 have assisted the learning all the time the coroner is  
9 pursuing his statutory obligations, and it might have  
10 assisted Mr and Mrs Roberts, the PSNI and indeed this  
11 inquiry. And as part of the process of informing  
12 the coroner, the comprehensive reply from Dr Rooney on  
13 behalf of hospital dated 12 January 2005 was forwarded  
14 to the coroner on 25 January 2005 with the observation  
15 that:

16 "I will leave it to you whether you wish to forward  
17 them to Dr Bingham to assist in the compilation of his  
18 report."

19 And further inaccuracies were supplied to the  
20 coroner, not in consequence of any independent  
21 investigation, but rather and in part on the basis of  
22 Dr Steen's own interpretation of Claire's case and her  
23 medical record.

24 So now, finally, Mr Chairman, to the inquest.

25 Mr Walby's preparation for inquest included

62

1 non-convulsive status epilepticus to be quite probable  
2 given her past history of seizures."

3 He regarded the management of those diagnoses to  
4 have been appropriate and did not comment on  
5 hyponatraemia because he wasn't charged to. He  
6 considered Dr Webb and the other members of the team  
7 looking after Claire had given careful and informed  
8 advice and, at the inquest, he gave his opinion as to  
9 the cause of death to be:

10 "Cerebral oedema, encephalitis/encephalopathy, and  
11 hyponatraemia, and thirdly, status epilepticus."

12 And Dr Bingham agreed with Dr Maconochie's  
13 formulation.

14 So the inquest verdict given as cause of death was:

15 "Cerebral oedema due to meningoencephalitis,  
16 hyponatraemia due to ADH production, and  
17 status epilepticus."

18 And the coroner found that the degree of  
19 hyponatraemia suffered contributed to the development of  
20 the cerebral oedema, which caused her death, but also  
21 that the meningoencephalitis and status epilepticus were  
22 also causes, albeit he couldn't determine the  
23 proportional contribution of each cause. And as  
24 a result of all of that, a new registration of death  
25 certificate was issued on 10 May 2006 with the cause of

64



1 death amended to reflect the coroner's verdict at  
2 inquest. So that's what the coroner found and it will  
3 be part of what you consider as coming out of the  
4 clinical hearings whether any of that could have been  
5 found earlier if better consideration had been given to  
6 Claire's treatment during life, and if that hadn't been  
7 possible and she died as she did, then whether if there  
8 had been proper investigation following it, what the  
9 coroner found could have been found also and could have  
10 identified the reasons why that had occurred, rather  
11 than Claire's family having to wait quite so long to  
12 hear in this inquiry some of the concessions that they  
13 have heard and now, in this part of the inquiry, to try  
14 and understand whether the systems that should have been  
15 in place were indeed in place and, if they were, how it  
16 was that they were unable to either prevent what  
17 happened or to ensure that something positive was learnt  
18 from what happened.

19 That really is the area of course, Mr Chairman, of  
20 this part of the inquiry. There is a much more detailed  
21 opening, obviously, and I haven't sought to go through  
22 it all. What I was trying to do is pull together some  
23 of the strands of it and I hope that nobody will take  
24 what I have said here as a substitution for the full  
25 opening: that has all the detail, it's fully referenced,

65

1 Governance opening by MR QUINN  
2 MR QUINN: First of all, Mr Chairman, I want to thank  
3 Michael McCrea of counsel and John Ferguson, my  
4 solicitor, together with the Roberts family for their  
5 input and assistance with the opening statement on  
6 behalf of the family. Secondly, we're greatly  
7 encouraged by Ms Anyadike-Danes' opening, her abridged  
8 verbal opening statement, which we agree is very well  
9 pointed. We agree that it addresses a number of issues  
10 that we see as extremely important in the case and  
11 I want now to try and highlight some of those issues  
12 that the family want particular attention drawn to.

13 The inquiry has a very detailed and comprehensive  
14 opening on the governance issues, there's a written  
15 opening on the governance issues prepared by  
16 Ms Anyadike-Danes and her team. This sets out the  
17 evidence received relating to governance and lists the  
18 governance issues that the inquiry team feel relevant  
19 and important. It also quotes and highlights some of  
20 the clinical evidence and how it relates to governance.

21 The Roberts family fully support the governance  
22 opening prepared by the inquiry team. However, they  
23 want they to deal with the governance issues on a more  
24 personal level and examine how they affect Claire and  
25 her family and examine their relevance, particularly

67

1 and that really is the place where we have set out all  
2 the evidence that we have found to date and the reasons  
3 why we are pursuing the courses that we are in the  
4 course of this hearing.

5 THE CHAIRMAN: Thank you very much. That's a very good  
6 balance between the full written opening, which is  
7 available to everybody, and the summary of it.  
8 Thank you.

9 Mr Quinn, I presume you're going to be a little  
10 while, are you, in opening?

11 MR QUINN: I would say no more than 45 minutes.

12 MR GREEN: Before my learned friend starts the opening on  
13 behalf of the Roberts, the parents, may I make a point  
14 which is a point that concerns Dr Sands, about  
15 a particular passage in the opening? I am in your hands  
16 as to whether you want to hear from me now.

17 THE CHAIRMAN: Would you speak to Ms Anyadike-Danes during  
18 the break and decide between you? I'll deal with any  
19 point after the break.

20 MR GREEN: I have spoken to Mr Quinn about it.

21 THE CHAIRMAN: Why don't you speak during the break and  
22 we'll pick it up at 12.15? Thank you.

23 (12.10 pm)

(A short break)

24 (12.20 pm)

66

1 in relation to the safekeeping of children who are  
2 treated at the Royal Belfast Hospital for Sick Children  
3 in the future.

4 Of course, the family want the full list of  
5 governance issues investigated and support that  
6 investigation. But they see some of those issues as  
7 more pertinent to them and, hopefully, these are issues  
8 upon which they can comment and provide some useful  
9 input that may assist this inquiry.

10 Having listened to the evidence relating to the  
11 clinical issues, the family are aware that the inquiry  
12 has already identified numerous errors, oversights and  
13 shortcomings in Claire's diagnosis, treatment and  
14 management.

15 Of course, the family want to know why the treating  
16 clinicians responsible for her care in 1996 repeatedly  
17 failed to identify the errors and still deny them to  
18 this day. The family acknowledge that mistakes are made  
19 in every walk of life and it is doubtful that anyone  
20 sitting in this room today has not made a mistake in  
21 their professional career. Some of those mistakes have  
22 very little impact on our lives and careers. Some of  
23 those mistakes may have led to embarrassment or, even  
24 worse, professional criticism and admonishment.

25 However, in this case, a catalogue of errors led to

68

1 the death of a child. Tragic incidents occur in every  
2 walk of life. Children are lost in boating accidents  
3 when on family holidays, they're killed in the back of  
4 their parents' cars when a serious crash occurs, and  
5 we have heard of numerous farming accidents -- in fact,  
6 I have been involved in quite a few where an unfortunate  
7 father tragically crushes a child in a tractor accident.

8 Those mistakes are open to investigation and  
9 criticism, but in Claire's case nothing seems to have  
10 been properly investigated. There has been little or no  
11 criticism levelled at anyone and, most tragically,  
12 it would seem that for a number of years after the death  
13 of Claire, nothing changed at the Children's Hospital.  
14 There are a number of points that appear in the table of  
15 content in the opening document that Mr and Mrs Roberts  
16 feel are more relevant to users of the hospital and the  
17 contact with medical staff and hospital administration.  
18 They feel they can perhaps help the inquiry with the  
19 evidence on those issues and those include:  
20 communication with parents; children with learning  
21 disabilities; medical records and general record  
22 keeping; drug administration and keeping parents  
23 informed about the administration of drugs; post death  
24 events; post-mortem request procedures; conduct of the  
25 autopsy, in particular where the autopsy was limited to

69

1 is that, just over 30 hours post admission, she was  
2 dead. The cause of death has been a matter of debate  
3 and dispute, but what no one can ever dispute is that  
4 Mr and Mrs Roberts have waiting 16 years to discover  
5 what actually happened to Claire.

6 Alan and Jennifer Roberts, like the other parents in  
7 this inquiry, have no medical expertise. However, like  
8 all parents in the inquiry, they have a good firm  
9 grounding in common sense, and they have an excellent  
10 memory of what went on because we are dealing with  
11 a child of their family, and that memory is pertinent to  
12 that child. So when Dr Bartholome, in hindsight, agreed  
13 and Dr Sands told the inquiry that undoubtedly Claire  
14 was the sickest child on the ward, this came as  
15 a complete shock to them. Dr Sands has gone so far as  
16 to say that Claire had "a major neurological problem"  
17 and that "she was very neurologically unwell".

18 The parents are now more than a little confused as  
19 they have heard in the last few days that Dr Webb may  
20 not fully agree with that assessment of Claire's  
21 condition.

22 THE CHAIRMAN: Well, he's quite a way away from it because  
23 he went home on the Tuesday evening expecting Claire to  
24 improve and recover gradually.

25 MR QUINN: Exactly. So he is long way away from it.

71

1 brain only; the autopsy request form; the autopsy  
2 report; and informing the parents about the contents of  
3 the contents of the report in plain and simple language;  
4 the adverse incident reporting; the investigations into  
5 Claire's death immediately after her death in 1996; and  
6 thereafter, the investigations that arose out of the UTV  
7 documentary in 2004; and the investigations leading up  
8 to the inquest in 2006.

9 Today, Mr Chairman, you have said -- and I endorse  
10 this and the family endorse it -- it seems that no one  
11 has yet identified a single point that was learned from  
12 Claire's death.

13 The parents' approach. Fundamental to how the  
14 parents approach this case is their belief that the  
15 doctors who were treating Claire did not realise how ill  
16 she really was. Once you accept this basic premise,  
17 then everything else falls into place. The parents  
18 believe that they were misled throughout the course of  
19 events from around the time of Claire's death to the  
20 start of this inquiry. They were never given a proper  
21 and adequate explanation of what happened to Claire,  
22 what treatment she received and what caused her death.

23 She was admitted to the Children's Hospital with a  
24 tummy bug at 8 pm on Monday 21 October 1996. By 4 am on  
25 the 23 October, she was beyond help. The shocking fact

70

1 We also know that the nurses did not seem to be very  
2 concerned and although Dr Sands maintains that he did  
3 tell the staff she was very unwell, that view does not  
4 seem to have been transmitted to the parents by either  
5 Dr Sands or the staff and this is a major issue that we  
6 want to have investigated.

7 To set the scene for what happened later in relation  
8 to the governance issues, any neutral observer with  
9 a fair amount of common sense would have to ask the  
10 following questions: if she was the sickest child on the  
11 ward, then why did Dr Steen not see her first thing  
12 in the morning on 22 October? Why did she not see her  
13 after the ward round if Dr Sands assessed her as being  
14 very seriously ill or perhaps just before -- that is  
15 Dr Steen -- went to her clinic? Why did she not come  
16 back after her clinic at around 5 pm when she was fully  
17 aware -- or should have been fully aware -- that Dr Webb  
18 was seeing her patient?

19 Of course, all of that makes sense when you take  
20 into account Dr Steen's comment that it was disgraceful  
21 that her parents were not told how ill Claire really  
22 was. The answer and the fundamental truth is that the  
23 parents were not told how ill Claire was because most of  
24 the doctors didn't realise how ill she was. In fact,  
25 it is probably the case that no one realised how ill she

72

1 was and, if they did, they certainly did not transmit  
2 that to the parents when they were present at the Royal  
3 Victoria Hospital.

4 Why did Dr Webb leave at 5 pm if Claire was the  
5 sickest child on the ward? His treatment plan had not  
6 been implemented so he did not know what results would  
7 be produced if he left the child described as the  
8 sickest child on the ward and went home without  
9 arranging for any other cover. The conclusion I would  
10 bring out of that, Mr Chairman, is that he didn't  
11 realise at all.

12 Why did Dr Webb not inform the parents that she was  
13 very sick? The parents went home at 9.15 and the  
14 inquiry has seen what effect that has had upon the  
15 parents when they gave evidence. They would never have  
16 left the hospital had they been properly informed. The  
17 communication process between doctors and nurses and  
18 between the staff and the hospital users should be  
19 examined by this inquiry.

20 Why did Dr Webb not advise the parents that they  
21 shouldn't go home until Claire showed some improvement?  
22 Why did the nurses let Mr and Mrs Roberts leave the  
23 hospital at 9.15 pm? In fact, the evidence would  
24 suggest that the nursing staff were quite nonchalant  
25 about them leaving and gave them no cause for concern

73

1 investigations such as an EEG or a CT scan.

2 If he had, this would have immediately raised  
3 serious concern. The alarm bells would have been  
4 ringing and Mr and Mrs Roberts definitely would never  
5 have left the hospital. Once again, you can see how  
6 this fits with the fundamental point that Mr and  
7 Mrs Roberts make and they want this expressed -- and  
8 I repeat it on their behalf -- they don't believe that  
9 the doctors realised how ill Claire really was.

10 THE CHAIRMAN: And if that's right, then it makes it  
11 difficult to understand how at 4 o'clock on Wednesday  
12 morning a decision was taken not to refer to the coroner  
13 and a decision was taken to limit the autopsy to brain  
14 only. If Dr Steen hadn't come back at 5 o'clock and if  
15 Dr Webb had gone home and Dr Sands had gone home -- with  
16 some level of concern but not a great level of  
17 concern -- then Claire's death became entirely  
18 unexpected at 4 in the morning.

19 MR QUINN: Exactly.

20 THE CHAIRMAN: And one couldn't be sufficiently confident,  
21 on this approach, of the cause of her death to decide  
22 not to have a full autopsy and not to refer to  
23 the coroner.

24 MR QUINN: Exactly because no one was aware that she was  
25 ill. It was totally unexpected and unexplained.

75

1 whatsoever. The answer may be that the nurses weren't  
2 told, weren't aware, and did not appreciate that Claire  
3 was very neurologically ill. Why did the doctors act as  
4 they did if, in fact, they did realise that Claire was  
5 very neurologically ill and could be described as the  
6 sickest child on the ward?

7 Why did Dr Bartholome not engage with the consultant  
8 on call when they got the blood results at around  
9 11.30 pm on 22 October? Why were the parents not called  
10 back to the ward at that point? Because at that point,  
11 they realised that Claire was ill. Even the most junior  
12 doctor on the ward, Dr Stewart, was aware that they had  
13 a serious problem on their hands. So we have  
14 a registrar who, on her own evidence, is run off her  
15 feet and yet no one calls for assistance from more  
16 senior clinicians and no one informs the parents. It is  
17 on these fundamental issues of common sense that the  
18 parents want an answer. The system for dealing with  
19 such emergencies should be fully reviewed by this  
20 inquiry.

21 Let's put the parents' evidence in to the framework  
22 of events on 21, 22 and 23 October 1996. They say that  
23 Dr Sands never told them that Claire had a major  
24 neurological problem and that he was going to get an  
25 opinion from a neurologist, that she may require

74

1 I make the point: what explanation were they given  
2 about their daughter's sudden and totally unexpected  
3 death? What happened then was they had a meeting with  
4 Dr Steen and Dr Webb in relation to the brain coning and  
5 the brainstem tests. They are adamant that they were  
6 told that Claire had died of a viral illness and no  
7 other specific information was given, and they will tell  
8 this inquiry when they give evidence on the governance  
9 points that that is correct. Hyponatraemia or fluid  
10 management was never mentioned. Quite justifiably, the  
11 parents are angry that a simple procedure like a blood  
12 test was not carried out. The chairman of this inquiry  
13 has repeatedly made the point that something as simple  
14 as a blood test could have turned this case around. The  
15 witnesses are still disputing responsibility over the  
16 blood test, but it would seem to be an undisputed fact  
17 that had bloods been done at an earlier stage and the  
18 sodium level discovered, then Claire would have been  
19 alive today, and in fact, Mr Chairman, you recall that  
20 Dr Webb was still disputing that point when he gave  
21 evidence.

22 Even at 11.30 on 22 October, when the SHO Dr Stewart  
23 realised that the patient might be suffering from  
24 hyponatraemia, no one with any experience had the time  
25 to examine Claire. We have heard from the experts that

76

1 even at that late stage there was some chance of saving  
2 Claire.

3 It would seem that it was only at this point that  
4 the SHO appreciated that Claire was very ill. If it was  
5 appreciated by other staff, then why was there no  
6 emergency procedure put in place when Dr Stewart  
7 contacted Dr Bartholome? There is a question mark as to  
8 whether or not she may have been beyond help at that  
9 stage, but unfortunately her condition was not fully  
10 appreciated and even though the notes suggest that the  
11 fluids were restricted, the mathematical calculations of  
12 the fluids shows that, in fact, when one takes into  
13 account the intravenous drug infusions, the fluids were  
14 actually increased.

15 Further, there should have been more discussion  
16 about whether sodium should have been added to the  
17 fluids, and you'll see that is a note made by Dr Stewart  
18 on the medical records. The bottom line is that she was  
19 failed by the system as there does not seem to be any  
20 clear guidelines on what should have happened in this  
21 type of case and a review of the system may save lives  
22 in the future.

23 The problems with staffing levels, the skill and  
24 experience of the doctors diagnosing and advising the  
25 treatment and the information that the parents are given

1 the coroner. That's in the transcript of 4 December  
2 2012.

3 The parents will say in evidence that they feel that  
4 a doctor has a statutory and ethical duty to inform  
5 the coroner of the sudden death of a child. They want  
6 to make the point that when a child's death is sudden  
7 and unexpected, and without clear diagnosis, then it  
8 should be referred to the coroner. If the clinicians  
9 were in any doubt whatsoever, they should have referred  
10 it to the coroner. The family want to know why it  
11 wasn't referred, given the uncertainty of the diagnosis  
12 and the doubts that were in the clinicians' mind at that  
13 time.

14 Autopsy request form. They are now aware that the  
15 autopsy request form was full of misleading information.  
16 I opened the family's case on the clinical issues  
17 highlighting several errors on this form, errors that  
18 the family say should not have been on the form because  
19 the information was never given by them. That's the  
20 family. They acknowledge the work done by the inquiry  
21 on this is issue. They find it ironic that the clinical  
22 notes are brief, but that the autopsy report form is  
23 full of information, albeit mostly wrong. They have now  
24 heard Dr Herron agreeing with the proposition that if  
25 the information provided on the form was factually

1 on the ward are individual to each case. All families  
2 are aware that in busy hospitals there are always risks  
3 and children fall between the gaps in the care regime  
4 and do not get correct treatment quickly enough. Mr and  
5 Mrs Roberts and their extended family know that there  
6 are risks when children go into hospital. They may have  
7 been able to deal with Claire's death had a proper  
8 investigation been carried out and a full and frank  
9 explanation given to them in late 1996 or early 1997.

10 However, in this case, Alan and Jennifer Roberts  
11 were misled. They believe they were misled in relation  
12 to the explanation given for Claire's death or, at the  
13 very least, they didn't get the whole truth. In the  
14 beginning they were given a limited version of what  
15 happened in Claire's treatment, but as things went on,  
16 they make the case that they were actually misled on  
17 certain issues that fall within the governance of this  
18 case.

19 Then I ask: should the coroner have been involved in  
20 1996? This leads us into the question about why  
21 Claire's death was not referred to the coroner. We have  
22 now heard evidence from Dr Scott-Jupp, an expert  
23 paediatrician, who seems to have no doubt that because  
24 of an uncertain diagnosis, ie not a firm diagnosis, that  
25 this was an indicator for reporting the case to

1 incorrect, then it would influence the way that he would  
2 approach his pathology investigations. Simply stated,  
3 if the clinical summary is wrong, then it is probably  
4 repeated throughout the investigation and the mistake is  
5 compounded. That was confirmed by Dr Herron.

6 What they wanted was for someone to stand up and  
7 say, "We made a mistake, we are sorry and we hope that  
8 we can put things right so that this doesn't happen to  
9 another child". The most distressing part of the case  
10 is that this is precisely what did not happen. Instead,  
11 Mr and Mrs Roberts had to wait until 2004 when  
12 a documentary was aired by Ulster Television in relation  
13 to children who died from hyponatraemia before they saw  
14 the link between the cases and started the second part  
15 of their investigations.

16 Brain-only autopsy. Was the brain-only autopsy  
17 appropriate? One thing that sticks with the parents  
18 is that Dr Herron, the pathologist, stated that "brain  
19 only" was underlined. That is on the request form. And  
20 he had never seen that before. We now have  
21 Dr Scott-Jupp's evidence on this, and he is of the  
22 opinion that if the parents consent, then a full autopsy  
23 is more appropriate as it may provide more information  
24 that would assist in reaching a conclusion about  
25 a child's death. They also find it interesting that the

1 pathology evidence is that the level of an inflammation  
2 found is low grade, sub-acute, and on a scale of 1 to  
3 10, it rates as a 1 or 2. Experts such as  
4 Professor Harding and Dr Squier state that there is no  
5 evidence of acquired infection. Further, Dr Squier's  
6 evidence on 5 December 2012 is clear on this point,  
7 relating to brain-only autopsy. She said:

8 "In 1996, [she] would always expect to do a full  
9 autopsy unless the parents do not consent."

10 However, at a meeting on 3 March 1997, Mr and  
11 Mrs Roberts were told by Dr Steen and Dr Webb that the  
12 post-mortem had concluded that a viral infection was  
13 responsible for the brain swelling, though the virus  
14 itself could not be identified.

15 Then we come to the events, Mr Chairman, after the  
16 2004 UTV documentary, and what happened after that. In  
17 her witness statement at WS143/1, Dr Steen states that  
18 she has no recollection of the events other than  
19 Claire's parents were aware of low sodium being  
20 implicated as this is what jogged their memory and  
21 resulted in them contacting the Trust to discuss  
22 Claire's death.

23 The Roberts will say that this statement is  
24 incorrect. They were never aware of hyponatraemia or  
25 Claire's low sodium level until after the meeting with

81

1 contact with the various clinicians who had charge of  
2 Claire's care during her admission to hospital on 21, 22  
3 and 23 October 1996.

4 Of particular relevance is the contents of file 139,  
5 which could loosely be described as the coroner's  
6 investigation file relating to the Royal Victoria  
7 Hospital and this death. There are a number of issues  
8 relating to the correspondence in that file that cause  
9 us concern. The parents want the full file investigated  
10 and the letter of 5 October 2012, which I will attach to  
11 the opening, from their solicitors, Messrs Ferguson &  
12 Company, to the inquiry solicitor sets out in detail the  
13 issues raised by the family.

14 They want to make the following points in this  
15 opening -- and I stress at this stage that Mr and  
16 Mrs Roberts have had a substantial input into this area  
17 of the opening. I wonder if you'd be kind enough to  
18 pull up document 139-153-001.

19 This is an e-mail from Professor Young to  
20 Michael McBride dated 6 December 2004. What has to be  
21 realised here is this is the day before the meeting with  
22 Mr and Mrs Roberts on 7 December, when he was put  
23 forward, that is Professor Young was put forward, as an  
24 independent investigator. When you look at the contents  
25 of that e-mail, you can see that he met with

83

1 the clinicians and Professor Young on 7 December at the  
2 Children's Hospital. They contacted the hospital  
3 because the TV programme had highlighted that the wrong  
4 type of fluid had been administered to children featured  
5 in the programme. Their first enquiry with the hospital  
6 was in relation to the fluid management, fluid type and  
7 amount of fluid given. You will hear of this when they  
8 given their evidence at the inquiry on 13 December.

9 I'm indebted to Ms Anyadike-Danes for highlighting  
10 this issue and going through the correspondence in  
11 detail, which saves me the trouble of going into it any  
12 further. However, I want to mention the meeting of  
13 7 December and what happened during that meeting. When  
14 the parents attended the meeting, the parents were told  
15 that Professor Young was going to conduct an independent  
16 investigation.

17 I stress this -- and I stress this for the  
18 transcript -- they were in no doubt that Professor Young  
19 was introduced to them by Dr Rooney as someone who would  
20 carry out an independent investigation. That's the  
21 evidence they will give. And that investigation was  
22 into the events surrounding Claire's death. They now  
23 challenge Professor Young's independence. It became  
24 clear after reading the files, examining the  
25 correspondence and e-mails, that Professor Young was in

82

1 Heather Steen on the afternoon of 6 December and that  
2 they had a discussion about hyponatraemia. I will read  
3 out what is relevant:

4 "We met with Heather Steen this afternoon and  
5 reached a measure of agreement about the role of the  
6 hyponatraemia. She wants to be present at the meeting  
7 tomorrow and will deal with any questions about the  
8 clinical journey, while I deal with the fluid issues.  
9 Hopefully this will work. Heather has definite views  
10 about the significance of the fluid management, which  
11 are not quite the same as mine. Nichola will offer the  
12 parents the opportunity to meet with me separately if  
13 they wish to. Heather thinks it is important that  
14 someone should speak to David Webb in Dublin so that  
15 he is informed about what is happening. Do you want to  
16 do this or will I try to contact him?"

17 I've already mentioned that he has met Dr Steen on  
18 the 6th, they reached an agreement, and she wanted to  
19 present the clinical journey while he deals with fluid  
20 issues. And he comments, "Hopefully, this will work".  
21 We want to know what will work, what is he working at?  
22 The parents want to know what this means.

23 They also want to know who else was at the meeting  
24 when the e-mail opens with "we met Heather Steen this  
25 afternoon." We want that investigated.

84

1 At the end of the email, Dr Steen recommends someone  
2 should speak to David Webb in Dublin "so that he is  
3 informed about what is happening". What was happening?  
4 We were expecting an independent review to happen. What  
5 was happening in Dublin? Why should Dr Webb be informed  
6 about what was happening? Why would Professor Young  
7 contact Dr Webb to tell him what is happening when he is  
8 carrying out an independent investigation? If he is  
9 contacting him for information, that would be  
10 a different matter, but why is he contacting him about  
11 what's happening?

12 Referring to the note of the meeting of 7 December,  
13 which is reference 089-002-005, Professor Young added  
14 that:

15 "At the time of Claire's treatment, there was a lack  
16 of awareness of low sodium."

17 However, Dr MacFaul, who is an expert to the  
18 inquiry, will say that, from 1994 onwards, there was an  
19 awareness of fluid management, hyponatraemia and  
20 encephalopathy.

21 It was during this meeting that the parents first  
22 heard that, on admission to hospital, Claire's sodium  
23 level was 132, but had later fallen to 121. It was at  
24 this same meeting that they were first advised that she  
25 had received Solution No. 18. This was the first time

85

1 checked them and reviewed the notes and charts, and that  
2 they reviewed the treatment and the drug therapy.

3 The Roberts then want to draw attention to these  
4 references. Reference 5(a), that was page 113 of the  
5 same document, paragraph 5(a) of the same letter,  
6 please. It's 112.

7 At 5(a), the last sentence:

8 "It is not possible to say whether a change in the  
9 amount and type of fluids would have made any difference  
10 in Claire's case as she was very ill for other reasons."

11 The parents were never told about any other reasons.  
12 They were never told she was very ill and that  
13 a neurologist was summoned or that a CT scan was  
14 organised. In fact, they were never told at this  
15 meeting for the day after. What evidence, tests or  
16 results did Dr Steen have other than the sudden fall in  
17 sodium level within 23 hours? It seems some clinicians  
18 are still in denial and perhaps a proper review could  
19 have come up with some answers.

20 Let's go to the next page, please, 113, reference  
21 6(b).

22 THE CHAIRMAN: If you pause there. When Mrs Roberts met  
23 Dr Webb at about 5 o'clock on the Tuesday afternoon, did  
24 she know that he was a neurologist?

25 MR QUINN: No. So far as I'm aware, she knew he was

87

1 they were advised that a blood check to test the sodium  
2 level had not been carried out between admission and  
3 approximately 24 hours later.

4 However, they were not advised of the implication of  
5 the lack of blood testing. Further, Professor Young  
6 made no comment about the mistakes in treating Claire:  
7 the absence of appropriate tests, the poor record  
8 keeping, or the overdose of drugs.

9 The letter of 12 January 2012, which is reference  
10 096-018-113, from Nichola Rooney, who chaired the  
11 meeting of 7 December 2004. Mr and Mrs Roberts are  
12 critical of this meeting and this is a letter of  
13 explanation arising out of it. It should be noted that  
14 Dr Steen and Professor Young rely on the medical charts.  
15 It's paragraph 3 in the first page of the letter,  
16 please. It'll be 111.

17 If you look at the third paragraph:

18 "I know it has been difficult to fully answer some  
19 of the very specific questions as Dr Steen and Dr Young  
20 could only reply on the documentation available in the  
21 medical chart and their knowledge of the practices of  
22 the time."

23 So clearly, Professor Young and Dr Steen have the  
24 charts.

25 We therefore must assume that they have read them,

86

1 a doctor, but not whatever specialist he was. She  
2 wasn't aware of what he did.

3 THE CHAIRMAN: Or the fact that he was being called in meant  
4 something different from Dr Sands?

5 MR QUINN: No. She was not aware that he was a neurologist,  
6 I'm certain of that.

7 THE CHAIRMAN: Thank you.

8 MR QUINN: 6(b) records:

9 "With regard to why Claire was not moved to PICU,  
10 her hourly CNS observations had remained stable for  
11 a period of time and no clinical signs of further  
12 deterioration were noted."

13 During this period, it must be pointed out that  
14 Claire's Glasgow Coma Scale reading fell from 9 to 6  
15 during the same period. There was no improvement in  
16 Claire's condition due to an incorrect diagnosis,  
17 medication overdoses and an incorrect fluid plan.

18 Why would the doctors not act? Why did they not act  
19 when the GCS dropped to 6? We now know that Dr Webb  
20 changed his statement at Mr Walby's request where it  
21 relates to dealing with the issue of PICU referral. We  
22 know that, and Ms Anyadike-Danes actually opened her  
23 part of the case and mentioned that particular point.

24 THE CHAIRMAN: There's even an issue about whether you wait  
25 until the Glasgow Coma Scale drops to 6.

88

1 MR QUINN: There is. The parents would make the case that  
2 there should have been more attention paid when it went  
3 down below 9.

4 Let's go to the next paragraph, 7(b) in the next  
5 letter. The parents were here being assured that the  
6 correct action was taken. In fact, correct action was  
7 not taken, and this statement is incorrect. Her fluids  
8 were actually increased when one adds in the intravenous  
9 fluids. Dr Bartholome failed to turn up and examine  
10 Claire at 11.30. No consultant was informed and Claire  
11 was unattended for a further three hours before her  
12 respiratory arrest at 2.30 am. So the parents feel  
13 insulted that someone is trying to tell them that  
14 correct action was taken.

15 No decision was taken on whether to increase sodium  
16 levels in fluids, but it was considered by Dr Stewart.  
17 The last section of paragraph 9 of the letter sets out  
18 the practice of the time, but was this done? So  
19 therefore, what we have here is the Royal admitting that  
20 there was a best practice in place, so let's have a look  
21 at paragraph 9. The practice at the time, as appears in  
22 the letter, seems to have been, firstly, to restrict  
23 fluid intake and, secondly, to consider administration  
24 of fluid with a higher content of sodium if symptoms  
25 attributable to hyponatraemia were present.

89

1 That seems to suggest that another review of the  
2 case notes has been carried out and the parents cannot  
3 understand why the mistakes that are now so apparent in  
4 the case notes were not detected. By way of papers  
5 served yesterday, we now know that Mr Walby also had  
6 some input amending this letter. This letter was sent  
7 in draft to him by Dr Rooney, and the parents want the  
8 inquiry to fully investigate Dr Walby's input into this  
9 case. Just for the sake of reference, the letters to  
10 Dr Rooney and the amended -- it starts in or about  
11 139-173-001, where there's a string of e-mails and  
12 references to Dr Rooney's letter and amendments in  
13 handwriting suggested by Mr Walby. Let's go to the  
14 inquest then in 2006.

15 There are a number of points the parents will raise  
16 in their evidence, but one of the main issues is that  
17 the parents find it absolutely incredible, I can use no  
18 other term to describe their feeling about this, that  
19 Professor Young's review and analysis of the papers  
20 leading up to the inquest -- and those were seen by  
21 Dr Steen and Webb and others, and during the public  
22 examination during the inquest no one realised that  
23 Claire had two substantial overdoses of drugs.

24 Dr Steen reviewed the clinical notes when making her  
25 statement to the coroner and again when making a police

91

1 We now know that neither was done, that there was  
2 a mathematical error in the fluid restriction and that  
3 no further consideration was given to giving fluids with  
4 a higher sodium content. Yet there seems to be an  
5 assumption in that letter, Mr Chairman, that it was  
6 done. And the point the parents make here is that if  
7 a comprehensive review or audit had been carried out  
8 at the Children's Hospital, it would have had to  
9 conclude and arrive at the conclusion that there were  
10 mistakes and system failures.

11 THE CHAIRMAN: That leads you into a two part issue, doesn't  
12 it? Part 1 is: what was the ambit or extent of the  
13 exercise being done through Dr Rooney and  
14 Professor Young? The second part is: if that was  
15 limited, as it appears to have been, should there not  
16 have been a more significant investigation and  
17 intervention?

18 MR QUINN: Of course. Of course that's the point.

19 When you look at paragraph 10 of the letter,  
20 if we go through to the next page, please, 114, you will  
21 see in paragraph 10:

22 "Having brought Claire's case to the attention of  
23 the medical director, a review of Claire's case note was  
24 carried out, with independent advice sought from Queen's  
25 University Professor of Medicine."

90

1 statement, as did Dr Webb. Claire had an overdose of  
2 midazolam of more than 300 per cent and an overdose of  
3 phenytoin, but that was not picked up by any of the  
4 witnesses or experts and in particular it was never  
5 mentioned by Dr Steen, Dr Webb or Professor Young.

6 Did the inquest clear things up for the Roberts?  
7 Absolutely not. Not one expert spotted any of the  
8 mistakes that were in the notes, even though they all  
9 gave evidence. No one criticised the notes for content  
10 and structure, lack of timing, dating and signing, and  
11 we must question how that would fit with any audit or  
12 review of the notes.

13 Inquiry counsel has highlighted this aspect of the  
14 case in the opening statement, but I feel that I must  
15 repeat Dr Steen's concession. She states:

16 "I can in no way defend the quality of my  
17 documentation or anyone else's."

18 That's on 3 October 2012.

19 She then went on to say:

20 "Our documentation is poor and we know it's poor."

21 That's on 15 October 2012.

22 The fundamental point that the family make is they  
23 want to know why the witnesses did not point this out to  
24 the coroner. A number of witnesses reviewed the notes  
25 for the coroner's case and they discussed various

92

1 references in the notes and, in fact, you will see that  
2 at reference number 139-156-005 Dr Steen discusses  
3 various elements of the notes in her police statement.  
4 I know now that this is a statement prepared for the  
5 Coroner's Court, may I add.

6 She reviews the drugs, but fails to mention the  
7 overdoses and misses that the prescription records show  
8 a massive overdose of 120 milligrams of midazolam,  
9 though we do concede there may be an issue as to whether  
10 she ever received that, but it is fundamental that it  
11 was not picked up in any of the notes. You can see  
12 halfway down the third paragraph, five lines down:

13 "He felt that she continued to be in  
14 a status epilepticus and advised commencement of  
15 midazolam with a stat dose of 12 milligrams."

16 It's clear that she has reviewed the notes and has  
17 recorded 12 milligrams, yet we know now that that's  
18 a 360 per cent overdose. It may be relevant that  
19 Dr Sands added to the note the entry  
20 "encephalitis/encephalopathy".

21 THE CHAIRMAN: She has corrected the note, hasn't she? The  
22 note says 120. The actual hospital note says 120.

23 MR QUINN: It does.

24 THE CHAIRMAN: She has corrected that in her statement.

25 MR QUINN: The 12 milligrams is from the clinical records.

93

1 example, there is a letter from Mr Walby to the coroner,  
2 139-149-001, where in paragraph 3 it states:

3 "She was examined by a paediatric neurologist,  
4 Dr Webb, and he considered her to have a postictal acute  
5 encephalopathy and was treated as such. She developed  
6 hyponatraemia and consideration was given to whether  
7 this was from fluid overload with low-sodium fluids or  
8 a stress-induced antidiuretic hormone effect and her  
9 fluid management was altered."

10 What we ask is: did Doctors Steen, Sands or Webb  
11 give consideration to fluid overload with low-sodium  
12 fluids in 1996? Because the parents were told it was  
13 a virus. Was Claire's fluid management considered  
14 reviewed in 1996 or at any time before the parents  
15 started asking all of these questions in 2004?

16 The parents will say -- and will give evidence next  
17 week -- to say that there was no discussion about fluid  
18 overload or low-sodium fluids in 1996. So why were the  
19 parents not told about hyponatraemia in 1996?  
20 Hyponatraemia appears in the clinical records, it was  
21 entered by Dr Stewart, who was probably the most junior  
22 doctor on the ward, and then it appears in the intensive  
23 care record notes. Why wasn't this raised with the  
24 parents?

25 The clinical mistakes, errors, oversights, lack of

95

1 She hasn't picked up the prescription records. That's  
2 the point I'm making. What she says in the statement is  
3 an entry taken from the clinical notes when the stat  
4 dose of 12 milligrams was prescribed for Claire. But  
5 what nobody seems to have picked up in any of the notes  
6 is that the prescription records have an entry of  
7 120 milligrams, which is a massive overdose.

8 THE CHAIRMAN: Yes.

9 MR QUINN: Going back to the entry

10 "encephalitis/encephalopathy", that entry was undated,  
11 unsigned and, obviously, in a different hand and pen  
12 than that which appears to have written the note on the  
13 ward round. Why was there no criticism of that,  
14 Mr Chairman? Why was that not picked up and criticised  
15 at the Coroner's Court when this was reviewed by at  
16 least four different people and Queen's University?

17 In relation to this entry made by Dr Sands,  
18 "encephalitis/encephalopathy", the parents have  
19 a genuine doubt as to why the entry was made as it  
20 doesn't fit with the nursing notes. In fact, they will  
21 say that it fits with nothing at all in the case.

22 The family want the issues that were tested in the  
23 inquest to be reviewed by this inquiry. They want those  
24 issues raised again in light of the expert evidence and  
25 the further statements that have been made. For

94

1 audit and review, limited autopsy, et cetera, meant that  
2 Claire slipped through a gaping hole in the safety net  
3 provided by the National Health Service. Once she was  
4 through that hole, she was dead.

5 The family believe that the cover-up began after  
6 Claire was transferred to PICU and it was recognised  
7 that there was no hope of recovery. If the family are  
8 not correct about a cover-up, then what did happen in  
9 1996? How can it be explained? How would a neutral  
10 observer interpret the evidence? What is the  
11 explanation for the events surrounding investigations  
12 and information given to the family?

13 They have already raised issues of concern on  
14 file 139 and want to highlight the following as a  
15 further small example of what any member of the public  
16 with an ounce of common sense would want reviewed and  
17 investigated.

18 In file 139, at reference 139-096-001 -- it's not an  
19 e-mail as I've stated -- it's a letter from Mr Walby to  
20 Dr Webb dated 31 July 2005. Mr Walby suggested a change  
21 to Dr Webb's statement and we can see that in his draft  
22 statement, which I don't need to pull up. This has  
23 already been covered by Ms Anyadike-Danes in her  
24 opening, but I want to emphasise that this has already  
25 been highlighted in Dr Webb's evidence of Monday of this

96



1 week, but it is something that the parents are  
2 particularly concerned about as it looked as though  
3 there is a hand steering the evidence behind the scenes  
4 and I want to highlight that in other documents.

5 If we then look at document 139-106-001. We have  
6 another piece of correspondence from Mr Walby, this time  
7 to Dr Sands, dated 6 June 2005, suggesting that he  
8 should leave out a part of his statement. This  
9 discusses fluid therapy and concludes paragraph 1 by  
10 stating:

11 "All in all, it sounds very defensive and, at this  
12 stage, if you leave your comments out, it is probably  
13 better."

14 The parents would like that examined.

15 Similarly, at reference 139-148-001, we have  
16 correspondence from Mr Walby to Dr Steen dated  
17 22 December. It is worth reading the handwritten note  
18 at the bottom:

19 "I hear you have identified errors in my letter  
20 reporting the death to the coroner. If so, perhaps you  
21 would let me have corrections so that I can appraise  
22 the coroner of this as soon as possible, please."

23 What errors did Dr Steen -- he addresses her as  
24 "Heather" -- identify? And what impact did those errors  
25 have? What did Mr Walby do in relation to Dr Steen's

97

1 discusses various issues that have been raised in  
2 Claire's case. Perhaps that could be brought up.  
3 THE CHAIRMAN: They don't have it, I'm afraid. We'll sort  
4 that out over the weekend.

5 MR QUINN: Why was Professor Young corresponding with  
6 Peter Walby, who was in the litigation management  
7 office, if he was conducting an independent review? Why  
8 was the correspondence flowing between the independent  
9 reviewer and the litigation office? What is the meaning  
10 of the e-mail of 5 May from Mr Walby to Pauline Webb.  
11 And I quote the third paragraph, which may again not be  
12 on the website yet:

13 "I spoke to Mr Roberts at the end of the inquest  
14 ..."

15 This is a letter reviewing what was said by  
16 Mr Roberts to Peter Walby:

17 "... and advised him that if he still has concerns,  
18 he should write to the chief executive. The clinicians  
19 would be happy to meet with the family if that would  
20 assist. However, I wish to warn you that there were  
21 questions raised, which will properly be answered by the  
22 O'Hara inquiry in due course, and you need to be aware  
23 of their interest in discussing policy changes,  
24 et cetera, arising out of the death of Adam Strain in  
25 1995. I would counsel you against allowing the Roberts

99

1 input and why was she adding any input at all?

2 We've already highlighted the e-mail from  
3 Professor Young to Dr McBride on 6 December. We would  
4 also like to refer to the e-mail passing between  
5 Professor Young and Mr Walby on 10 April 2006, which is  
6 139-038-001. In this e-mail, Professor Young states  
7 that Doctors Sands and Steen should be appraised of  
8 Dr Webb's comments:

9 "I think that Andrew Sands and Heather also need to  
10 be appraised of David Webb's comments on these issues if  
11 they are not already aware of them."

12 Bear in mind that the inquest in Claire's case was  
13 held on 4 May, so what we want to know was why was  
14 Professor Young, as an independent investigator,  
15 ensuring that the witnesses be appraised of each other's  
16 comments? A neutral observer would have to conclude  
17 that his independence was compromised. A parent would  
18 jump to only one conclusion.

19 Further additional papers have been served in  
20 file 139. We have already raised the issue in relation  
21 to Mr Walby's advice to Dr Rooney in relation to her  
22 letter of 12 January and the corrections that he  
23 advised. The parents also want the inquiry to  
24 investigate Professor Young's email to Mr Walby of  
25 7 April 2006, which is 139-170-001. In this e-mail he

98

1 to run their own mini-O'Hara inquiry themselves."

2 What does that mean? Claire's parents would like  
3 those comments to be fully investigated. How were they  
4 running a "mini O'Hara inquiry" themselves? There are  
5 dozens of issues that have been highlighted in the  
6 opening statement prepared by the inquiry team -- and  
7 again I am indebted for the abridged version today --  
8 but Mr and Mrs Roberts want to put a personal slant on  
9 the opening. They want to make the following points.

10 Nothing was done after the death of Adam Strain. In  
11 fact, the inquest into Adam's death came only a matter  
12 of months before Claire's death. What lessons were  
13 learnt? Nothing was done after Claire's death. There  
14 is no hard evidence or records of any meetings or review  
15 procedure, staff or nursing reviews, or the review of  
16 any element of supervision or staffing on the wards.  
17 Not one part of the system that was in place at the time  
18 was reviewed or overhauled, not one member of staff was  
19 criticised in any way whatsoever. Why was nothing done  
20 after the inquest? And what I mean here is Adam's  
21 inquest. Because when we heard evidence from  
22 Dr Murnaghan -- who I understand is the medical  
23 administrator, not the medical director -- he was asked  
24 by the coroner to address the problems and he undertook  
25 to do something. So what we have here is a situation

100

1 where the coroner requests Dr Murnaghan, being in  
2 a position of authority in the Royal Victoria Hospital,  
3 to take this on board and do something about it. And  
4 when he was asked why he didn't do anything about it  
5 in relation to what the coroner requested him to do, he  
6 replied "mea culpa". A fitting answer for a man who  
7 failed to do anything.

8 Alan and Jennifer Roberts have reached the  
9 inevitable conclusion that no one did anything because  
10 no one wanted to raise ripples in an otherwise quite  
11 smooth pond. What hurts the parents most is that Claire  
12 seems to have died for nothing. The hospital learnt  
13 nothing, they did nothing and therefore what else can  
14 reasonable-thinking parents make of this other than that  
15 there was a general cover-up going on? Why did Claire's  
16 parents have to wait 16 years to get to the truth?  
17 It is absolutely incredible -- and the parents again  
18 instruct me to use those words -- that the public now  
19 have to hear that after the death of two children, Adam  
20 and Claire, that nothing was done. In fact, hopefully  
21 Dr Murnaghan speaks on behalf of the Children's Hospital  
22 when he says "mea culpa". Will the clinicians and  
23 administrators of the Children's Hospital fall in behind  
24 Dr Murnaghan and also acknowledge the blame that falls  
25 on them?

101

1 "In relation to this entry made by Dr Sands [and  
2 then it is repeated], the parents have a genuine doubt  
3 as to why this entry was made as it does not fit with  
4 the nursing notes. In fact, they will say that it fits  
5 with nothing at all in the case."

6 May I preface the concern I advance about that by  
7 saying that nothing I say now is meant by way of  
8 criticism of the parents of Claire Roberts or the fact  
9 that they rightly feel entitled to make wide-ranging  
10 observations about matters which cause them genuine and  
11 ongoing concern. But if we look at it for a moment from  
12 Dr Sands' point of view, it appears to him, and you may  
13 think there's some force in it, that the way that is put  
14 is somewhat loaded with the innuendo that this was  
15 perhaps a self-serving addition to the notes after  
16 Claire's death in order to give the reader the  
17 impression that the picture that Dr Sands was seeing on  
18 22 October was a different one than the picture he was  
19 actually seeing in real time.

20 That causes him real concern. It causes him concern  
21 particularly because none of this was put to him for him  
22 to deal with when he gave his evidence live on  
23 19 October, and perhaps if this point was to be raised,  
24 it would have been better had it been put to him when he  
25 gave his live evidence.

103

1 Thank you, Mr Chairman.

2 THE CHAIRMAN: Thank you, Mr Quinn.

3 Mr Green, I suspect you want to take me back to  
4 page?

5 MR GREEN: 17, sir. If we start with the run-in to the  
6 passage which has caused some concern to  
7 Dr Andrew Sands. It's six lines down from the top, sir:  
8 "It may also be very relevant that Dr Sands added to  
9 the note the entry 'encephalitis/encephalopathy', that  
10 this entry was undated, unsigned and obviously in  
11 a different hand and pen as that which appears to have  
12 written the note at the ward round. Why was there no  
13 criticism of this entry?"

14 I make no complaint about that run-in part because  
15 Dr Sands now understands, more than anybody, that one is  
16 vulnerable to criticism if one makes a note in medical  
17 notes and doesn't sign it, date or time it. But it's  
18 the next passage which causes particular concern --

19 THE CHAIRMAN: Sorry, just pausing there, the fact that it's  
20 in a different hand and different pen is because it's  
21 his writing rather than Dr Stevenson's, isn't that  
22 right?

23 MR GREEN: Absolutely.

24 THE CHAIRMAN: So that's not the issue.

25 MR GREEN: That's just the run-in. But then next:

102

1 Sir, it may be said that we're now on to governance,  
2 so different issues are being analysed, but the reality  
3 here is that this particular note and the issues  
4 surrounding it are at least as relevant to the clinical  
5 matters as to the governance side of things.

6 I therefore ask aloud, as it were, what is to be done  
7 about it? It may well be, sir, that you can allay both  
8 the concerns of Mr and Mrs Roberts and Dr Sands if  
9 you were prepared to make the observation that you will  
10 scrutinise all the concerns that are raised during this  
11 inquiry process and give all interested parties an  
12 opportunity to deal with any such issues if you think  
13 that the point comes, for example, when they need to be  
14 recalled to speak to them.

15 But when one looks at it, perhaps at the end of all  
16 of the evidence, it may be that this issue isn't as  
17 troubling for either Dr Sands or the parents of  
18 Claire Roberts as it appears to be on paper now.  
19 Drawing the strands together, I can see matters  
20 sympathetically from the point of view of the parents,  
21 but I hope, sir, you can see them sympathetically from  
22 the point of Dr Sands.

23 THE CHAIRMAN: I can, and I can see the tension between  
24 them. What I'll do over the next couple of days is  
25 I will re-read the transcript of 19 October to see

104

1 exactly the extent to which this point was or was not  
2 developed, and if necessary, then we can revisit it  
3 at the start of the week with Mr Quinn and take a view  
4 as to whether, on this particular point, it may not be  
5 necessary to ask Dr Sands to come back to the witness  
6 box.

7 MR GREEN: I'd be grateful for that. If he is to come back,  
8 I'd be grateful if he could be called the week after  
9 next. It's simply that I have a personal matter which  
10 is going to involve my absence for the whole of next  
11 week. I mean no discourtesy by my absence.

12 THE CHAIRMAN: I understand because I don't think you'd have  
13 been anticipating the recall of Dr Sands at all. We can  
14 work our way around that.

15 MR GREEN: Thank you, sir. That's all I have to say.

16 THE CHAIRMAN: Ladies and gentlemen, we'll break for lunch  
17 and we'll take Mrs Jackson's evidence at 2 o'clock.  
18 Thank you.

19 (1.15 pm)

(The Short Adjournment)

21 (2.00 pm)

MRS MARGARET JACKSON (called)

Questions from MR STEWART

24 MR STEWART: Good afternoon. You have made two statements  
25 to the inquiry. One in relation to Adam Strain's case,

105

1 Q. In relation to either of those deaths, were you asked to  
2 make a statement by the hospital?

3 A. Not to my recollection, no.

4 Q. In respect of either of those cases, were you involved  
5 in any audit or review?

6 A. No.

7 Q. In respect of either of those cases, were you contacted  
8 by any investigation into the circumstances of those  
9 cases?

10 A. No.

11 Q. In relation to your position and role at the time of  
12 Claire's admission, you are described as acting nurse  
13 manager responsible for a number of particular areas of  
14 the hospital. Can you describe what "acting nurse  
15 manager" meant at the time?

16 A. My understanding would be that it wasn't a substantive  
17 post. We were not appointed to a permanent post; it  
18 was, I suppose, a fill-in. They hadn't -- the posts had  
19 been advertised and they weren't filled. And as  
20 a result of that, as an interim, I believe that they  
21 appointed three of the internal staff to carry out until  
22 such times as they did advertise and appoint.

23 Q. It was a temporary stopgap?

24 A. Yes. That was my understanding.

25 Q. How long did that continue for?

107

1 WS262/1, and one in relation to this case, WS272/1. Are  
2 you content that the inquiry should adopt those  
3 statements as your formal evidence?

4 A. I am, yes.

5 Q. And also, you made a statement to the police on  
6 2 May 2006. Are you likewise content that that should  
7 be admitted to your evidence?

8 A. Yes.

9 Q. Thank you.

10 As part of your witness statement, 272/1, you kindly  
11 supplied us with your CV, which is at WS272/1, page 14.  
12 I wonder if that might be shown on the screen.

13 This is relevant, if I can bring you down to  
14 two-thirds down the page:

15 "1993 to July 1996: sister in theatres."

16 And immediately beneath that:

17 "July 1996 to May 1998: acting nurse manager  
18 responsible for theatres, day procedure unit and  
19 intensive care."

20 And the reason I draw attention to those two entries  
21 is that you were theatre sister at the time of  
22 Adam Strain's surgery and death in the theatre and  
23 you were acting nurse manager for the intensive care  
24 unit at the time of Claire's death.

25 A. That's correct.

106

1 A. Approximately two years, I think it was. I think we  
2 finished around 1998. I'm not very clear on the exact  
3 dates.

4 THE CHAIRMAN: When the jobs were advertised, do you know  
5 why they weren't filled?

6 A. The applicants were unsuccessful.

7 THE CHAIRMAN: Okay, thank you.

8 MR STEWART: There were three sisters acting up as nurse  
9 managers.

10 A. Yes.

11 Q. Was there subsequently a single individual who performed  
12 the role of overall nurse manager?

13 A. Yes. There was a single person appointed around the  
14 middle of 1998, I believe.

15 Q. So your ambit of responsibility was, as you described  
16 it: theatres, day procedure unit and intensive care.

17 A. Yes.

18 Q. Was there an equal division of responsibility between  
19 the three acting nurse managers?

20 A. I believe it was more or less equal. I think probably  
21 in staff numbers and responsibility, it would have been.  
22 The ambulatory care was, in actual fact, A&E and all the  
23 outpatient departments, which made quite a substantial  
24 group. And then the wards together, they came together  
25 naturally, I believe, and would be naturally managed

108

1 more easily by one person than mixing them, say,  
2 through -- having myself with the acute theatres and so  
3 on trying to manage a ward would be more difficult. As  
4 well as that, myself and the sister in charge -- the  
5 nurse in charge of the ambulatory care areas, we were  
6 preparing for transfer of services of our areas into  
7 a new building, so we were also heavily involved and  
8 increasingly so during that two-year period with that  
9 transfer of services, which would have taken us away  
10 from trying to manage ward areas.  
11 Q. So you were busy and you had additional responsibilities  
12 outside the ward.  
13 A. Yes.  
14 Q. Did you have other duties to perform in addition to your  
15 acting nurse manager duties?  
16 A. As in?  
17 Q. Any other ward duties?  
18 A. Not in ward, no. I would have -- in cases of shortage  
19 of staff or so, I would have gone back into theatre to  
20 help out, that sort of thing. But we had -- not really,  
21 no. It was mostly within the areas that we were  
22 designated plus the ... We also would have -- sorry,  
23 I'm not being very clear. I apologise.  
24 THE CHAIRMAN: Don't worry.  
25 A. We had a rota that we would have been on call, if you

109

1 manager to the wards group. And the specialist nurses,  
2 research nurses and the play specialists, the research  
3 and specialist nurses being more outpatient driven  
4 largely, were added into Mrs Moneypenny's group, which  
5 was the ambulatory care.  
6 Q. Did you yourself ever have to, as it were, cover the  
7 responsibility of Allen Ward if Sister Surgenor was  
8 unavailable?  
9 A. We would, yes, if one of us was on leave or not on duty  
10 or not available. Through the bleep we would have  
11 covered, but it would have been -- if it was something  
12 that had to be dealt with that was other than just, say,  
13 a ward problem, initial(?) problem, staffing, something  
14 like that, I would certainly have handed it back over to  
15 whichever one of them was their area. If it was  
16 ambulatory care, I would have directed back to  
17 Mrs Moneypenny because I don't have a lot of knowledge  
18 of that area and ward areas I have, if you like, even  
19 less knowledge. I don't think I have worked in a ward  
20 from about 1970 -- the late 1970s.  
21 Q. Did you have a regular system of meeting with the other  
22 two nurse managers?  
23 A. It was sort of ad hoc, but it would have been more or  
24 less on a daily basis we would have met. I actually  
25 shared an office with Mrs Moneypenny. Sister Surgenor

111

1 like. We carried a bleep on rota for the whole hospital  
2 so there would be one of us available at all times to be  
3 contacted by any of the ward or departmental staff who  
4 had problems or maybe staffing problems, any type of  
5 problem. We would have been on call.  
6 MR STEWART: Were you a natural port of call for somebody  
7 with a problem or request for help?  
8 A. That would have been the -- yes, the bleep holder would  
9 have been the port of call for that.  
10 THE CHAIRMAN: And the call comes from the sister, does it?  
11 A. The sister or whoever's in charge, their deputy.  
12 MR STEWART: We have had difficulty ascertaining who was the  
13 nurse manager with responsibility for Allen Ward, where  
14 Claire was at this time in October 1996. What is your  
15 recollection?  
16 A. It wasn't me.  
17 Q. Can you remember who you think it might have been?  
18 A. To the best of my recollection, it was Sister Surgenor.  
19 Q. Do you have any reason to remember that as being the  
20 case?  
21 A. My recollection was that the jobs were divided initially  
22 as theatres, intensive care, ambulatory care, and the  
23 wards. After we were appointed, we realised that the  
24 night sisters had not been included and they were then  
25 added in in discussion, I believe, with the directorate

110

1 had an office at the back of her own department, but  
2 we would have met day and daily and possibly more often.  
3 We tried to keep each other up-to-date with what was  
4 going on and to deal with things as far as possible  
5 together.  
6 Q. So if issues arose, you'd have been aware of them as  
7 they arose?  
8 A. I would have been aware of them as they arose, yes.  
9 Q. Did you also have meetings with the sisters on the  
10 wards?  
11 A. I would have gone to my own areas when I was on duty on  
12 a daily basis, but we had sisters' meetings monthly at  
13 which all the sisters and specialist nurses, I think,  
14 would have come. I think the play specialist -- play  
15 leader would have come and we would have met. Those  
16 meetings were minuted.  
17 Q. Would people have brought problems arising in practice  
18 to those meetings for discussion?  
19 A. Very often, yes.  
20 Q. Would they have been tabled and put on an agenda for  
21 specific --  
22 A. They could have been, yes. If they had them far  
23 enough -- we preferred them to be tabled, but sometimes  
24 they brought them on the day of the ...  
25 Q. You described in your witness statement something called

112

1        directorate meetings.  
2    A. Yes.  
3    Q. What were they?  
4    A. They were meetings that were chaired by the clinical  
5        director, I think. And basically, all the medical  
6        staff, nursing staff, were invited, and other -- the  
7        laboratory people, everybody came together to talk about  
8        the issues within the Children's Hospital and report on  
9        ... Again, laboratory people would have given reports  
10       so they would have had -- I can remember they used to  
11       have reports on blood product, changes in practice, that  
12       sort of thing would have been brought through there.  
13    Q. Did the nurse managers submit a regular report to the  
14       directorate meeting?  
15    A. We give a report on the nurse staffing. That would have  
16       been the most common one. Sickness, which was always  
17       usually on most months.  
18    THE CHAIRMAN: Would Miss Duffin have been there at that  
19       meeting?  
20    A. She would have come to ... She would have been invited,  
21       have come to some of them. That wouldn't have been --  
22       she would have come to the sisters' meetings sometimes  
23       as well.  
24    MR STEWART: She described when she gave evidence to the  
25       inquiry something called "nursing executive team

113

1        monthly or bi-monthly, depending on her commitments.  
2        And she would have visited some of the wards, not every  
3        one on each visit. But she would have talked with us  
4        about any problems and we had the opportunity to air any  
5        problems then with her. As well as that, we could  
6        contact her office by phone at any time if we had  
7        a major problem that we felt we needed advice with.  
8    THE CHAIRMAN: Who was between you and Miss Duffin in the  
9        nursing hierarchy or was there anybody between you and  
10       her?  
11    A. I don't recall. She had people in her office who  
12       were ... No, I don't think so. I think we would have  
13       had a direct link with her, I think.  
14    MR STEWART: I think that's exactly what she said.  
15        Do you think there was much that happened in the  
16        Children's Hospital at that time that you didn't know  
17        about?  
18    A. I didn't know about?  
19    Q. Yes.  
20    A. Well, it seems to be that I didn't know about Claire's  
21       death.  
22    Q. Yes.  
23    A. Well, I may have known that Claire had died, I may not  
24       have known her by name, but we would have -- the three  
25       of us would have been aware that a patient had died

115

1        meetings", which were monthly meetings where she met  
2        with nurse managers.  
3    A. Yes, those were trust-wide. I believe those are the  
4        ones she's referring to, the executive ones.  
5    Q. Yes.  
6    A. And yes, I'm trying to think, did I ever go to them?  
7        I think I may have been to one or two of them -- I think  
8        we would have gone when we could, depending on what our  
9        workload was.  
10    Q. Would it be fair to say that there was a network --  
11    A. There was a network, yes.  
12    Q. You could gauge what's happening on the wards from the  
13        sisters --  
14    A. Yes.  
15    Q. -- and at meetings with the other nurse managers, and  
16        that could be brought to the director of nursing, it  
17        could be brought to the clinical lead, and so, in  
18        theory, you can get issues of concern to you and pass  
19        them up the line so somebody with influence and control  
20        could address them.  
21    A. Absolutely, yes.  
22    Q. And did that happen?  
23    A. I believe it did, yes. We would have passed on issues  
24        within Children's Hospital and Miss Duffin would have  
25        visited the Children's Hospital fairly regularly, either

114

1        within the hospital. But we would not -- when I say  
2        Claire's death, I wasn't aware there was anything  
3        potentially untoward about it.  
4    Q. When a child died, was that something that was looked at  
5        because there was a death?  
6    A. Not as routine, no. Not unless there was something  
7        untoward.  
8    Q. Was there a view that lessons could be learnt from cases  
9        of death?  
10    A. I don't believe that we at that time were reviewing each  
11       case. Certainly, within my own department -- and I can  
12       really only talk about theatres with any knowledge -- on  
13       those very rare occasions when a child sadly died in  
14       theatre, we certainly would have reviewed it, reviewed  
15       what had happened, talked it through, very often with  
16       the anaesthetists and surgeons, because everybody would  
17       have got together to talk about if it was preventable,  
18       you know, was there something that we could have done,  
19       maybe we would have prevented it. And I don't believe  
20       we ever did have ... I can only think of ... Well, one  
21       child stands out in my mind, and it wasn't at all  
22       preventable, but we did sit down and talk about it at  
23       length afterwards, both as a nursing group and with the  
24       consultant and with the anaesthetist. Sort of a -- just  
25       talking it through, you know.

116

1 Q. Were cases ever selected at random --  
2 THE CHAIRMAN: Sorry. I understand that, but that makes it  
3 all the more difficult for me to understand why there  
4 was no such review when Adam died. Because if you  
5 specifically and clearly remember a review of the death  
6 of another child whose death could not be prevented,  
7 then that suggests to me that even in a case where  
8 a child -- some children unfortunately have illnesses  
9 and conditions which will inevitably kill them very  
10 young. The incident you're talking about -- and you are  
11 not giving me the child's name and I don't want the  
12 child's name -- but you're saying to me that you  
13 remember that specific example where, even though the  
14 death was unavoidable, you sat down, the doctors sat  
15 down, and you talked through it and discussed what had  
16 happened and what might be done. But do you understand  
17 my difficulty --  
18 A. I do.  
19 THE CHAIRMAN: -- in understanding why that didn't happen in  
20 Adam's case, where Adam wasn't expected to die at all?  
21 A. I'm sorry, I may have misled you a little bit. This was  
22 very informal, it wasn't a formal review as such.  
23 THE CHAIRMAN: Unfortunately, in Adam's case, whether you  
24 would call it an informal or formal review, there  
25 doesn't seem to have been any review at all, certainly

117

1 surgeons were from another hospital and possibly we  
2 wouldn't have had the opportunity to talk it through  
3 with them in the same way.  
4 MR STEWART: You had some responsibility for training staff  
5 and for their continuous professional development.  
6 A. Yes.  
7 Q. If you heard people talking about a death such as  
8 Claire's, would you not have thought, "What do the  
9 nurses say? Is there a nursing issue here? Let's look  
10 at it"?  
11 A. I mean, I have to say that I was not aware of Claire's  
12 death and I don't recall ever hearing her death being  
13 discussed by anybody. So it would be difficult for me  
14 to answer that.  
15 Q. You had issues that you took to the directorate meeting.  
16 A. Mm-hm, yes.  
17 Q. You mentioned staffing levels.  
18 A. Yes.  
19 Q. Wouldn't it be of assistance to know if a death perhaps  
20 might touch upon one of the issues that you were  
21 interested in?  
22 A. If it had affected theatres or intensive care, then  
23 I would certainly have done so, but with wards  
24 I wouldn't have had the same knowledge.  
25 Q. But you would have met with the nurse managers on

119

1 not one which involved any nurses. From what you've  
2 said, that seems unusual, doesn't it?  
3 A. I have little memory, I must admit, of Adam's death.  
4 I'm not quite sure why. I do recall people talking  
5 about it, but it would more it was a ...  
6 THE CHAIRMAN: As a tragedy --  
7 A. A tragedy, yes --  
8 THE CHAIRMAN: -- rather than any sort of analysis?  
9 A. Yes. I think, when I talk about it, it's more of  
10 a support for the staff, who, you know, would find it  
11 difficult and to make sure that everybody is dealing  
12 with it appropriately with themselves.  
13 THE CHAIRMAN: I gathered from the discussion that you were  
14 suggesting a few minutes ago that part of the reason for  
15 this was to see whether anything could be learned from  
16 it. You are supporting each other and that, of course,  
17 is important. But you're also looking to see if  
18 anything can be learnt from it: might there be anything  
19 we could do better next time, even if what we did last  
20 time wasn't wrong? That sort of thing.  
21 A. Yes. I see, yes. I think that the case I'm thinking  
22 of, this other case, it was a totally ... It was our  
23 own surgeons, for a start, and we would have had more  
24 communication with them, and they would have spent more  
25 time with us, talking to us. In Adam's case, the

118

1 a daily basis.  
2 A. With Adam Strain, you mean?  
3 Q. No, with Claire's case.  
4 A. In Claire's case? Well, I wouldn't have met with  
5 Miss Duffin on a daily basis.  
6 Q. The nurse managers?  
7 A. I would have met with the nurse managers. But I'm not  
8 aware that they ever brought to me anything about  
9 Claire.  
10 Q. The issue of staffing levels and workloads, was that  
11 a pressing concern in 1996?  
12 A. I think that there was concern about staffing. I think  
13 that there was always concern, particularly it was more  
14 on the grading, but there's always concern about  
15 staffing levels.  
16 Q. And indeed, this was a particular responsibility of  
17 yours, according to your witness statement:  
18 "Monitoring staff levels, making sure that staff  
19 were cost-effectively deployed and effectively managing  
20 absence of --  
21 A. I think that was within my own department in particular.  
22 But we would have had a cross -- you know, for the whole  
23 hospital, particularly for my own area. I would have  
24 been responsible for that, yes.  
25 Q. Was it a problem that was discussed at directorate

120

1 meetings?  
2 A. It would have been, yes. It would have been highlighted  
3 that there were problems.  
4 Q. The inquiry has obtained a document, which is a 1996  
5 strategy for Children's Services called "Getting it  
6 together". And the title page is at WS266/1, page 28.  
7 If we look at the cover that, do you recognise that  
8 publication from 1996?  
9 A. Yes.  
10 Q. And indeed it had input, I think, from a predecessor of  
11 yours, Sister Brush, who was on the team.  
12 A. Yes.  
13 Q. And if we go to page 50 of the document, we'll see  
14 a description of current services. If we run through to  
15 the tenth line down:  
16 "Though the Royal Belfast Hospital for Sick Children  
17 has the advantage having paediatric trained staff in all  
18 disciplines, workload pressures are evident,  
19 particularly among nursing staff and in certain medical  
20 areas."  
21 Was it a particular concern for nurses that they  
22 were short staffed?  
23 A. I had very little contact, really, with the wards. If  
24 they had concerns, they would have been going to the  
25 nurse manager who was responsible for that area. She

121

1 therefore, your skill mix was difficult to maintain.  
2 MR STEWART: I wonder if you can help me with an entry in  
3 this strategy document, which is at page 54. Halfway  
4 down there's a paragraph commencing:  
5 "The Royal Hospitals have recently reviewed staffing  
6 levels and cost pressures within the Royal Belfast  
7 Hospital for Sick Children on the basis of current  
8 activity levels."  
9 Halfway down is "Nursing staff":  
10 "A review of nursing staff, current work practices  
11 and standards of care was recently completed by  
12 a project team. The review confirmed that services are  
13 under-resourced and that an increase of at least 18.2  
14 wte nursing staff is required to sustain service  
15 levels."  
16 That's quite technical management speak. Do you  
17 understand that?  
18 A. Yes.  
19 Q. That seems as though there is more or less an ongoing  
20 shortfall in staff and that a considerable increase is  
21 required to bring it to strength.  
22 THE CHAIRMAN: Can you give me some idea, Mrs Jackson, you  
23 need an increase of at least 18.2 working --  
24 A. Full-time equivalents.  
25 THE CHAIRMAN: Give me an idea of how significant that is.

123

1 might have highlighted it to myself and to the other  
2 acting H, but she would have dealt with it herself.  
3 I would have been dealing mostly with theatres and  
4 intensive care.  
5 Q. Yes. You were present at the meetings when this, as  
6 an issue, was discussed.  
7 A. Yes.  
8 Q. What was the problem, why was there a short staffing  
9 issue?  
10 A. Um ... I'm sorry, my recollection of that time is a bit  
11 vague. Funding, probably. Well, not funding, but there  
12 was always a squeeze on funding overall.  
13 Q. Yes.  
14 A. And recruitment was a problem, obtaining the correct  
15 staff. There were other calls on the student nurses, as  
16 they qualified, and quite a lot of them would have gone  
17 away or gone closer to home when they qualified, and  
18 we weren't able to recruit them.  
19 THE CHAIRMAN: Back to Tyrone or Fermanagh or somewhere  
20 rather than stay in Belfast?  
21 A. Yes, very much so. So I mean, it's always hard to keep  
22 up with those you lose, to replace them, and then when  
23 you do replace, you're replacing, we found in  
24 Northern Ireland, certainly in Belfast here, we found  
25 that we were replacing with newly-qualified staff. So

122

1 How many nurses, just in round figures, to the best of  
2 your memory, would have been working in the Children's  
3 Hospital in around 1996? We're talking about 100, 200,  
4 300?  
5 A. I honestly have no recollection of that, I'm sorry.  
6 THE CHAIRMAN: Okay.  
7 A. Sorry.  
8 MR STEWART: The inquiry has already heard evidence  
9 in relation to possible shortfalls in staffing levels on  
10 Allen Ward in October 1996, specifically 22 October.  
11 At that time, there was no one designated night  
12 sister for the ward, but rather one night sister  
13 designated for the entirety of the hospital; is that  
14 correct?  
15 A. That's correct.  
16 Q. Why was that?  
17 A. I think that that had always been, I suppose -- you  
18 could say, historically, it had been and we had not at  
19 that time any changes in staffing ... You'd have to  
20 make a case for it and that would have to go forward to  
21 the directorate and then on to the Trust. And that --  
22 although we would have liked more sisters overall, we  
23 hadn't been able to get funding for it. And as you can  
24 see, I'm not sure who made that, but it was identified  
25 that we did need more staff. But there had only ever

124

1 been one night sister and I suppose -- no, there used to  
2 be more than that, but they would have overlapped on  
3 occasions.  
4 THE CHAIRMAN: There was a time when there was more than one  
5 night sister in the Children's Hospital?  
6 A. There used to be -- there would usually be two night  
7 sisters covering the week. Or three, there were three  
8 night sisters covering the week. That gradually eroded  
9 to two, and when one of those night sisters was off, the  
10 day sisters would have rotated on to night duty to  
11 cover.  
12 MR STEWART: I have just been handed a figure at lunchtime  
13 today that, on 22 October, 114 beds were occupied in the  
14 Children's Hospital.  
15 A. Right.  
16 Q. Does that sound about average or --  
17 A. At that period, yes, that sounds about right.  
18 Q. And of those beds, 19 were in Allen Ward.  
19 A. Right, yes. That would be ...  
20 Q. And the ward sister on duty in Allen Ward during the  
21 day, if she couldn't be there, she had to rely upon  
22 back-up, and evidence has been given that she, as  
23 a G-grade sister, would then rely upon an F-grade  
24 sister, if there was one, to fill in for her. Would it  
25 have been your task to ensure this sort of cover in the

125

1 because it is a ward ... I can answer for my own area.  
2 In my own two areas, generally speaking, we would have  
3 contacted other staff who were off duty to see if they  
4 could come in to help out, and I believe that that would  
5 have been the same in the ward areas, that they would  
6 have, first and foremost, contacted their own staff to  
7 see if any of them could come in.  
8 THE CHAIRMAN: Is there any reason in principle why there  
9 would be a difference between the theatre nursing  
10 situation and the ward nursing situation in terms of  
11 cover and absences and so on?  
12 A. Not in the terms.  
13 THE CHAIRMAN: So you expected your experience in theatres  
14 would be similar to the experience that your two acting  
15 colleagues had in --  
16 A. I would imagine so, yes.  
17 THE CHAIRMAN: Thank you.  
18 MR STEWART: Did it ever cause you worry that there were  
19 staffing shortages?  
20 A. Well, yes, because it put added pressure on the staff  
21 that we had in that we were asking them to do extra  
22 hours and it put pressure on -- within theatres and  
23 intensive care, we weren't able in the same way to fall  
24 back on bank and agency staff because there weren't bank  
25 paediatric intensive care or theatre staff out there in

127

1 event of an absence?  
2 A. No, that would be her responsibility to ensure that she  
3 was adequately covered by her own staff.  
4 Q. And then if a G-grade sister or F-grade sister wasn't  
5 available, an E-grade sister would step in?  
6 A. Yes.  
7 Q. Was it your responsibility to ensure that there was  
8 a proper supply of E, F and G-grade sisters?  
9 A. Within each ward on a daily basis?  
10 Q. Yes.  
11 A. That would be the responsibility of a ward sister to  
12 ensure she had adequate staffing on duty that day. If  
13 through sickness or unexpected reason, then she would  
14 notify what we call nursing admin and whoever was on  
15 that day would endeavour to find help from another area  
16 if possible, but it would not have been a D grade or  
17 an F grade; it would be somebody, probably an E grade or  
18 a D grade, who would have gone from another area because  
19 they wouldn't have had the knowledge of that particular  
20 ward.  
21 THE CHAIRMAN: Was this a recurring problem because you said  
22 there was an issue about staffing level and there was  
23 also an issue about absences? So was this something  
24 that everybody just got on with because you had to?  
25 A. I am finding it difficult to answer about Allen Ward

126

1 those areas. So we were very much reliant upon our own  
2 staff to fill in for us.  
3 Q. And did you perceive that as a risk, potentially?  
4 A. There would have been times when the pressures were high  
5 and stressful in very busy periods.  
6 Q. And would that have translated into a patient risk?  
7 A. I can't recall ever having to ... No, I would say no  
8 because certainly, within my own areas, I believe that  
9 we always managed, through the goodwill of the staff, to  
10 cover.  
11 THE CHAIRMAN: Sometimes it would have been a struggle --  
12 A. But we managed and I believe generally I would be  
13 surprised if you couldn't say the same for the ward  
14 areas because the staff were fantastic.  
15 MR STEWART: Was it ever suggested at directorate meetings  
16 that it might be a risk as a way, perhaps, of leveraging  
17 some --  
18 A. Yes, I think that it could be. What was continually  
19 highlighted was the pressure under which the staff were  
20 working and continually being asked to -- and during  
21 busy periods being contacted on a day and daily basis,  
22 "Could you come in today?", "Could you come in?", "No,  
23 I can't come in today, but I could come in tomorrow".  
24 That sort of thing. And that does put pressure on them  
25 when they're at home.

128



1 Q. Did the nursing budget come from the Children's Hospital  
2 or the Royal Group of Hospitals?  
3 A. From the Children's Hospital, as far as I recall.  
4 Q. Therefore, it wouldn't have been a matter that you'd  
5 have brought necessarily to Miss Duffin?  
6 A. I believe Miss Duffin -- we would have informed her that  
7 we were having these pressures. She would have been  
8 informed.  
9 Q. I'm looking at your job responsibilities from your  
10 witness statement and, listed amongst your designated  
11 areas, is a monitoring of pharmacy usage. That is a  
12 particular responsibility of yours. There was no  
13 paediatric pharmacist --  
14 A. No.  
15 Q. -- at that time?  
16 A. We did have pharmacists who were responsible for our  
17 ward or department areas, and they would have been  
18 contactable.  
19 Q. Yes. I'm quoting from the witness statement of  
20 Dr Sean O'Hare at WS295/1, page 4. He was the head of  
21 the pharmacy services and, at letter (j), Dr O'Hare has  
22 told the inquiry:  
23 "There were no paediatric pharmacists in the Royal  
24 Hospitals in 1996. The pharmacy staffing complement for  
25 the Royal Hospitals was the lowest of any tertiary care

1 page 3, "risk management" is given in the second  
2 grouping of areas and fourth down as yet another  
3 responsibility put on your shoulders. What did that  
4 mean?  
5 A. Within theatres we worked very much to the National  
6 Association of Theatre Nurses guidelines, which included  
7 risk management. We used their tool for risk assessment  
8 within theatres and we would have -- I would have gone  
9 to other theatres within the Royal Trust and we would  
10 have done checks of their theatres and they would have  
11 come to mine.  
12 Q. Were you aware of the hospital's health and safety  
13 policy of November 1993, WS061/2, page 232? This is the  
14 cover of it, perhaps you recognise that. And if we go  
15 to page 247, this sets out a series of responsibilities  
16 given to departmental managers, including ward sisters  
17 and charge nurses. Would that, broadly speaking,  
18 encompass your role as a nurse manager?  
19 A. I believe, yes, it would.  
20 Q. And the various obligations placed upon these managers  
21 are set forth. At paragraph (i):  
22 "Responsibility to ensure investigation and  
23 reporting procedures for untoward incidents and  
24 accidents are carried out and that corrective action,  
25 where indicated, is taken."

1 teaching hospital in the UK. Sheffield Children's  
2 Hospital, which is approximately the same size as the  
3 RBHSC, had, I believe, seven clinical pharmacists."  
4 Was that an issue that came to your attention as  
5 nurse manager?  
6 A. I wasn't aware of what he has said there. We had  
7 an issue with the fact that we didn't have a pharmacy  
8 within the Children's Hospital, that all our drugs had  
9 to come from the Royal and the delays -- and sometimes  
10 even from the City Hospital -- and the delays that that  
11 could cause, not in treating the patients, but  
12 particularly when they were waiting to go home.  
13 Paediatric pharmacists -- I only know that we had  
14 pharmacists who would have come over and come into the  
15 wards, spent some time in each ward or department.  
16 I can't remember how often, and that we had their names  
17 that we could contact them if we needed to because --  
18 theatres had a contact person we could contact if  
19 we were having problems with drugs. But I don't know  
20 whether they were paediatric.  
21 Q. Was a request ever made that a paediatric pharmacist be  
22 appointed?  
23 A. Not to my recollection. There may well have been, but  
24 I wouldn't have been involved with that.  
25 Q. Reading again from your job responsibilities at WS272/1,

1 What did you understand an untoward incident to be?  
2 A. An incident that was ... That the cause was unknown,  
3 why it happened.  
4 Q. Would that encompass an untoward clinical incident?  
5 A. Absolutely, yes.  
6 Q. Well, can I ask you then, what were the reporting  
7 procedures for untoward clinical incidents in 1996?  
8 A. Assuming that it was made -- supposing it happened in  
9 theatre or a ward, and I had been notified, I would  
10 expect to be notified by the nurse in charge or a member  
11 of staff in that ward that there was a problem, that  
12 there was something that was causing concern. I would  
13 then probably have gone to the ward or a department to  
14 make an assessment of what had happened and tried to  
15 find out just what had happened there and then. If  
16 I felt competent to deal with it, I would have dealt  
17 with it at that time.  
18 I would also probably have contacted Miss Duffin's  
19 office for advice because it would not have been  
20 something necessarily that I had dealt with before.  
21 I would have discussed it with the medical staff, the  
22 medical director -- sorry, not the medical director, the  
23 lead clinician, and the directorate manager.  
24 Q. That's if you were notified?  
25 A. If I was notified.

1 Q. The notification of the matter to you is, in fact, the  
2 report. What systems were in place for that report to  
3 be made to you?  
4 A. If there were any problems like that, they would  
5 have the bleep, they would have bleeped the bleep,  
6 whichever one of us was carrying the bleep, and reported  
7 to us direct.  
8 THE CHAIRMAN: When you say "they would have bleeped you"?  
9 A. Well, whoever.  
10 THE CHAIRMAN: This procedure is triggered by you being  
11 informed that something untoward has happened --  
12 A. Yes.  
13 THE CHAIRMAN: -- and something untoward can be a whole  
14 range of things. It's obviously not confined to a child  
15 dying.  
16 A. No.  
17 THE CHAIRMAN: There's a whole lot of things way, way below  
18 that that can go wrong.  
19 A. Yes.  
20 THE CHAIRMAN: But once you're notified of it, you have the  
21 obligation under this to carry out the investigation and  
22 so on?  
23 A. Yes.  
24 THE CHAIRMAN: Okay.  
25 MR STEWART: Do you remember anything called a "statement

133

1 and fell out. Let's suppose that, by an oversight or  
2 pressure on the nurses, that the side of the bed isn't  
3 up and a child then falls out of bed during the night.  
4 How does that find its way into the statement book?  
5 A. The nurse who was in charge would have written that  
6 statement and contacted, if it was at night, the night  
7 sister. If it was during the day, whichever one of the  
8 three of us was carrying the bleep.  
9 THE CHAIRMAN: And then what happens next?  
10 A. The statement book, they keep a copy for themselves.  
11 A copy goes to nursing administration and there's a copy  
12 that goes then to ... I think we used to send them, at  
13 that time, to the occupational health, which is where  
14 the team were based who dealt with them. I can't  
15 remember. I think that's where we sent them to. But  
16 they went to the Trust management, in other words.  
17 MR STEWART: Let's suppose there was an untoward clinical  
18 incident. Let's say a clinical error is made and  
19 a patient has suffered harm. Were those things recorded  
20 in the statement book?  
21 A. Yes.  
22 Q. Did that happen very often?  
23 A. I can only, again, speak about my own area, but no, not  
24 very often. If a nurse was involved, I would expect the  
25 nurse to write the statement. If it was a member of the

135

1 book" that might have been kept on a ward?  
2 A. Yes.  
3 Q. This is something Mr McKee has described to the inquiry  
4 as being a system for the record of untoward incidents.  
5 Could you describe it, please?  
6 A. Describe the book?  
7 Q. The system and the book.  
8 A. As far as I remember, it was a triplicate book and it  
9 would have been ... The report would have been  
10 completed by the individual who was involved. In other  
11 words, say it was a child that had fallen and hurt  
12 itself or had been injured in a ward or something like  
13 that, the nurse who had found it or who it had been  
14 reported to would have completed the statement. If it  
15 was an untoward incident, it would have been completed  
16 by the senior nurse or the senior nurse on duty in the  
17 ward or department area. They would have also notified  
18 myself, or whichever one of the nurse managers was on  
19 the bleep, direct, if ... Supposing it was theatre,  
20 I would have expected them to come to me direct, to be  
21 honest.  
22 THE CHAIRMAN: Let's take an example. One point that Mr and  
23 Mrs Roberts raised on Tuesday night before they left the  
24 hospital was to make sure that the side of Claire's bed  
25 was up in case she fell out or moved during the night

134

1 medical staff, they would be expected to write the  
2 statement.  
3 Q. And were you responsible to ensure that that happened,  
4 that a nurse made the statement?  
5 A. Yes.  
6 Q. Made the entry?  
7 A. Yes. Within my own area, yes.  
8 Q. How did you enforce that expectation?  
9 A. With the nursing staff?  
10 Q. Yes.  
11 A. By simply telling them that they had to do it and  
12 ensuring that they did.  
13 Q. How did you ensure? Did you monitor their performance?  
14 A. Yes, you'd check it and check that it had been  
15 completed. It would usually be left for myself or  
16 whoever was senior on the next day to send it round to  
17 nursing administration. If it was extremely urgent, it  
18 would have been taken round immediately or the nurse  
19 manager would have been informed.  
20 Q. Was there any monitoring of the nurses' performance to  
21 see if indeed they were making any errors?  
22 A. Having reported an error or routinely?  
23 Q. Routinely, randomly, even.  
24 A. Well, when we were doing our monitoring with the --  
25 what's the word I'm looking for?

136

1 Q. Audit?  
2 A. The quality audit. When we were doing that, which we  
3 did once a year, but other than that, the documentation,  
4 we would have reviewed that.  
5 THE CHAIRMAN: I think Mr Stewart is getting at a slightly  
6 different point. Once you have a report in the  
7 statement book, then you can follow it, but for a report  
8 to go into the statement book, a nurse or a doctor --  
9 for your purposes, a nurse -- has to, in a sense,  
10 self-report that they've made a mistake.  
11 What Mr Stewart is asking you is: you have a degree  
12 of confidence in the honesty and integrity of your  
13 nurses, but for any of us, it's not the easiest thing in  
14 the world to put up our hands and to say we made  
15 a mistake and then make a report on it: so how do you  
16 know if mistakes or adverse incidents are in fact being  
17 self-reported? I suppose one way is that you find out  
18 by word of mouth later on --  
19 A. Yes.  
20 THE CHAIRMAN: -- and then you bawl out the nurse for not  
21 having reported it.  
22 A. Yes. You'd usually hear that something had happened and  
23 that it hasn't been reported or something else would  
24 have reported it. It's a small area where we were  
25 working at that time, very, very small, and nothing

137

1 that is Trust policies in relation to record keeping  
2 because those policies were based upon UKCC nursing  
3 guidelines. I want to give you a quote from  
4 Miss Duffin, which appears at WS245/1, page 10. At 24,  
5 this is in relation to nursing audit of nursing records,  
6 and Miss Duffin has said:  
7 "It was agreed at the nurse executive team that all  
8 nurse managers would ensure that nursing records were  
9 audited by the ward sisters on a monthly basis to ensure  
10 that the records were complying with UKCC guidance. Any  
11 areas of concern would have been addressed by the ward  
12 sister."  
13 Can I ask you about what you did to ensure that the  
14 nursing records in your area of responsibility were in  
15 fact audited?  
16 A. I did request charts on, as far as possible, a monthly  
17 basis to check that the documentation made by the nurses  
18 within theatres was complete and correct, and if there  
19 were any errors that I saw within those, then I would  
20 have brought them to the attention of the staff.  
21 Q. Did you take a random selection of the records?  
22 A. Yes.  
23 Q. You say "as best you could on a monthly basis". Were  
24 there some months --  
25 A. It might have slipped to six months. It might not have

139

1 really went unnoticed.  
2 THE CHAIRMAN: Okay.  
3 A. It would be difficult for anything to go unnoticed.  
4 THE CHAIRMAN: Thank you.  
5 MR STEWART: I see. Going back to your list of  
6 responsibilities at WS272/1, page 4, in the top section,  
7 about five lines down:  
8 "Ensure all staff adhere to hospital and Trust  
9 policies."  
10 Another onerous duty placed on you. How did you do  
11 that? How did you ensure that staff -- I take it that's  
12 nursing staff -- adhered to hospital policies?  
13 A. You'd ensure that they were aware of them, and we had  
14 the Trust policies file in each department and ward. If  
15 there was any minor or major deviation from any Trust  
16 policy, you'd refer them to it and ensure they were  
17 fully aware of what it was after that. One particular  
18 one that I think would come to mind would be the wearing  
19 of jewellery. Some nurses would have difficulty in  
20 removing jewellery and you had to remind them quite  
21 frequently that it should be removed. That's maybe  
22 a minor one, but ...  
23 THE CHAIRMAN: It's an example?  
24 A. An example, yes.  
25 MR STEWART: I was going to ask you about a more major one,

138

1 been just on a month.  
2 Q. And would you regularly have had to make recommendations  
3 to individuals, to ward sisters, and so forth?  
4 A. I would only have been dealing with my own areas.  
5 Q. Yes.  
6 A. And occasionally, you would have had to just remind them  
7 about clarifying their signatures or their names,  
8 writing their names properly, that sort of thing, and  
9 ensuring that they had dated correctly the dates.  
10 Sometimes if you're in a hurry, you might forget to do  
11 something like that. But generally speaking, within  
12 theatres, the documentation was pretty good.  
13 Q. Because generally speaking, in this case of  
14 Claire Roberts, the documentation has not been good.  
15 A. I cannot comment on that.  
16 Q. Have you been following --  
17 A. I have followed some of it as far as --  
18 Q. Has it surprised you that the documentation has been  
19 poor, in Dr Steen's words?  
20 A. To the extent that it is, yes, I am quite surprised,  
21 although I can ... When a ward is very busy, it can be  
22 difficult to complete the documentation as you go along,  
23 and there would be the occasion, I would imagine, that  
24 you could be called away and maybe it might slip your  
25 mind. But documentation on the whole, I found --

140

1 certainly within my own areas; I cannot speak for the  
2 wards.  
3 Q. If the documentation was poor on Allen Ward, would that  
4 suggest to you that an adequate system of monitoring and  
5 enforcement of guidance was not in place?  
6 A. I don't think I can comment. I really don't know enough  
7 about the ward areas.  
8 Q. Would it have been the responsibility of the nurse  
9 manager, had there been a failure in documentation?  
10 A. It would have been the responsibility of the ward  
11 sister, the manager and the nurse or nurses concerned.  
12 It's all of their responsibility to ensure that the  
13 documentation -- it's the nurse manager's responsibility  
14 to monitor.  
15 THE CHAIRMAN: And if it has got a bit sloppy or if it's got  
16 a bit messy, then just to give a few reminders of the  
17 sorts of things you were describing a few minutes ago?  
18 A. Absolutely.  
19 MR STEWART: In relation to the audits that you carried out  
20 in theatre or in intensive care, were they then carried  
21 across and incorporated into larger audits,  
22 multidisciplinary audits?  
23 A. Not at that time.  
24 Q. Would there have been any multidisciplinary  
25 consideration of issues arising from any case in

141

1 decide what's to be done.  
2 A. Yes, what, if anything, needs to be done.  
3 THE CHAIRMAN: Okay.  
4 MR STEWART: Nurse McRandal told the inquiry on 29 October  
5 that if medication errors were flagged up, these were  
6 referred to the nurse manager to speak to the nurses.  
7 Would you have found yourself involved in enforcing and  
8 correcting medication errors?  
9 A. Yes.  
10 Q. Was that a regular occurrence?  
11 A. Not in my areas.  
12 Q. In the Children's Hospital, to your knowledge?  
13 A. There may have been, I don't recall the numbers of them.  
14 I may not have been aware of them all. Again, they were  
15 ward areas.  
16 THE CHAIRMAN: In theatres, are the sisters almost  
17 constantly working side by side with the doctors,  
18 whereas on the wards they might be working more without  
19 the doctors necessarily being around?  
20 A. In theatre, the nurses would not have been normally  
21 administering any medications apart from in the recovery  
22 ward.  
23 THE CHAIRMAN: Thank you.  
24 MR STEWART: Can I take you back to read you something that  
25 appears in that "Getting it together" publication we

143

1 Allen Ward, in the medical wards, at that time?  
2 A. I wouldn't know.  
3 Q. You had, as we touched upon earlier, some responsibility  
4 for pharmacy and drug-related matters. In this case,  
5 there appear to have been errors in the recording of  
6 drugs, prescription of drugs, maybe even the  
7 administering of drugs. And these errors went  
8 unnoticed. Were you aware of the systems for auditing  
9 of drug documentation?  
10 A. I don't recall specific ... No. No, I'm sorry, I don't  
11 recall.  
12 Q. If a drug or a medication error was spotted, what would  
13 be done with that information?  
14 A. It would be reported immediately to, depending on who  
15 was available, but certainly to the doctor, whether it  
16 be the junior doctor who was there and then to the  
17 consultant.  
18 Q. Would the nurse not have reported it to a ward sister or  
19 a nurse manager?  
20 A. Oh yes. Sorry, yes, they would have.  
21 THE CHAIRMAN: Does it go in the statement book?  
22 A. It would have, yes.  
23 THE CHAIRMAN: I think the point that you were focussing on  
24 in answer to Mr Stewart's question was that it goes to  
25 the doctor because the doctor has to know in order to

142

1 looked at earlier at WS266/1, page 52? This is an  
2 account of the clinical audit programme and it starts  
3 at the top of the page:  
4 "There is an active clinical audit programme within  
5 the Royal Belfast Hospital for Sick Children.  
6 In addition to regular medical ward audits involving all  
7 members of the ward teams, and interface audits with  
8 general practitioners, other recent assessments have  
9 included ..."  
10 And the third bullet point down is "medication  
11 prescribing". Do you have any recollection of audit  
12 programmes and assessments and advice on medication  
13 prescribing?  
14 A. I don't have any recollection of medication prescribing.  
15 That would not have been something that we would have  
16 been doing within theatres. I think it was maybe being  
17 started in the wards.  
18 Q. One of the striking aspects of this case is that  
19 Claire's condition deteriorated on Allen Ward when she  
20 was being observed on an hourly basis by nurses. They  
21 don't seem to have reacted her condition, and she died.  
22 Would you agree that that scenario presents a perfect  
23 object lesson to examine to see if there were nursing  
24 lessons to be drawn?  
25 A. I really don't feel I can comment. It was in a ward.

144

1 Ward areas are not my areas. I wouldn't have enough  
2 experience of what was going on in the wards.  
3 Q. So you wouldn't have thought so stark an adverse outcome  
4 should be the subject of some form of inquiry at the  
5 time?  
6 A. I don't feel I can comment on it, I really don't have  
7 enough knowledge.  
8 MR STEWART: I see. Thank you.  
9 I have no further questions, sir.  
10 THE CHAIRMAN: Could I ask just two points, Mrs Jackson?  
11 You have described, and the documents show, that  
12 nurses were, in the mid-1990s, overstretched and  
13 you have described the problems that that could give  
14 rise to. You're struggling sometimes to get the staff  
15 in, you're worried about nurses overworking and calling  
16 on them too often and them being tired. Is that problem  
17 aggravated by the fact that the doctors are also  
18 overstretched? For instance, in particular, I'm  
19 thinking about through the night -- in Claire's case,  
20 Monday night through to Tuesday morning, Tuesday night  
21 through to Wednesday morning. There appears to have  
22 been on each night a registrar with a very small number  
23 of junior doctors. And they were stretched so badly for  
24 instance that Dr Bartholome, who everybody seems to  
25 regard as an exceptionally good doctor, was called to

145

1 it was recognised that Claire was very seriously ill.  
2 Given your nursing experience, and I know you have  
3 said you weren't on wards from perhaps the 1970s, if you  
4 as a nurse realised that a child was very, very  
5 seriously ill and parents who'd been attentive and had  
6 been a constant presence at their child's bedside all  
7 day came to you and said, "We're going on now, we'll be  
8 back tomorrow morning", however it's phrased, would you  
9 do anything to discourage them from leaving or ... If  
10 they're leaving because they don't appear to realise  
11 that she's very, very ill, but the nurse knows that the  
12 child is very, very ill, obviously you can't force them  
13 to stay, you can't order people to stay --  
14 A. This is it. Without knowing -- yes.  
15 THE CHAIRMAN: I think the concern is here, the Roberts have  
16 a concern about whether the state of Claire's health was  
17 truly appreciated.  
18 A. Right.  
19 THE CHAIRMAN: And I may ask you maybe the same point in  
20 a different way. If you were a nurse on duty in that  
21 ward and you had known how seriously ill Claire was, and  
22 you'd seen the Roberts or known that the Roberts were  
23 there constantly through the day, and they came to you  
24 and said, "Look, we are going on now", would you have  
25 tried to do something to suggest to them that maybe they

147

1 see Claire and wasn't able to get to her for about three  
2 hours at a time when she was very, very seriously ill.  
3 Does that sort of overstretching of the doctors increase  
4 the problems which the nurses face?  
5 A. It would certainly increase their stress because they're  
6 worried, they want a doctor to look at the patient, or  
7 the child needs -- if it's medication that only a doctor  
8 can give, and the nurses are aware that it's not being  
9 given at the time it should be given. But any  
10 shortages, you know, it puts pressure on everybody both  
11 ways.  
12 THE CHAIRMAN: A shortage on one level puts pressure on the  
13 next level, but a shortage at both levels is potentially  
14 catastrophic.  
15 A. It certainly would make things more difficult.  
16 THE CHAIRMAN: It makes managing things more stressful,  
17 doesn't it?  
18 A. Yes.  
19 THE CHAIRMAN: I want to ask you about a second issue, which  
20 is this -- I know you weren't there and I'm asking you  
21 about a hypothetical situation because, as you may have  
22 gathered from the evidence, Mr and Mrs Roberts were at  
23 Claire's bedside on the Tuesday evening around about  
24 9 o'clock. They had their sons with them and decided to  
25 go home for the night. There is an issue about how much

146

1 shouldn't or else ask them to wait and get a doctor to  
2 speak to them, whether you do it yourself or whether you  
3 do it through a doctor?  
4 A. It's very difficult because I really haven't worked --  
5 I think you need to know ... I would have needed to  
6 have known the parents really well and whether there  
7 was ... Um ... If I was really sure that the child was  
8 unwell, really unwell, and if I felt that the parents  
9 didn't appreciate that, but I mean the parents, above  
10 all, more so than the nurses in many ways, would know  
11 their child.  
12 THE CHAIRMAN: But I think the problem here is that, perhaps  
13 unusually -- and one of the things as I understand it  
14 the Roberts have the most difficulty coping with -- is  
15 the fact that they left the hospital, knowing Claire was  
16 unwell, but not knowing she was seriously unwell to the  
17 extent that she died during the night. It's just one of  
18 a series of missed opportunities that, as I understand  
19 it, from them and from their lawyers, that they found  
20 very, very difficult to cope with afterwards.  
21 A. I think in the situation I would probably have sort of  
22 said, "Right, are you sure you really want to go now?  
23 Do you want to wait for a little while?", and tried  
24 to ... But it's very difficult when, as I say,  
25 I haven't worked in that situation.

148

1 THE CHAIRMAN: Are there any other questions for  
2 Mrs Jackson? No?  
3 Mrs Jackson, I'm very grateful for you for coming  
4 along. I know it is not easy.  
5 A. Thank you for fitting me in today.  
6 THE CHAIRMAN: Not at all. Mrs Jackson is free to leave.  
7 (The witness withdrew)  
8 10 o'clock on Monday. We have got Professor Young  
9 and Miss Duffin; is that right?  
10 MR STEWART: Yes.  
11 THE CHAIRMAN: Do you have a view or do you want to discuss  
12 with the others who goes first?  
13 MR STEWART: I have no view. I'll certainly accommodate any  
14 particular needs.  
15 THE CHAIRMAN: If you want to have a chat about it, it  
16 doesn't particularly matter to me who goes first.  
17 I suspect Miss Duffin might be rather shorter than  
18 Professor Young will be, so whatever suits them.  
19 10 o'clock on Monday.  
20 (3.10 pm)  
21 (The hearing adjourned until 10.00 on Monday  
22 10 December 2012)  
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1 I N D E X  
2  
3 Governance opening by .....1  
4 MS ANYADIKE-DANES  
5 Governance opening by MR QUINN .....67  
6 MRS MARGARET JACKSON (called) .....105  
7 Questions from MR STEWART .....105  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
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25