Tuesday, 11 December 2012

(10.00 am)

Discussion

THE CHAIRMAN: Good morning. Mr Stewart, just before we start, has everyone now received the documents from file 139 for which the Trust has now waived privilege? You have those? Okay.

There's nobody here for Dr Webb today? Does anyone have any idea if Mr Sephton is coming back or his solicitor? Okay, let me raise this now. There are two issues that concern me. One is that if you turn to the page you just got this morning, 139-165-001, which is the first page of a two-page letter from Gary Daly, solicitor of Brangam Bagnall, to Mr Walby. At the end of the last paragraph on the first page, Mr Daly says:

"In particular, I understand that you are to bring to the attention of the clinicians that the sodium serum level was measured at 121 on two separate occasions."

As a matter of fact, I don't think that's right, is it?

MR McALINDEN: There's no evidence at all that the serum sodium was measured at 121 on two separate occasions and I can't explain where that comes from.

THE CHAIRMAN: The only record we have is the reading which came back at about 11.30, isn't it?

MR McALINDEN: Yes.

MR McCREA: Mr Chairman, that's not correct. I think it was measured on two occasions. The second occasion may have been at the admission to PICU or thereabouts.

THE CHAIRMAN: We'll check that. Thank you, Mr McCrea. Later on, it was measured at 129. We'll double-check whether it was 121. Okay?

The second issue -- and the reason I was looking for Dr Webb's representatives -- is this: if you then go on to 139-166-001 and 002, you'll see this is a letter, a further letter from Mr Daly, again to Mr Walby, and it talks about who's going to give evidence at the inquest on the following day.

If you go to the second page, the third paragraph up:

"Dr Webb is also of the view that the family were fully aware of the extent of the deceased's illness."

When Dr Webb gave evidence here on 3 December he said -- and this was about the fact that he had seen Claire at about 5 o'clock and had then left the hospital:

"Certainly, if I thought that Claire was going to get worse, I would have conveyed that to Mr and Mrs Roberts, but my expectation, as I've said, was that Claire was going to respond to treatment and that she

could make a full recovery from this."

That's 3 December at page 189. Then I followed that up on page 190 at line 14:

"Question: Did you think she was seriously ill? We've discussed this in a number of ways. I think you thought she was ill, but that you thought she was going to improve.

"Answer: That's correct.

"Question: Had you thought she was seriously ill, then you would definitely have spoken to PICU.

"Answer: Yes, and I would have spelt it out to her mother, but I thought she was going to improve."

I don't understand on the face of the document how that sits with Dr Webb being of the view that the family were fully aware of the extent of Claire's illness, unless Dr Webb is saying that her illness wasn't all that serious.

MR McCREA: That can't sit with his view that he thought he should refer the child to PICU or at least speak -- those two facts don't sit side by side. This is simply another one.

THE CHAIRMAN: Yes. Well, I'll refer this specifically to Tughans. I'm not terribly keen, as you'll understand, to try to bring back Dr Webb back in again, but we will need some explanation for that statement if

that's the impression and understanding which had been picked up by the Trust solicitor immediately before the inquest.

MR McALINDEN: Mr Chairman, could I refer you back to the sodium readings? The comment that I previously was made in relation to the period prior to her admission to PICU.

THE CHAIRMAN: Okay.

MR McALINDEN: If you look at 090-057-207, you'll see a number of sodium readings at the top of the page. That might well be the information that was contained in that letter.

THE CHAIRMAN: Okay. 121.6 and then 121?

MR McALINDEN: Yes.

THE CHAIRMAN: Thank you very much.

MR McALINDEN: Certainly prior to the deterioration, there seems to have been only one 121 reading, and that would have been the 11.30 one.

THE CHAIRMAN: Let me get that. What file is that, 090?

MR McALINDEN: 090-057-207. It's the intensive care records.

THE CHAIRMAN: I can't quite make out on that copy, Mr McAlinden, what the timing is of the second ...

MR McALINDEN: If you look at the previous page, it's a continuation on from the previous page, so the timing

is in the bottom column of 090-057-206.
THE CHAIRMAN: Okay. Thank you very much.
MR McCREA: Mr Chairman, if you also look at 090-022-056 and the following page, 057, you get the results taken at 9.30 and received at 11.30 pm on the 22nd. If you turn over the page, in the margin, what you have is another set of results.
THE CHAIRMAN: 4 am.
MR McCREA: And I think you have 4 am, and then below that at 3 am. Then below that again, you have another set of results among which are the sodium, which is in the middle of those results, "Na 121".
THE CHAIRMAN: So that's a fresh reading?
MR McCREA: It's a fresh reading because the potassium at 11.30 is different from that. So it's another reading. When it was taken, we don't know, but it's simply a measurement of 121.
THE CHAIRMAN: Thank you.
MR FORTUNE: Sir, if I could just ask a question apropos the documents we were handed this morning. In looking through them, there seem to be three pairs of letters. In each case, there is a letter that certainly does not bear the stamp of the Royal Hospitals litigation management. And in two cases, the letters do. Are these supposed to be file copies? How does it work? If

I take you through the letter, 139-159-001 and 139-160-001, the two letters are what should be the 16 June, no stamp.
THE CHAIRMAN: I think if you pause there, the difference between 159 and 160 is that 159 is a signed letter.
MR FORTUNE: It's also dated, sir.
THE CHAIRMAN: Yes. That's a signed copy which has gone from Mr Walby to Mr Daly so that the 160, one might guess, is a file copy.
MR FORTUNE: Well, then, 164 and 165 are both signed, both dated, and the former, 164, bears the stamp of the Royal Hospitals litigation management. Then the same appears at 166.
THE CHAIRMAN: Just before you go on, let's compare 164 and 165. 164 is the document which we originally were advised yesterday was the one in respect of which privilege would be waived. I think we'll come to it during the evidence, but I think, Mr McAlinden, that's because Mr Walby wants to refer to the note on it, the handwritten note; is that right?
MR McALINDEN: Yes.
THE CHAIRMAN: So the difference between 164 and 165 is that about halfway down on the right-hand side, there's the handwritten date "4/5/06". And then on the one above it and the other one below it, there's a signature, and

then there's the hospital stamp. Can you help us, Mr McAlinden? This is the coroner's file.
MR FORTUNE: If that's right, sir, then what is the copy letter in each case doing in the coroner's investigation file, unless of course it's litigation management's file named as the coroner's investigation file?
THE CHAIRMAN: This comes from the Mallusk inspection, doesn't it? This is from Brangam Bagnall.
MR McALINDEN: My understanding is that it's not. These are Royal documents that were in the litigation office.
THE CHAIRMAN: Okay. So the letters come in from Mr Daly and it's stamped on one version at 164. I think your query, Mr Fortune, is that it's not stamped on the other version at 165.
MR McALINDEN: I think Mr Walby will be able to explain why there are two copies of letters in the file. In some cases it may be that the letters were first of all faxed to the litigation office and then a hard copy posted. That could be one explanation. But I think Mr Walby will be able to explain why there are two copies of each letter.
THE CHAIRMAN: Okay.
MR FORTUNE: Sir, bearing in mind that we've only just been presented with these letters, through you, could we establish whether legal professional privilege is still

claimed for any other documents? Because it seems to us that if privilege is claimed for any document, then that's one thing, but if privilege is waived for a document, privilege is waived completely. And I see my learned friend Mr Stewart would nod in agreement.
Is there anything being withheld that might be material, bearing in mind that the purpose for which privilege is now waived is to enable Mr Walby to give evidence about the handwritten entry on 164?
THE CHAIRMAN: Well, I think what has now happened simply is that the privilege has been waived in relation to this file. I'll need to go back and check. Do you know off the top of your head, Mr McAlinden? There must be some other claim for privilege.
MR McALINDEN: As far as I'm aware, this was the only file in which legal professional privilege has been claimed. There are other documents that were not provided on the basis of relevance in other files.
THE CHAIRMAN: That's right, there were.
MR McALINDEN: Certainly, in relation to legal professional privilege, it was only sought to claim legal professional privilege in relation to the contents of this file and all the documents in the file as I explained yesterday. I'm not sure if Mr Fortune was here at the time, but as I explained yesterday, all the

documents for which it was previously claimed have been provided.

MR FORTUNE: I'm grateful for that because my concern was clearly that any document that has so far formed the basis of questions to Professor Young might, of course, provide the basis for questions to Dr Steen.

THE CHAIRMAN: Yes. Okay. Thank you very much.

Mr Stewart?

MR STEWART: Thank you, sir. Dr Elaine Hicks, please.

DR ELAINE HICKS (called)

Questions from MR STEWART

THE CHAIRMAN: Just before you start, I have just been handed a note that there is an extant claim for privilege for some documents in file 140. Let's deal with Dr Hicks' evidence and then we can look at that.

MR STEWART: Good morning.

A. Good morning.

Q. Doctor, you've been kind enough to give us two witness statements: WS244/1 in Adam Strain's case and WS264/1 in Claire Roberts' case. Are you content that those statements should be adopted in this inquiry as your formal evidence?

A. I am.

Q. Thank you. You have also forwarded to us a copy of your CV. That's at 311-013-001. This sets out your

employment history and your medical education.

Can I ask a question of you -- I don't mean to surprise you, but it's a question that arose from the evidence of Professor Young given yesterday in relation to a fluid balance chart entry. I don't mean to bounce you, I wanted to simply ask you for what you interpret an entry to mean. It's at page 090-038-135.

Do you recognise this format of fluid balance and IV prescription sheet?

A. Yes.

Q. Can I take you down the left hand amount column in the IV intake side, and do you see three entries from the bottom, timed at 2400 hours, "1037" and, just immediately after the number, there is what appears to be a small "H"; do you see that?

A. Yes.

Q. How would you interpret that little symbol, that H?

A. I'm not sure. A symbol like that can, on occasion, be used to indicate discontinuation --

Q. Yes.

A. -- of fluid or of whatever is in the column.

Q. And why would an H indicate discontinuance?

A. I'm not sure whether it is an H or whether it's usually a longer line with two shorter lines at the end.

Q. All right. Very well. Thank you.

THE CHAIRMAN: [Inaudible: no microphone]. Doctor, the reason why this has arisen is, when Professor Young gave evidence yesterday, this records the amount of fluid being given intravenously to Claire at about midnight and 1 am on 22 and 23 October; okay?

A. Yes.

THE CHAIRMAN: What had happened was Dr Stewart had been called to see her at between 11 and 11.30, and he has prepared a note on that. If we could bring this note up side by side, please. It's 090-022-056.

You'll see there that this is his note at the top of the page, 22 October, 11.30, where he'd been called to see Claire. He thinks actually he was called because a result had come back showing how much phenytoin was in her system. But at the same time, he was given a sodium reading of 121 and that led him to make the entry about:

"Hyponatraemia, query fluid overload with low-sodium fluids, query SIADH."

And he then has:

"Query need for increase in the sodium content in fluids."

I think the next entry in effect means he spoke to the registrar:

"Reduced the fluids to two-third of the present value, send urine for osmolality."

Okay?

A. Yes.

THE CHAIRMAN: The registrar was Dr Bartholome, as you may know, and the idea was that she would hurry along as soon as she possibly could to see Claire, but unfortunately she wasn't able to see her for the next few hours, and Dr Stewart did not return. So on that plan, which we had understood until Professor Young picked up the point yesterday, the fluids were reduced, but not stopped, and there was a query about whether the type of fluid should be changed to have one with more saline in it.

What's then curious is that on the note on the left-hand side of the screen in front of you, if this record is right, she received no fluid between midnight and 1 am, and you'll see how the 1,037 reading stands between midnight and 1 am. But that was not as a result of any action which we're aware of from any doctor. It wasn't as a result of what Dr Stewart said and it can't be as a result of what Dr Bartholome said because she didn't see her.

So if it's right -- and Professor Young was speculating a bit yesterday by querying whether the H meant "halt" and he was suggesting, in context, that's what it might mean because the total fluid administered

does not increase between midnight and 1 am, so on the face of it, it's at least a sensible guess at what happened.

But if neither of the doctors did it, then presumably the only other person who could have stopped the fluid would have been a nurse. We've heard evidence from some of the nurses. They weren't specifically asked about this, but there is no note to say that they stopped the fluid. Accepting records are imperfect, if a nurse did stop fluid being administered, that is something that you would expect a note on, isn't it?

A. You would expect, sorry?

THE CHAIRMAN: That there would be an entry or note to that effect in the records.

A. I would normally, yes.

THE CHAIRMAN: On the other hand, the fact that the reading is 1,037 at midnight and again at 1 am would support Professor Young's theory that it was stopped, but by who and for what reason, we don't know. The other curious thing is it was stopped and then started again. So who decided to stop it if it was stopped and then who decided to start it again if it was started again? It doesn't really make sense, does it?

A. Well, I can't explain it.

THE CHAIRMAN: Well, there are two points. The H might mean

"halt", but not necessarily so. That isn't necessarily the indicator you'd expect to find in the records to show that a fluid was stopped, is it?

A. I can't ... I'm afraid I can't recall what would happen. There would normally be a note somewhere to say that fluid was to be stopped.

THE CHAIRMAN: Yes. And I think your other point was that you weren't sure if that was actually an H at all.

A. Yes.

THE CHAIRMAN: Because if it is an H, it is rather broad and short.

A. Yes.

THE CHAIRMAN: Thank you.

MR McALINDEN: I have taken preliminary instructions on that point. It would appear that the symbol that's been used -- there are two short vertical lines and then a long horizontal line between them. My preliminary instructions from senior nursing staff in the Trust is that that is an indication of discontinuation. And I have instructed the Trust to provide a statement to the inquiry from a senior nursing person, indicating the abbreviation used and what it was meant to describe.

THE CHAIRMAN: Okay. Well, that's a start, Mr McAlinden, thank you. We might have to revisit this with the particular nurses.

MR McALINDEN: Yes.

THE CHAIRMAN: We'll come back to that in due course.

MR STEWART: Doctor, back to your CV. You were, in 1996, the clinical lead for the paediatric directorate.

A. I took that on on 1 October 1996, yes.

Q. That in essence means that you're leading the Children's Hospital.

A. It means the paediatric directorate, which is not exactly the same as the whole of the Children's Hospital.

Q. Explain the difference, please.

A. The Royal Hospital, at this stage, was managed by a directorate system and there were a number of directorates which were made up of, to some extent, areas such as the Children's Hospital, but more likely around, if you like, medical or surgical specialties. For example, there was a medical directorate, surgical directorate, a neurosciences directorate. Paediatrics covered most of what was carried out in the Children's Hospital, but not all the consultant staff were, if you like, managed directly by the paediatric directorate.

Q. Would ATICS, the theatre and intensive care staff, have been outside the --

A. The consultant anaesthetists were managed through the ATICS directorate.

Q. But to all intents and purposes you were directing most of the operations of the Children's Hospital?

A. Yes.

Q. Were you in post as clinical lead in the paediatric directorate in 2004?

A. No.

Q. Who was in late 2004?

A. I believe that Dr Heather Steen took over.

Q. Dr Steen?

A. Yes. I can't remember at what stage she took over.

Q. Would it have been the beginning of the year or the middle of the year?

A. I don't know. I ceased at the end of -- I believe, at the end of March 2002.

Q. Thank you.

THE CHAIRMAN: And did Dr Steen take over from you straightaway?

A. I think not, but I can't remember exactly.

THE CHAIRMAN: But at some point, and if not immediately afterwards, reasonably soon afterwards?

A. I think so, but I can't be certain of the date.

THE CHAIRMAN: I presume it's a post that the Trust would not want to leave empty for too long. It does have some responsibilities attached to it.

A. Quite.

THE CHAIRMAN: Thank you.
MR STEWART: The medical notes and records from Claire indicate that you, in fact, treated her in your practice as a neurologist in 1991. I don't suppose you retain any memory of that, do you?
A. No, I'm afraid not.
Q. Do you remember the case of Adam Strain?
A. I know about it now. At the time, I knew very little about it. I think I may have been aware that a child had died following renal transplant surgery. I didn't know the circumstances of the case or the details.
Q. How long before you assumed duties as clinical lead did you know that you were going to take up the post?
A. I suppose -- well, I was interviewed and I was in formal roles for some months beforehand.
Q. So you were sort of director-in-waiting for a period?
A. Well, yes. I mean, I think my interview was quite close to the time before I took up the post. I can't remember exactly.
Q. Do you remember hearing of the inquest into Adam Strain's death in June 1996?
A. I have no memory of that at all.
Q. After that inquest, Dr Murnaghan and Dr Carson considered convening a seminar to discuss issues arising out of Adam Strain's case in totality. Was it ever

mentioned to you?
A. I don't believe so.
Q. Do you have any recollection of hearing anything about it?
A. No.
Q. Because your name appears on a list, you probably are aware of this, of people who should be contacted as soon as possible in relation to setting up this meeting.
A. I understand that. I've seen that on the inquiry website. But I had no knowledge of it prior to seeing it there.
Q. At that time in 1996, did you know anything about hyponatraemia? Had you read the paper, the Arieff et al paper that's been referred to?
A. I knew about hyponatraemia. I can't recall whether I knew of the Arieff paper.
Q. When UTV came to broadcast their programme in October 2004, did you see it at that time?
A. I didn't see it initially, no.
Q. Did you see it soon afterwards, was there a recording?
A. I saw it subsequently. I can't remember when I saw it.
Q. It must have been talked about a great deal in the hospital.
A. It was the subject of discussion, yes.
Q. I'm sure. I'm sure there were copies, tapes of it

getting around. Did you not view it at the time?
A. I can't remember the circumstances under which I saw it. I didn't see the original broadcast, but I did see it subsequently.
Q. The day or so after it was broadcast, Mr Roberts telephoned the Royal and they were put into contact with Dr Rooney, who was deployed to contact them and liaise with them. She told them that the case, Claire's medical notes and records, would be reviewed, and Mr Roberts remembers that your name was mentioned as somebody who would take part in that review of the case notes.
A. I've had no part in that at all. I wasn't involved.
Q. That appears in his witness statement WS253/1, page 18. It's paragraph (c), half way down:
"She informed me that Dr Steen, Dr Webb, Dr Hicks and Dr Sands would carry out the review and a meeting would be arranged in two or three weeks time."
Do you know why Dr Rooney might have said such a thing?
A. Well, presumably she believed that that might happen.
Q. And was there any reason why she might hold such a belief?
A. I'm not -- I don't know why she would have included my name there, other than that I was clinical director

at the time that Claire died.
Q. And you're a consultant neurologist.
A. Yes. I'm not sure whether she would have determined that or who would have.
Q. In 1996, did you have responsibility for ensuring nursing staffing levels?
A. Yes, that was part of the directorate, paediatric directorate.
Q. Did you have responsibility for appraising the performance of nurse managers?
A. I can't recall whether that was ... I can't recall doing that.
Q. Okay.
A. I think the directorate manager would have ... They answered to him, so I think he would have been responsible for that.
Q. I see. It was the director of nursing, Miss Duffin, who told us yesterday that she wasn't responsible for appraising nurse managers, so that's why the question is posed to you. Would you have been responsible then for the managers who were appraising the nurse managers?
A. Yes.
Q. And would you have appraised their performance?
A. Yes. I'm not sure whether the word "appraisal" was used in 1996, but there would have been a performance review.

Q. How often would you have conducted a performance review?
A. Once a year, I think.
Q. And which members of staff would have their performance reviewed by you?
A. The directorate manager.
Q. And anybody else?
A. At that stage, no. Later on, towards 2000, then the consultant staff in the paediatric directorate had an annual appraisal.
Q. Was the annual appraisal just a spot-check and a comment made at one time of the year or did it take into account a monitoring that had been performed throughout the year?
A. There was a performance monitoring system in the Royal called an accountability review, where the directorates were ... And I think that occurred twice yearly. I can't exactly remember the details, but we gave account to the team from the executive: the medical director, the director of finance, and maybe another director. So the directorate manager and I, along with the directorate accountant, would attend that.
Q. Were these meetings minuted?
A. Yes. Well, they were minuted along -- yes, I think they must have been.
Q. And the performance reviews that you conducted annually

for the manager, was that recorded in writing?
A. I think it must have been. I don't recall the details.
Q. Do you remember, in 1996, who the nurse managers were? Because we've been told that three sisters were acting up and jointly sharing responsibility of nurse managing.
A. Yes. Sister Surgenor, Sister Jackson and another one. I'm sorry, I have forgotten the name.
Q. Moneypenny?
A. Yes.
Q. Do you recall which of those sisters had responsibility for the wards and for Allen Ward specifically?
A. I think Sister Surgenor.
Q. Thank you. Were there, in your recollection, any changes in the clinical governance pertaining to the Children's Hospital between October/November 1995 and October 1996?
A. I don't recall any specific changes in that time.
Q. Did you have any concerns at that time about staffing levels and workloads imposed upon staff?
A. I think it's true to say that many, many staff in the Children's Hospital had very busy workloads and there was really a continual review of workloads. It was a core part of the work of the clinical director and the team at senior medical, junior medical, nurse staffing level and other staff.

Q. Did it cause any concern for you at the time?
A. At times it did cause concern.
Q. What was the concern?
A. Well, the concern was that we should maintain a safe service at all times and that we had sufficient, appropriately-trained staff to --
Q. Is there an implication in what you say that at times the service was not safe and that risk was posed?
A. No, I think what I'm saying is that we constantly worked to monitor the situation so that the service was safe.
Q. Did you have responsibility for the budget?
A. I did.
Q. And was the staffing provided for from the budget that you had responsibility for?
A. Mostly, yes.
Q. Did you have to go begging annually for your budget?
A. For, sorry?
Q. Was there an annual budget review?
A. Yes.
Q. And would you have to make a representation for your budget at that?
A. Yes.
Q. Were staffing levels something that featured in your annual pitch?
A. Always.

Q. Always.
THE CHAIRMAN: In that you're always looking for more?
A. Generally speaking, yes.
MR STEWART: Can I refer you to a Children's Hospital strategy document called "Getting it together" from 1996? The cover page is at WS266/1, page 28. Do you remember that? It's a rather hazy photocopy.
A. I did, yes.
Q. If we go through to page 51. And I just want to draw your attention to the first paragraph:
"It was acknowledged that nursing and medical staff are under considerable pressure of work, but there were cases where mothers felt that standard of care were inadequate or insensitive. The first phase of the redevelopment of the Royal Belfast Hospital for Sick Children will alleviate some of these problems (see section 7) but the Trust is concerned that the pressure on staff has continued to intensify."
Was this a problem that was growing as the years went on during the course of your directorship?
A. Well, it was continuous, I think, and constant. We constantly worked with a number of agencies on a number of fronts to increase and improve the staffing levels.
Q. The sense of that is there was a problem and it was intensifying, it was getting worse.

A. One of the things that's happened in, I think, all children's hospitals, and certainly in our Children's Hospital, was that while the overall number of beds and indeed the overall number of admissions to hospital may not increase -- and this is alluded to, I think, in documents around that time -- the nature of the work that is performed changes all the time and that particularly happens because of increasing specialisation and the increasing complexity of the work that is done. So that children, compared to a decade or two earlier, would be less likely to be admitted to hospital for some conditions, for simple conditions. There is much more likely to be more complicated and complex work carried out in many, if not all, areas of the hospital.

THE CHAIRMAN: Which makes it all the more important that your staffing levels are increased.

A. Yes.

THE CHAIRMAN: Because you're dealing with children who are, on your broad approach, sicker and need more care?

A. Yes.

THE CHAIRMAN: Thank you.

MR STEWART: The inquiry has received evidence, for example, that Dr Bartholome, who was the registrar on duty of the evening of 22 October, when Claire's condition was

deteriorating, that she was the only registrar on duty in the hospital between 5 o'clock that evening and 4 o'clock the following morning and she had to look after 114 patients in 12 wards and was also covering casualty. That seems to have imposed upon her a very extraordinary workload. Would that have been a commonplace occurrence at that time?

A. I ... The junior staff posts in children's were all approved for training and regularly inspected and there was a very frequent need to review and improve staffing levels. To say that it was constantly under pressure, I think is reasonable. However, the medical registrar didn't provide primary cover for absolutely all the beds in the hospital. For example, the surgical beds. She was there in case there was a crisis in the surgical beds. And I would acknowledge that these were hard-pressed posts. And in time, the number of staff were increased along with recommendations of the Royal Colleges, the recognition of the Commissioners, the regional task force and junior doctors' hours and so on, and we constantly worked to improve that.

Q. Yes. If we can move forward to page 54 of this document, at paragraph 6.3.3, a discussion ensues in relation to funding, but specifically in relation to staffing levels. The second paragraph:

"The Royal Hospitals have recently reviewed staffing levels and cost pressures within the Royal Belfast Hospital for Sick Children on the basis of current activity levels and the key conclusions were ..."

I wonder can we go through these so you can give comment on each of the paragraphs:

"Medical staff. Junior medical staff in post exceed current funded staffing levels -- a shortfall equivalent to at least four whole time equivalent senior house officer posts. Given current activity levels, there is no scope to reduce the medical staff complement."

What do you interpret that to imply?

A. All the junior medical staff posts were approved and had been approved for training, so there were no new posts developed that hadn't gone through the training approval and the necessary approvals, if you like. There was a funding shortfall and my memory is that when the budgets were handed down from boards to hospitals and thence to directorates, there was a shortfall in a number of places throughout the Royal. I can't remember the details, but I do know that the paediatric directorate had to work for years to agree and get the funding correct for the number of junior medical staff posts that we had.

Q. Then under "nursing staff", the commentary continues:

"A review of nurse staffing, current work practices and standards of care was recently completed by a project team ... The review confirmed that services are under-resourced and that an increase of at least 18.2WTE [whole time equivalent] nursing staff is required to sustain service levels."

How long did that continue for?

A. Well, I'm sure it's still going now.

Q. What is meant by "clinical professions"?

A. Clinical professions are physiotherapy, occupational therapy, clinical psychology. They were managed in a separate directorate.

Q. When individuals were unable to be at their posts, whether nurses, ward sisters or indeed consultants, did you have any role in ensuring that cover was provided for the wards?

A. Yes, I had the overall responsibility for that.

Q. How did you discharge that?

A. It was discharged by having the nurse managers -- they were delegated to look after the nursing complement, take responsibility for the nursing complement. We had a team of people, really, looking after junior doctors. There was a specific management-appointed or directorate-appointed consultant, as well as an administration -- a person from administration. Also

junior staff representatives and representatives of the approving colleges who made up a subcommittee, and they took responsibility for overseeing the junior medical staff cover.

Q. Dr Steen made reference to a consultant-led service within the Children's Hospital at the time, which I think referred to perhaps her role in ambulatory paediatrics, out in the community. Was this something that you were much involved with?

A. "Consultant-led service" is a phrase that has become, I think, core to the NHS over the last -- throughout the UK, throughout the last several decades. It reflects the fact that, compared to the past, consultants have become more and more personally involved in the day-to-day care of patients --

Q. In the community?

A. -- than they would have been in the past. In the community and in hospital. Community paediatrics is a specialty that has developed really from nothing over the last perhaps three decades.

THE CHAIRMAN: So consultants are more and more involved in day-to-day care of patients in the hospital and children in the community than before?

A. Yes. I think that's true. I didn't have any responsibility in the community, obviously, and I never

worked in the community.

THE CHAIRMAN: Is part of the rationale for the community service that that pre-empts -- are those some of the conditions or treatments which mean that children don't need to be admitted to hospital?

A. That's one of the reasons.

THE CHAIRMAN: Thank you.

MR STEWART: Can we go back to the page on the screen, back to the "clinical professions" again, which says:

"A shortfall in staffing across the range of clinical professions continues to inhibit the provision of comprehensive assessment, treatment and rehabilitation."

Would paediatric pharmacists come under the umbrella of the term "clinical professions"?

A. I suppose in a way they would, but I'm not sure whether they were included -- specifically included there.

Q. I'm sorry?

A. I'm not sure whether this definitely refers to them. But they --

Q. I ask because Dr Sean O'Hare, who was previously head of pharmacy at the Royal, gave a statement to the inquiry at WS295/1, page 4, where at paragraph (j) towards the bottom of the page he says:

"There were no paediatric pharmacists in the Royal

Hospitals in 1996. The pharmacy staffing complement for the Royal Hospitals was the lowest of any tertiary care teaching hospital in the United Kingdom. Sheffield Children's Hospital, which is approximately the same size as Belfast had, I believe, seven clinical pharmacists."

Were you ever trying to get a paediatric pharmacist for the hospital in the 1990s?

A. I can't remember the timing of it, but we did. I mean, Dr O'Hare's department -- we worked very closely with them and we certainly, at a later date, did have ward pharmacists and a much more direct daily presence in the hospital on the ward.

Q. And did those appointments come as a result of a long campaign by you or others? Was this a problem that you had to address?

A. I really can't recall the details, but ... I can't remember the details of how that came about.

Q. In relation to the other mechanisms of internal control over the clinical governance at that time, audit, of course, is one of the main machines. What would have happened at the mortality section of the paediatric audit meeting?

A. The audit coordinator would determine cases to be discussed. They would not be detailed on the notice of

the meeting for confidentiality reasons. The involved consultant or consultants, however, would be given notification so that they could prepare a presentation of the case at the meeting and then, at the meeting, the cases would be presented and discussed in turn.

Q. In terms of attendance, would all the doctors or clinicians involved in the particular case be there, or just the lead?

A. Usually, you would try to have all of the doctors involved. That wasn't always possible.

Q. Would that be conventionally a cast of six or two or ...

A. It varied from case to case.

Q. If an autopsy had been performed, would the mortality meeting take place before or after the report was available?

A. Ideally, it would take place after the autopsy.

Q. If it took place before, would it be perhaps adjourned for further discussion upon receipt of the --

A. Possibly, yes.

Q. Would such a meeting have been multidisciplinary?

A. Multidisciplinary involvement in audit was becoming a priority at that time, so that it would be encouraged, so there would be nursing staff and other staff present.

Q. And would all aspects of the case and care and records have been examined or would there have been focus only

on a particular part of it, the cause of death, for example?
A. In general, the details of the case would be presented and the course of the illness or whatever. The case notes weren't examined as part of that audit.
Q. Were the case notes examined as part of a separate audit?
A. Case note audit was performed as part of the overall audit programme, but it was generally random selection of case notes that were audited.
Q. Why would a death case not trigger a specific case note review given that it was a mortality?
A. In a way, the consultants that were involved as part of the process in preparing the presentation would have reviewed the case notes.
Q. Do you remember any audit or mortality meeting or review of Claire Roberts' case?
A. I don't.
Q. If such a review had taken place, would there have been a discussion of the adequacy of the notes?
A. There might have been.
Q. Would there have been a discussion about the drug prescription and administration if that was noteworthy?
A. Yes, there should have been.
Q. Would there have been a discussion of communications

between clinicians and parents?
A. If that was an issue, yes.
Q. If the care plan was in some sense deficient, would that have caused a discussion?
A. You mean the medical care plan or the nursing care plan?
Q. Nursing care plan or medical care plan.
A. Yes. The management ... I mean, I'm not sure at that stage -- I'm not sure whether at any stage in clinical audit meetings we discussed nursing care plans in huge detail.
Q. If for example there was a query between or a difference between the content of a medical certificate of cause of death and the diagnosis recorded or there was a difference apparent between the autopsy report findings and the conclusion of the surgeon in the notes, would that have been the subject of debate?
A. I would have expected so.
Q. Would it have been the subject of quite intense and heated debate or would it have been a leisurely discussion?
A. No, I think if there was -- it would have been the source of possibly quite intense discussion.
Q. On occasions, would doctors point out the failings of other doctors in such a meeting?
A. Well, they would point out discrepancies in care,

perhaps, rather than failings of other doctors.
Q. Might that amount to the same thing?
A. It might ultimately.
Q. Would they be shy about doing that?
A. There was a significant reticence to doing that.
Q. That's natural, isn't it?
A. It is.
Q. Was that something that was encouraged?
A. To be -- no, increasingly, there was an attitude of openness in discussing matters where there was a disagreement.
Q. And what would have happened if there had been an obvious disagreement amongst the clinicians involved in a case? What would have been the next step after that?
A. It would depend on what the disagreement was.
Q. But if there was a fundamental difference of view, for example, as to what had led to the death, would that have caused or provoked a further investigation to be --
A. It could have.
Q. And who would have been responsible for making that decision?
A. What one might have expected to happen would be the person chairing the meeting, who was normally the audit coordinator, would bring that to the attention of the relevant people -- perhaps the clinical director, if

that was the circumstance.
Q. And if such a debate had occurred, presumably, at the end of it, people would try to draw the strands together and crystallise lessons to be learnt?
A. Yes.
Q. Were those lessons ever recorded anywhere?
A. I don't think there was a formal -- at that stage, certainly, there was a formal system for doing that.
THE CHAIRMAN: Well, how do we know if any lesson is learnt? Accepting that there's no formal record, what do we look for to see if any lesson is learnt?
A. Um ... I suppose examples of circumstances where a problem had been highlighted. I'm not sure I can answer your question.
THE CHAIRMAN: That's rather the problem, isn't it?
Mr Fortune?
MR FORTUNE: Two matters, one I should have raised earlier. Let me deal with the second matter first.
Does it matter whether there was a formal or an informal record? Because so far, we've been told -- and we'll hear from Dr McKaigue that he remembers a mortality meeting relating to Claire Roberts -- that there's no record at any stage. That was true in Adam's case as well.
The other matter, it's at the bottom of page 25 of

today's [draft] transcript. My learned friend Mr Stewart asked Dr Hicks a very straightforward question:

"Was it a daily occurrence that the registrar ran the hospital at night?"

It's a matter for you whether you thought there was a straightforward answer. It could or should have been a "yes" or a "no". The bottom of page 25, top of page 26.

THE CHAIRMAN: Yes.

MR FORTUNE: Would you wish to press for a short answer?

THE CHAIRMAN: Let me go back on that.

Doctor, the question that was asked to you when Mr Stewart was talking about Dr Bartholome, she was on duty on 22 October and then through the night of the 22nd into the morning of the 23rd as the registrar on duty. He suggested that that would have imposed a very extraordinary workload on her:

"Would that have been a commonplace occurrence at that time?"

And you answered by reference to the fact that there were junior staff posts and that the registrar didn't provide primary cover for absolutely all the beds.

But it was, wasn't it, a commonplace occurrence for somebody like Dr Bartholome to be the registrar on duty,

the only registrar on duty overnight?

A. Yes. On the medical side she was the most senior person resident at night.

THE CHAIRMAN: We know in this inquiry the previous night it was Dr O'Hare who had the same workload, which has been described by a number of witnesses to the inquiry, witnesses who have experienced it in English hospitals, but I don't think you need to go to England for this. They've described this as "extraordinary", "overwhelming" and "unacceptable". Would you disagree with them?

A. Could you repeat that, please?

THE CHAIRMAN: Some of the previous witnesses who have given evidence over the last few weeks have described this burden being carried on the Monday/Tuesday, by Dr O'Hare, and Tuesday/Wednesday, by Dr Bartholome, they've described it in different terms, but they include "overwhelming" and "unacceptable".

A. I'm not sure that I can ... that I can agree with that because I don't recall anyone coming to me at the time to say specifically, "This is overwhelming or unacceptable".

THE CHAIRMAN: Well, if we take the specific example in Claire's case, Dr Stewart sees Claire at about 11 or 11.30, she has a sodium reading of 121. He talks to

Dr Bartholome, as far as we can make out, and they have some discussion, as a result of which he reduces the volume of fluid, but there's some debate between them about whether he should change the type of fluid.

In any event, he leaves it on the basis that he understands from her that she will be along to see Claire as soon as she possibly can. And when Claire has an arrest at approximately 3 am, Dr Bartholome has not been able to get to Claire for the previous three-and-a-half hours. I don't believe for one second that Dr Bartholome was taking it easy or doing something she shouldn't have been doing, but she does not appear to have had the time in that evening to go back and Dr Stewart didn't get back to her. You can't possibly think that that's acceptable.

A. Well, it's not acceptable that nothing happened.

THE CHAIRMAN: No, but as a matter of fact, subject to one query about fluid, that appears to be what happened in Claire's case. And if I assume, as I'm inclined to assume, that the doctors who were there are doing their best, the only conclusion I can reach, I think, is that they're doing their best, but they can't look after Claire because there's so much pressure on them left, right and centre. This leads on to further issues, but what astonishes me about this is that this just passed

by everybody in the Royal after Claire's death. As I understand it, not a single voice was raised after Claire died to say, "We really can't continue like this". Is that your understanding too?

A. That's what seems to have happened.

THE CHAIRMAN: Is that remotely acceptable?

A. No.

MR FORTUNE: Sir, even if a voice had been raised, would senior managers have actually listened and acted upon it? That's the follow-on question.

MR McALINDEN: If my learned friend wishes to continue in this vein of making submissions, I think it's important that it's appreciated that he is representing the consultant who was in charge of this patient's care. And it would be very interesting, and I am sure you will be very interested to hear --

THE CHAIRMAN: I'll surely be coming to Dr Steen about this on Monday, Mr McAlinden. I accept that there's a specific point about Dr Steen. I'm more concerned at the moment about the overall position because I think what we're going to come to in a few minutes is that Dr Hicks was not aware of Claire's death. Sorry, let me take you to that now.

Were you aware of Claire's death?

A. No.

THE CHAIRMAN: Do you understand how that seems absolutely extraordinary?
A. I do.
THE CHAIRMAN: Because I'm told -- and I'm sure it's right -- that actually very few children die in the hospital. Obviously some children die, but the numbers of children who die are quite small. There are some children who are chronically ill and, regrettably, there's nothing anyone can do to save them, and those children will die. But the Children's Hospital is the hospital in Northern Ireland where children have the best prospect of being saved because it is the regional centre for this part of the United Kingdom; right?
A. Correct.
THE CHAIRMAN: When a child dies, I am told from Claire's case and particularly from Adam as case, that it can be quite a traumatic event for the staff; right?
A. Correct.
THE CHAIRMAN: And despite that happening, I've had a series of witnesses in Claire's case as well as in Adam's, who didn't know, can't really remember, heard about it in a bit of general chit-chat around the hospital and, in Claire's case, absolutely nothing was done. If you were Mr and Mrs Roberts sitting here today and you know that they're only finding out about this because they picked

up from a documentary some concerns, which then translated into them going to the hospital, things being opened up sufficiently for an inquest to be held and then sufficiently for Claire's case to be added to the inquiry, what confidence would you have in the Health Service if you were Mr and Mrs Roberts?
A. I understand. Not much.
THE CHAIRMAN: And you had just come into the position of paediatric lead. If the news of Claire's death doesn't reach you, it's not going to get very far at all, is it?
A. Yes.
THE CHAIRMAN: Okay. Mr Fortune, was there something else?
MR FORTUNE: No, sir, I'm grateful to my learned friend Mr McAlinden. I'm well aware of the questions that Dr Steen may face.
MR UBEROI: Sir, if that matter is concluded, to return to the matter of the mortality meetings. I wonder if we might establish with this witness -- she has talked about how the clinician responsible for the patient would present the case in the mortality meeting on the one hand, and on the other she has been asked hypothetically about debate being triggered and has said debate could be triggered. Could it be established with this witness how that debate is to be triggered? Is it to be triggered by the individual who presents the case?

THE CHAIRMAN: Right. Can you help with that, doctor?
A. The debate can be triggered by anyone in the room if I'm understanding the question right.
THE CHAIRMAN: Can you give us an example? I don't want names, but can you give us an example of a debate being triggered?
A. It's a completely different type of case, but I do recall a case being presented -- I think it possibly was a child with meningitis -- and there was an issue about ambulance transport and the child being taken to another hospital, which was closer to home, and that delaying treatment before they arrived at Children's. It was much later on, by my memory, than this. It triggered a considerable discussion about how to take that forward and it was pointed out that maybe that was something that should be referred on to be discussed regionally with other hospitals, with the ambulance service. That's just one example.
MR STEWART: Did that happen?
A. It did.
Q. And therefore, did that leave a paper trail --
A. It should do.
Q. -- of what happened in consequence of the mortality meeting?
A. Yes.

Q. I see. Tell me, at the sort of meetings you're describing, how many doctors would attend?
A. Well ...
Q. Clinicians.
A. All the consultants from -- most of the consultants from the Children's Hospital. You'll appreciate other directorates were having audit meetings at the same time because we had this calendar that most of the directorates followed whereby the meeting rolled from one session to another each month, Tuesday morning, Tuesday afternoon, and so on. And this was because all elective activity was cancelled at the time of the meeting, so there were no clinics, there was no elective surgery.
So most of the junior doctors who were present in the hospital at that particular time and most of the consultants --
Q. There'd be 30 people?
A. It could be 30 people.
Q. Who would have the medical notes and records relating to the child's case that was being discussed? Would they be circulated or would it be only the clinicians involved in the case?
A. No, the clinician involved in the case would have them.
Q. Nobody else would have them?

A. Only if there was another consultant involved.
Q. In answer to the chairman's questions, you indicated that you hadn't received complaints from registrars or from medical staff about being overburdened with work. Was there an ethos about complaining at that time? Would people complain or would they stoically continue?
A. No, there was a system for them to make their views known. When I say "no complaint", I meant I don't recall any specific complaint around that time. But if -- the registrars had an open door to comment, to come to the clinical director, to come to their representative, the consultant that had special responsibility for supervising the junior staff or overseeing them. And that was ongoing.
Q. Did that system have documentation attached to it? Would it leave a trace?
A. I believe that the minutes of the junior doctors' subcommittee would have been kept in the directorate.
Q. In answer to another of the chairman's questions, you indicated that Claire's case was not brought to your attention. Can I ask for WS264/1, page 3, paragraph 6, please?
"Would you have expected the death of Claire Roberts to have been brought to your attention? If so, how? If not, how do you explain this? I would not have expected

the death to have been brought to my attention unless it was thought that there had been an untoward event."
So you were leaving the reporting of such cases to the judgment of others and on the basis of whether or not they thought there might have been an untoward event?
A. Yes.
Q. Was there any system for the reporting of untoward events?
A. There was.
Q. What was that?
A. There was a -- well, there was a paper system. At this stage -- it became much more developed later on, but at this stage there was a pro forma held. I can't remember whether it was held at ward level at this stage -- it certainly was later on -- or whether it was held in the administration office. So that could be performed, that could be completed and sent in.
I would have expected that people were particularly concerned -- anyone that was particularly concerned could come verbally outside of that.
Q. Was any guidance given to staff as to what may or may not constitute an adverse clinical incident?
A. I'm not sure that there was at that stage.
Q. Were there any published criteria available at that time

in the Children's Hospital to assist people?
A. I don't recall.
Q. So really, it was left to individuals to report themselves or each other?
A. Yes.
Q. Do you remember the King's Fund --
THE CHAIRMAN: Sorry, before you move on.
An untoward event. Dr Webb has told the inquiry that he went home after he saw Claire or soon after he saw Claire at about 5 or 5.30 on Tuesday 22 October. He knew that she was unwell, but he expected her to recover; okay? Dr Steen has said that she was out in Cupar Street that afternoon. There was some level of contact between her and the hospital, however that was triggered, as a result of which she understood that it was not necessary for her to return to the hospital to see Claire, or any other child for that matter.
So both the consultant who was formally responsible for Claire, Dr Steen, and the consultant who had been intervening to help identify what was wrong with Claire and treat her, Dr Webb, they left work at 5, 5.30, 6, something like that, on Tuesday evening, expecting nothing untoward would happen; okay?
They come back into the hospital in the early hours of Wednesday morning at 3 am -- maybe 4 am on Dr Webb's

case -- to find that, to all intents and purposes, Claire is dead. Entirely unexpected on their parts for a girl who had arrived in on Monday evening with her parents and was dead less than 36 hours later. Does that strike you as something untoward?
A. Yes.
THE CHAIRMAN: Do you understand or can you help me understand why that would not be regarded as an untoward event?
A. I can't understand it.
THE CHAIRMAN: Do you understand how either one or both of them, depending on which version I take, took the view that they were sufficiently confident about identifying the cause of Claire's death that it need not be referred to the coroner?
A. I don't.
THE CHAIRMAN: Or that they advised Mr and Mrs Roberts that it would be sufficient to have a brain-only autopsy?
A. I don't.
THE CHAIRMAN: Do you understand my problem?
A. I do.
THE CHAIRMAN: And more particularly, do you understand Mr and Mrs Roberts' problem?
A. I do. I appreciate it.
THE CHAIRMAN: If their understanding, as they've told the

enquiry, was correct, they should have come back into the hospital on Wednesday morning and Claire would still have been there, recovering or not recovering to some level, and the treatment would have continued. But what happened just doesn't stand up to any scrutiny at all, does it?

A. No.

THE CHAIRMAN: I heard some evidence yesterday and I'm going to hear more evidence today and tomorrow about what took place in 2004 and what took place before Claire's eventual inquest and the activity which, on one view, is entirely legitimate activity in presenting statements to the coroner and tweaking statements to the coroner and making sure that the Trust put its best foot forward publicly for the inquest. And what is utterly missing from the evidence is any sign that anybody did anything internally in 1996 or 1997. Can you help me with that?

A. I can't. I don't know.

THE CHAIRMAN: And it seems that even after the autopsy report was provided, which I think was in March 1997, that that did not provoke any discussion between the pathologists and the consultants, which, on the evidence of Dr Herron, would have been worthwhile because, to the extent that he identified any sign of encephalitis, he did not identify it as a contributory cause of Claire's

death. But that's not what the parents were being told. Mr and Mrs Roberts were told something different.

So I assume that a discussion between the pathologists and the consultants would have been helpful when the autopsy report came through; would that be fair?

A. I think that would be fair.

THE CHAIRMAN: Or even if it didn't tell them anything very much different, a discussion between the pathologists and the consultants would have been helpful in any event because of the sudden deterioration and collapse in Claire's condition, as it appeared to Dr Webb and Dr Steen; would that be right?

A. Yes.

THE CHAIRMAN: Well, let me take it on from that. I think you retired, doctor, in 2007.

A. Yes.

THE CHAIRMAN: Suppose Claire had died 10 years later, suppose Claire had died in 2006 instead of 1996. At the time when you retired or immediately before you retired, what was different about the system for reporting or investigating an untoward event?

A. I think there was much more awareness of the need for referrals to the coroner.

THE CHAIRMAN: Right.

A. The framework for incident reporting within the Trust had been strengthened and clinical governance itself had been implemented so that all of those systems for detecting errors or mishaps were stronger.

THE CHAIRMAN: Correct me if I'm wrong, but I understood that the trigger for this is still a recognition by the doctors involved that there is an untoward event.

A. That's true.

THE CHAIRMAN: So if it wasn't an untoward event in 1996, why would an equivalent death be an untoward event in 2006?

A. Well, because by 2006 there had been more work to highlight the need to recognise and perhaps acknowledge mistakes and bring them forward.

THE CHAIRMAN: You see, even if it's not a mistake -- let's suppose that Dr Webb and Dr Steen didn't recognise any mistakes. When Claire died, they were left with what was, on their evidence, an entirely unexpected situation: the fact that Claire had died. Even if you are not looking to see, "Did we make mistakes?", you're presumably looking to see, "What can we do better next time?", or, "If this arises again, how can we go differently?" Is that right? Taking an issue up isn't necessarily -- it may be pointing the finger at yourself a bit or letting other people point the finger at you,

but it is essentially a learning curve, isn't it?

A. It should be.

THE CHAIRMAN: But the Children's Hospital did have the procedures in place in 1996 and 1997 for learning from deaths or from incidents short of death. Maybe a bit less formal, maybe a bit less developed, but they were still there.

A. Yes.

THE CHAIRMAN: They just weren't followed; is that right?

A. So it seems.

THE CHAIRMAN: Thank you.

MR STEWART: That has largely covered the questions I was going to pose.

THE CHAIRMAN: Nothing further?

MR STEWART: Nothing further.

THE CHAIRMAN: Okay.

MR McCREA: Mr Chairman, a question that might be put to this witness would be: what does she expect the consultants themselves to actually do? In this instance, you have one registrar and two consultants. A registrar who believes the child, Claire, to be seriously ill, a consultant who has never seen the child, and another consultant, depending on which version you accept, doesn't appreciate how ill the child is. In those circumstances, would the consultants not

meet with each other and then consider referring the matter further up the chain, independently of --

THE CHAIRMAN: If we take the two consultants, Dr Steen and Dr Webb did meet each other in the hospital at about 3 am or 4 am on Wednesday 23rd; isn't that right?

MR McCREA: They did.

THE CHAIRMAN: And whatever discussion they had --

MR McCREA: They chose not to do anything.

THE CHAIRMAN: Ended up with no internal report, no referral to the coroner and a brain-only autopsy.

MR McCREA: So what would she expect the consultants in 1997 and 2007 to actually do? What should they do?

MR FORTUNE: Sir, before that question is put, it depends on the factual basis. There's speculation built on speculation there.

THE CHAIRMAN: Well, I think I understand from Dr Hicks -- and please correct me if this is wrong, doctor, before you leave the witness box. I think I understand from you that knowing now what you do know about even the broader circumstances of Claire's death, you are surprised that her death was not referred to the coroner and you are surprised that it was not reported to you.

A. Yes.

THE CHAIRMAN: Okay. Thank you. Anything further?

MR FORTUNE: No, if that's the end of the questioning on my

learned friend's question, that's fine.

THE CHAIRMAN: Okay. Mr McAlinden, have you anything?

Doctor, thank you for coming along. Can I make clear, I'm absolutely not picking on you about what happened in 1996 and 1997, but, as you'll understand, I'm very, very worried about a system which was activated in such a way that you as the paediatric lead weren't even told about Claire's death.

Thank you very much indeed. We'll break for 10 minutes, ladies and gentlemen.

(11.30 am)

(A short break)

(11.40 am)

Discussion

MR McCREA: Mr Chairman, just before this witness is sworn, if I could refer back to the issue about privilege and the waiving of privilege. We've just looked, over the break, at file 140, which is the Brangam Bagnall file on Claire Roberts' inquest. Throughout the contents of that, there are numerous references to letters that legal professional privilege has been claimed on. The issue is --

THE CHAIRMAN: And significantly, they're letters at approximately the same time as some of the letters for which privilege has been waived and some of them are

passing between the same two people, Mr Walby and Mr Daly. Mr McAlinden?

MR McALINDEN: I did receive a list of ten documents sent by Ms Dillon to my instructing solicitor in relation to that issue. Number 1, the exact letter also appears in both files and that has been disclosed.

THE CHAIRMAN: Okay, thank you.

MR McALINDEN: Number 3, again, it has been disclosed.

THE CHAIRMAN: Thank you.

MR McALINDEN: Number 5 has been disclosed. Number 7 has been disclosed.

THE CHAIRMAN: Right.

MR McALINDEN: Numbers 8, 9 and 10 relate to legal advice passing between MSC Daly and the Trust in relation to the inquiry and a claim for privilege is still maintained in relation to that.

The other documents on the list, numbers 2, 4 and 6, they relate to consultation notes between the solicitor and Dr Webb and Professor Young in relation to number 2; an attendance note between Mr Daly and Dr Webb, that's number 4; and a consultation note between Brangam Bagnall and company and Professor Young, that's number 6. Those three documents relate to the inquest.

The Trust is prepared to waive privilege in respect of those, but because they also involve clinicians who

have given evidence at the inquiry or are proposed to give evidence at the inquiry, it would probably be the case that those clinicians should be asked if they wish to waive privilege in respect of those before they're furnished to the inquiry. But certainly, the Trust has no objection to those documents being provided to you at this stage.

THE CHAIRMAN: Okay. I'll get this letter copied so that you all have the references. What Mr McAlinden is referring to there is: the document 140-036, that's a consultation note; 140-046, that's in effect a consultation note, but Dr Webb was on the phone for that; and document 140-061 is again a consultation note. So the Trust is no longer claiming privilege. Were the individuals Trust witnesses at the inquest, being represented by Trust solicitors?

MR McALINDEN: Yes.

THE CHAIRMAN: So do they have a separate, individual claim for privilege or do either of us know off the top of our heads?

MR McALINDEN: There certainly is an argument in relation to that and the practice so far adopted by the Trust was that the individuals involved should have some say before the documentation is provided because they may well have been under the impression at the time that the

lawyer/client relationship was a personal relationship between them and the lawyer.

THE CHAIRMAN: We did that for Dr Taylor once before, didn't we?

MR McALINDEN: Yes.

MR UBEROI: Sir, the situation there was we didn't actually bottom out the thorny question which you have just raised because, even if privilege had vested in him as well, Dr Taylor didn't seek to assert it.

THE CHAIRMAN: Let's see if any of the individuals want to assert a privilege which the Trust no longer claims. It would be interesting.

Just for the record, you'll see this letter in the next half hour, but there are ten documents on file 140 for which privilege was claimed. Four of them duplicate letters on file 139 for which privilege has been claimed, so we don't need to worry about those. There are effectively three consultation notes -- you'll see them on this list as items 2, 4, 6 -- for which the Trust waives privilege and there is now a question of whether the individuals waive privilege. The last three -- items, 8, 9 and 10 -- are legal advice given by the Trust's former solicitors, MSC Daly, in relation to the inquiry itself.

So why don't we park this until lunchtime and we'll

get on with Dr Taylor's evidence?

MR McALINDEN: Just for the sake of completeness, Mr Chairman, you'll see that your list, 8, 9 and 10 refers to 140-069-078 and 080. There is another document on file 140, 079, which is not on this list, but for which legal professional privilege is claimed, and that is in relation to the inquiry as well.

THE CHAIRMAN: Right. So that's 069, 078, 079 and 080?

MR McALINDEN: Sorry, there's also 072. Again, it's an inquiry-related piece of advice.

THE CHAIRMAN: Thank you. Okay, we'll come back to that issue later on. Obviously it's preferable to resolve it before Mr Walby gives evidence.

MR FORTUNE: Sir, if you're inviting a submission about whether the individual has a right to claim privilege, then firstly the witness concerned must see the document because, otherwise, how is he or she to know whether there is to be a claim of privilege maintained? At the moment, all we have are redacted documents.

THE CHAIRMAN: We'll see, Mr Fortune. The individuals concerned are Dr Webb and Professor Young. There's only two individuals concerned.

MR FORTUNE: In which case, it doesn't concern Dr Steen.

THE CHAIRMAN: No. The two individuals concerned are Dr Webb and Professor Young. We'll see how quickly they

are contactable to see what they say about claiming privilege which the Trust no longer claims and if they need to see the documents. Okay, let's leave that until 2 o'clock. Dr Taylor, please.

DR ROBERT TAYLOR (called)

Questions from MR STEWART

MR STEWART: Dr Taylor, you have kindly given us two further statements in relation to this case, WS157/1 and 2. Are you content that they be received into evidence as a formality?

A. Yes.

Q. Thank you. Can I take you back to 1996, June 1996? You appeared at the inquest into Adam Strain's death and you had prepared for that with considerable research into the medical literature surrounding hyponatraemia; is that correct?

A. I think so, yes.

Q. The result of the inquest, the finding of the coroner, was something with which you did not agree.

A. Well, I've given previous answers to that. I had some problems with the mechanism that the coroner had used to achieve his cause of death. I think that's been well documented previously. I don't wish to ...

Q. At that time, there was also a medical negligence case outstanding in relation to Adam Strain's death.

A. I wasn't aware of that --

Q. You weren't aware of that?

A. -- until I received a letter from Dr Murnaghan to say it had been settled.

Q. You weren't informed by Dr Murnaghan that a claim had been brought?

A. I was given a letter after the claim had been settled.

Q. But you weren't aware that it had been brought in the immediate aftermath of the initiation of proceedings?

A. I was given a letter to say it had been settled. That's the only recollection I have of the negligence claim.

THE CHAIRMAN: Is that a case, doctor, in which you were not named as an individual defendant, but the Trust was named as the defendant?

A. I'm sorry to repeat my answer, but the only knowledge I remember of the medical legal case was the letter I received to say that it had been settled.

THE CHAIRMAN: Thank you.

A. And that's been in evidence, I believe.

THE CHAIRMAN: Yes.

MR STEWART: Does that surprise you now that a case in which you were involved and which provoked litigation was not brought to your attention at the time?

A. Yes, I would have liked to have been involved in the decision, yes.

Q. That surprised you?
A. I would like to have been involved in the decision --
Q. Okay.
A. -- about the case.
Q. Can I ask the question a third time: are you surprised that you were not notified of the commencement of legal proceedings?
A. I'm not sure I'm happy with the word "surprised" in your question.
Q. Puzzled?
A. I would have preferred to have been informed of the decision.
Q. Did it strike you as odd that you were not?
A. Yes.
MR FORTUNE: Sir, can I assist in relation to Dr Taylor on this point? If you recall, Professor Savage was not aware there was litigation going on in respect of Adam. He learnt after or at the time of the settlement.
THE CHAIRMAN: That doesn't take away from the questioning. It's a point perhaps in passing, but it's a point, however way this litigation is conducted, when the individuals who have been involved in the treatment of a child who dies, the fact is that, on this evidence, they're not informed the Trust is being sued over what happened.

MR FORTUNE: Yes. I didn't mean to be unhelpful, sir. It is just that it is an extraordinary coincidence that, in two sets of litigation, the clinicians involved do not seem to have been told.
MR STEWART: After the inquest, did you maintain your interest in hyponatraemia and reading about it?
A. I can't remember.
Q. Okay. WS008/1, page 8. This is the penultimate paragraph:
"As a consultant in the Royal Belfast Hospital for Sick Children, with my colleagues, I have had the opportunity since 1995 to teach and train junior anaesthetic and paediatric trainee doctors in all aspects of fluid management in children undergoing major surgery. I have maintained my professional knowledge of all aspects of such cases by reading widely on the subject of fluid management and passed on such knowledge in formal and informal teaching sessions."
So it looks as though you have at least told us at one stage that you did maintain an interest and maintained a reading interest.
MR UBEROI: May I rise to request perhaps that the question is phrased a little more specifically? That answer coming from one of Dr Taylor's earlier witness statements to the inquiry could potentially engage

a vast number of years. We know the hyponatraemia working party is established and Dr Taylor is asked to sit on that. If the question is relating to the immediate aftermath of Adam Strain's inquest, I'd be grateful if it could be put in that sphere.
MR STEWART: Perhaps I can do just that, but divide it into two parts. Did you actually conduct searches of the medical literature in preparation for and at the time of the inquest?
A. I believe so, yes.
Q. After the inquest, did you continue that interest and continue your reading of medical literature in all aspects of fluid management?
A. Well, I can't remember, but my statement is a statement of a generic knowledge of what a paediatric anaesthetist would know about fluid management. I don't claim to have had specific expertise on hyponatraemia, for instance. I think I was in keeping with my peer group, my colleagues.
Q. Would you categorise that as a general awareness?
A. I was in keeping with what my job as a paediatric anaesthetist and as a teacher of the aspects of paediatric anaesthesia would involve.
Q. You had read the Arieff paper at the time of the inquest, hadn't you?

A. Yes.
THE CHAIRMAN: I think, doctor, it must be fair to say that because of the tragic circumstances of Adam's treatment and death, you had a particular interest in hyponatraemia as a direct result of that, didn't you?
A. It's hard to remember exactly if my knowledge was more or less than my colleagues' knowledge. I'm not claiming to have been a world expert on hyponatraemia.
THE CHAIRMAN: I understand that, but because of what happened with Adam and because of what we've already been through before about the inquest and what was being said about your treatment by the coroner's experts, that prompted you to go into your own research?
A. Yes.
THE CHAIRMAN: And you had considerable difficulty in accepting Dr Sumner's line of thought and his approach; isn't that right?
A. The mechanism, yes.
THE CHAIRMAN: So at least in that regard you had read up on hyponatraemia more than you had previously done? How far ahead of your colleagues that puts you is a different matter, but you had unfortunately found out a lot more about it during the previous year than you had done previously.
A. I think that's fair.

THE CHAIRMAN: Thank you.
MR STEWART: WS157/2, page 4. This is just at question 13:
"Did you accept the coroner's findings in the case of Adam Strain? At the time, 1996, I did not agree with the coroner's findings that dilutional hyponatraemia caused his death."
And that's the mechanism point to which you refer.
A. Yes.
Q. Were you smarting a bit after the inquest finding?
A. I don't understand what you mean.
Q. Did you perceive it to be a professional setback that your view had not prevailed and that Dr Sumner's had?
A. No, I think I've said that I was devastated at the death of Adam Strain.
Q. I'm asking a different question. Were you smarting from the finding of the coroner?
A. I don't think so. I don't recognise that --
Q. Did you entertain any feelings that you wished to prove your argument?
A. No, I think that ... No.
Q. When you were on duty in the intensive care unit on the morning of 23 October 1996, you had to review Claire Roberts' history and make a care plan for her.
A. That's correct.
Q. To do that, you had to presumably acquaint yourself with

her recent medical history.
A. In the time I had available on the ward round, I believe I would have -- I believe I had a verbal handover from Dr McKaigue that morning. He was going off duty, having been on the night before, and obviously up the night before. And I believe he gave me a verbal handover and then a summary.
MR UBEROI: To assist the witness and perhaps my learned friend, may I suggest the note be put on the screen so the witness has the benefit of it?
MR STEWART: Of course. 090-022-061. This is your writing at the top of the screen, the note dated 23 October; is that correct?
A. Yes.
MR UBEROI: It strikes me in light of the witness's previous answer, perhaps if the previous page could be placed side by side with it. He has referred back to Dr McKaigue and the previous entry is, of course, his.
MR STEWART: I wonder if we could just go through what you have said in your witness statements about what you did before we actually examine the note. Because you explained what you did at WS157/1, page 3. 4(a):
"Describe in detail your actions in the care and management and treatment of Claire. My actions in the care, management and treatment of Claire, as the PICU

consultant, were from approximately 08.30 to 17.00 on 23 October. From my note [that is the note we are just looking at], at around 10 am on the morning of 23 October, I had knowledge of her recent medical history, examined her and produced a management plan to prepare to meet the requirements for brainstem testing ..."
And so forth. Did you have access to her medical records at that time?
A. I would have.
Q. Yes.
MR UBEROI: I rise again. Dr Taylor's note seems to have disappeared from the screen. Could it be placed back up, please?
MR STEWART: Dr McKaigue made a note, which immediately preceded the note you made in the entry; did you read it?
A. Well, I can't remember, but I believe I would have, yes.
Q. And would you have read any of the entries that preceded Dr McKaigue's entry?
A. I can't remember, but bearing in mind it was a busy ward round with potentially -- I can't remember how many, but up to six patients to see, examine and manage in PICU, I would have potentially read the latest entry and the latest summary, which was actually a very -- I believed

a very complete summary of the recent illness that I referred to.
Q. Yes. But it was not the only summary written when Claire was in PICU.
A. Sorry?
Q. If we go back to 090-022-057, we find that, at 4 am, Dr Steen has written this synopsis and the most recent test results down the left-hand side after her admission into the intensive care unit; would you have read that?
A. I can't remember. If Dr McKaigue's note, which it was, was very complete, I may have -- I was on a busy ward round, seeing a patient, taking over her management, and there was clearly quite a bit of management to do with her, to set her up prior to her second set of brainstem tests, which was obviously my duty for her that day.
Q. Would you have read what the consultant neurologist had written at 4.40 am in PICU?
A. I can't remember what I read. I was on a busy ward round, as I said.
Q. Well, might you, in this world of hypotheticals, have read the entries recorded in the notes whilst she was in PICU?
A. That would be my usual practice.
Q. And if you had pursued your usual practice, you'd have seen that Dr Webb had recorded his diagnosis there:

"SIADH, hyponatraemia, hypoosmolality, cerebral oedema and coning following prolonged epileptic seizures."

You'd have read that, wouldn't you?

A. Potentially, yes.

Q. In which case, you would have been aware of the involvement of hyponatraemia in Claire's case as a word, hyponatraemia, just as you were aware of it as a sodium reading.

A. I believe so. I believe it was in Dr McKaigue's note as well.

Q. I'm so sorry?

A. I believe it was mentioned in Dr McKaigue's summary note.

Q. I'm not sure he used the word "hyponatraemia", but I'll stand corrected. I wonder if we could look at WS157/2, page 14, at (c)(viii) at the top and the end comment:

"I was not aware that Claire Roberts' death involved hyponatraemia until 2012."

Can you explain how you were able to tell the inquiry you weren't aware that her death involved hyponatraemia until this year?

MR UBEROI: If I may rise, I'm slightly concerned the question is put slightly unfairly. The word "hyponatraemia" has been fished out of medical records,

which also mention other word such as "encephalitis", "status epilepticus", and hyponatraemia can be present without causing death. So I'm slightly concerned the impression is being given that the notes rather point to hyponatraemia when, in fact, they don't.

THE CHAIRMAN: Sorry, apart from the notes in 1996, we have the referral of Claire's case to the coroner in 2004, we have the referral to the inquiry after the inquest, and I have to say, Mr Uberoi, I'm taken aback that Dr Taylor, both from his knowledge of Adam's case and from his continued working in the Royal, has told the inquiry that he didn't know that Claire's death involved hyponatraemia until 2012.

I'll broaden the question out beyond Dr McKaigue's note, if you want, but it's a matter for you. That may make the question more difficult for Dr Taylor to answer as to how he didn't know there was any involvement of hyponatraemia until this year.

MR UBEROI: No, sir, I think my point really chimes with the observations that you have just made, where I can entirely understand if Dr Taylor is to be asked about Claire Roberts governance, about the systems that were in place and how it could be that, through any systems which were in place, this information didn't reach him. That's one matter, but it is a separate matter to

suggest that it must have struck him from looking back through the notes when he was on the ward round on that morning.

THE CHAIRMAN: Maybe it's a question with multiple parts or a number of questions one after the other about why he didn't realise or ascertain from the notes at the time and from what Dr McKaigue had said, at a very thorough handover, that hyponatraemia may have played a part.

MR STEWART: On that basis, Dr Taylor, it seems to me that Dr Webb's note at 090-022-057 links as almost a sequence:

"SIADH, hyponatraemia, hypoosmolality, cerebral oedema and coning following prolonged epileptic seizures."

It's almost an encapsulation of death and the causes of it.

A. What was the question? Is there a question, sorry?

Q. From that, would it not be reasonable to conclude that hyponatraemia might be implicated in the death?

A. Well, if I can go back to my statement that you showed a few minutes ago, the reference to 2012.

Q. Yes, of course. WS157/2, page 14.

A. Why I put that as an answer to that particular question, which was actually about my presentation to the -- presentation of the hyponatraemia working party, was

that was the first time, actually this year, that I had read the coroner's inquest, which was done in 2004, and the cause of death that he had written down on the death certificate, which involved hyponatraemia. Prior to that, I wasn't aware of the use of the word or the cause of death in the death certification process as being due to hyponatraemia.

Q. Are you trying to make the very, very subtle distinction between not knowing what the coroner had found and not understanding what you had read?

A. Sorry, I don't understand what you're saying.

Q. When you read Dr Webb's entry, if you did, and it would have been your usual practice, what did you understand that to mean?

A. I can't remember reading it and I can't remember what I understood it to have meant. But there was clearly a diagnosis going on of encephalitis/encephalopathy with Claire, and at that time --

Q. Sorry, let's go back to 090 --

MR UBEROI: Could the witness be allowed to finish his answers at all times, please?

THE CHAIRMAN: You were saying, doctor, you can't remember reading Dr Webb's note, there was clearly a diagnosis going on of encephalitis/encephalopathy with Claire. And at that time ...

A. I think, as I remember at the time, in the mid-1990s, there was unfortunately several children -- I wouldn't say many -- but it was not an uncommon presentation to intensive care to have seizures, encephalitis, and to die as a result of that. That's changed with vaccination and better care, recognition of meningitis, these days. But clearly, it appears that I was under the presumption that the cause of her illness was encephalitis, meningitis. That's what she has been treated for and that was the overriding diagnosis, I believed, at that time.

MR STEWART: Okay. Can I take you back to your statement here?

"I was not aware that Claire Roberts' death involved hyponatraemia."

It says "involved hyponatraemia", it doesn't say "principal diagnosis", it doesn't say "sole cause of death"; it merely indicates you were not aware that there was an involvement of hyponatraemia in the death. I'm suggesting to you from the notes that that seems extraordinary.

A. Well, that's what I understood.

THE CHAIRMAN: Sorry, remind me again, just to go on to where you were. Your first knowledge that Claire's death did involve hyponatraemia came about as a result

of what in 2012?

A. I believe that's the first time that I had set eyes on the coroner's cause of death -- the narrative cause of death that the coroner, and that was through visiting the documents on the website.

THE CHAIRMAN: Doctor, there must have been discussion within the hospital after 2004 about this inquiry and, in particular, after 2006 when Claire's inquest had taken place. I presume you knew that the inquest took place in 2006. I presume that was fairly common knowledge in the Children's Hospital.

A. I don't remember it as being common knowledge, whether I was on leave at the time, I can't remember, but I don't recall it being reported as common knowledge.

THE CHAIRMAN: Well, do you remember Claire's death being added to the inquiry in 2008 when the inquiry resumed after the completion of the various police investigations?

A. I remembered her name being highlighted as one of the children involved in the inquiry.

THE CHAIRMAN: And did it strike you that since Claire had died in the Children's Hospital a year after Adam and a few months after Adam's inquest, did that prick your interest at all?

A. I presume so. I can't remember.

THE CHAIRMAN: But not sufficient for you to have any awareness that there was suggested to be any connection between hyponatraemia and Claire's death? You must have thought: what was I doing adding Claire to the inquiry if her death didn't involve hyponatraemia?

A. I wasn't aware of my time with her -- my role looking after her in intensive care between her first and second set of brainstem tests until I received the witness statements.

THE CHAIRMAN: And even if I acknowledge that your involvement at the very, very end of Claire's life was a limited one, you weren't one of the treating consultants and you came into work on 23 October and find a girl who is, to put it bluntly, to all intents and purposes already dead or in a condition from which she cannot be saved --

A. Yes.

THE CHAIRMAN: So your role at that stage as a treating consultant is very limited. Okay. I'll leave it at that.

MR STEWART: So back in intensive care unit, I'm sure that you didn't fancy a second trip to the coroner's court in relation to another death involving hyponatraemia back in 1996.

MR UBEROI: Sorry, sir, I'm not really sure that's a proper

question or a fair question in an inquiry.

THE CHAIRMAN: Yes. Let's put it more ...

MR STEWART: Were you interested in whether or not Claire's death might be referred to the coroner?

A. I don't think I took a view on it.

Q. You took no view?

A. I was managing up to six patients in the paediatric intensive care unit. Some would have required more of my attention than others and, in those days, I had one SHO and myself and the nurses looking after up to six patients. So I had to prioritise and divide my time to those patients. So I don't imagine I would have spent an inordinate amount of time investigating a child whose -- my main duty that day was to have a management plan to prepare her for a second set of brainstem tests, which were to be taken place later that day. That's the perspective of my knowledge and attention with Claire.

Q. How many children would you have had dying in PICU on any given day?

A. I think there are approximately 24 deaths a year.

Q. Two a month. So in any given day, it would have been something that you might have stopped to think about?

A. Well, as is quite clear in the records, Claire was presented to me on the morning, on that morning, as a child who had succumbed to an illness. Her first set

of brainstem tests had been completed. There was little I or anybody else could do to reverse that process, and my duty at that time was to my other patients and to her to ensure that the requirements for the second set of brainstem tests were met that day in quite a challenging situation of polyuria.

Q. I'm not seeking in any sense to question what you did for Claire at that time. What I am suggesting is that the issue of whether or not it might have been a reportable death to the coroner should have exercised you.

A. If I had been present at the time when she died and was taken off the ventilator, then I would have taken a view on that. But during the day, when my attention was clearly divided between my other patients and her, I can't remember -- it clearly didn't strike a chord that I took a view about whether she -- and she had other clinicians that were looking after her at that time.

Q. The reason I ask you that is that, at that time, you believed that hyponatraemia was a treatable condition; yes?

A. With Claire, do you mean, or in general?

Q. In general, hyponatraemia was a treatable condition.

A. In general, symptomatic hyponatraemia is a treatable

condition. But after the performance of the first set of brainstem tests, which is --

Q. I'm not intending --

A. -- [OVERSPEAKING] to Claire, it was not a treatable condition.

Q. I do accept that. But in general, it's a treatable condition. She had it, you knew that, you had recorded her sodium levels, and you'd also read the Arieff paper, which repeatedly made the point that timely treatment can save children suffering from hyponatraemia. Did you not think there perhaps might be a connection between what looked like a death from hyponatraemia and a want of timely treatment?

A. You'll correct me if I'm wrong, but I believe Arieff reported hyponatraemia in healthy children undergoing surgery.

Q. No. I do correct you. It's a range of children with [OVERSPEAKING].

A. I believe it looked at children undergoing surgery and that's what I understood at the time, but I may have been wrong.

Q. Did you have any conversation with any of the other clinicians about whether or not the matter might ought properly to be referred to the coroner?

A. I can't remember.

Q. Did anyone ask you for your opinion?

A. I can't remember.

THE CHAIRMAN: Sorry, doctor, let me go back a bit. When you were asked about reporting Claire's death to the coroner, you said that:

"[You] may have taken the view, had I been there when she died and was taken off the ventilator."

A. That's a time when there would be discussion about whether it's a reportable death or not.

THE CHAIRMAN: In Claire's case, the discussion had taken place long before that. In Claire's case, when she died and was taken off the ventilator, that's after the second brainstem test, isn't it?

A. Yes.

THE CHAIRMAN: The decision not to report to the coroner was taken in Claire's case before the first brainstem test. You have just told me that the time to make a decision about reporting to the coroner is after the second test. Is that your experience in the Children's Hospital?

A. That's my experience.

THE CHAIRMAN: So if that's your experience in the Children's Hospital, can you help me on something, which I understand from your evidence is not something that you're involved in? Can you help me to understand how a decision was taken not to report Claire's death to

the coroner before any brainstem testing?

A. I'm not familiar with that scenario.

THE CHAIRMAN: No, because the scenario that you're familiar with is that a decision about reporting to the coroner is taken only after the final brainstem test, which has confirmed the position, and the child has died and is taken off the ventilator, or is taken of the ventilator and then dies?

A. If I can be helpful, the coroner won't accept a phone call from a doctor until the patient has died, and then he will make a decision whether it's a coroner's case or not and where he wants the body to be, unless there's organ donation. And if there's organ donation, then clearly a discussion has to take place with the coroner before the child is taken off the ventilator because the organs must be preserved by remaining on the ventilator. In all other cases, I believe the decision to phone the coroner -- and it would be my practice to wait until the patient is actually no longer has a heartbeat.

THE CHAIRMAN: Your practice is to wait beyond the point when the condition is irreversible to the point where the patient is actually dead?

A. Yes. I have on occasions phoned the coroner in advance when there's been a difficult case and he's left me in no doubt that he would only wish to be informed when the

patient is actually no longer -- beating heart.
THE CHAIRMAN: Okay. That being so, does that mean that that is invariably a decision in which, in the Children's Hospital, a paediatric anaesthetist who is in PICU is involved?
A. It's not hard and fast. It's usually the lead clinician who would phone the coroner, but on occasion it has been my job. I have taken on the responsibility to phone the coroner after the death.
THE CHAIRMAN: But even when the lead clinician contacts the coroner, that's where the coroner is being contacted, obviously.
A. Yes. You have to phone the coroner after the patient's died.
THE CHAIRMAN: But even where the lead clinician is making that call -- and we're talking about the mid-1990s and subsequently, unless you tell me there has been a change in practice -- is it typically the position that the lead clinician will engage you in some discussion if you've been involved with the child's care?
A. Yes.
THE CHAIRMAN: That's if you've been involved in the child's care in PICU?
A. Yes. I believe all the consultants involved in the care of the child at that time, around the time of death, or

leading to the death, would normally have a discussion about how to proceed with either death certification or with a coroner's phone call.
THE CHAIRMAN: Right. That in your experience in the Royal over how many years, 21 years?
A. 21 years.
THE CHAIRMAN: That has been the standard approach?
A. Yes.
THE CHAIRMAN: The coroner is contacted after the second brainstem test and after the child has formally died, and there is a discussion between those who are involved at that time, including the lead clinician, but also including the paediatric anaesthetists, about whether this is a death to refer to the coroner?
A. Yes. Basically, I would discuss it with the surgeon or the paediatrician to see if they could write a death certificate. So if we're certain as to the cause of death and a death certificate can be written, then that would obviate the call. There's been another change recently, as you may be aware in the coronial system, there's a medical adviser now available to discuss cases with. That was not the case in 1996.
THE CHAIRMAN: Right. That's a link between --
A. It's a doctor who I can phone, and many of us have used that as an improved way of discussing cases that may or

may not require a coroner's view.
THE CHAIRMAN: In effect, is that to help Mr Leckey as the senior coroner in reaching a decision?
A. It may well help Mr Leckey, but it certainly helps doctors. And if it is after the organ ...
THE CHAIRMAN: Let me take you back to Claire's case. The discussion with the parents about a brain-only autopsy and about non-referral to the coroner, that takes place before any brainstem testing. In your experience, that's unusual.
A. Um ... Yes. There's a certain choreography, there are certain methods of ... I guess there's some clinical freedom in how one pursues that, but certainly my practice would be to perform the brainstem test, tell the relatives after the first set that it's most likely an irreversible condition, but we are required by good practice to have a confirmatory set of brainstem tests, so there's an element of preparation for that. It's usually after the patient's separated from the ventilator or the organs are retrieved, if it's an organ donor, that we sit down with the parents and discuss what happens, either certification of the body or referral to the coroner, the medical adviser to the coroner.
THE CHAIRMAN: If it is the case that with Claire the

decision was taken not to refer her to the coroner before any brainstem testing, that's unusual?
A. In my practice, that's unusual.
THE CHAIRMAN: And also the practice which you see around you in the Children's Hospital? Because from what you said earlier, you don't have a unique practice in this, but this is the general practice in the Children's Hospital.
A. I'm only present at the death of patients that I'm involved with, so I can't comment on my presence because I'm not present at the death of --
THE CHAIRMAN: It's also the practice that, whether or not you're the treating clinician -- and I presume very often you're not the treating clinician -- but very often, even if you're not the treating clinician, you will be involved in the discussion about whether this is a death to be referred to the coroner?
A. Yes.
THE CHAIRMAN: Thank you.
MR STEWART: Do you think Claire's death should have been referred to the coroner?
A. Well, after what we've heard in this inquiry, yes. I think things have changed in the last number of years and that, as I said earlier, deaths with encephalitis, meningitis, were not uncommon in the mid-1990s.

Unfortunately, children did die and actually died quite suddenly having been relatively well with seizures and death could be quite sudden with or without hyponatraemia being present. And I believe -- I can only go by what I thought at the time -- my belief was that Claire was such a sudden death that the underlying diagnosis, tragic diagnosis of encephalitis, is what I'd been led to believe was resulting in her cause of seizures. I believe that's why she was admitted to intensive care after that had caused an irreversible brain injury. That was a very, unfortunately, not uncommon form of death in young children. It still does occur. I had a recent death with meningitis.

THE CHAIRMAN: If that is the cause of death, how would that be categorised in the Trust records? If it is as a result of encephalitis, how would that be categorised?

A. In terms of coding or in terms of ... What do you mean by --

THE CHAIRMAN: I have a letter, which we will now have to share with everybody. It's a letter dated 12 November 2012, which we got from the DLS in response to an inquiry we made about deaths in the Children's Hospital and in paediatric intensive care. It says:

"The Trust does not code the cause of death, but rather the primary diagnosis treated or investigated."

And we have the details for 1995 and 1996. I'm looking to see "encephalitis", which you say was not uncommon in the mid-1990s, and I can't see encephalitis. So I'm asking you what else would it be under?

A. Well, meningitis, I think. One of the diagnoses was meningoencephalitis. So meningitis can cause a swelling of the brain and can look like encephalopathy or a clouding of consciousness.

THE CHAIRMAN: Unless I'm missing it, I don't have meningitis either.

A. That was my recollection, that children did die suddenly.

THE CHAIRMAN: I'll tell you what, for the moment -- we'll copy this later on, ladies and gentlemen -- but doctor, would you look at this? (Handed). It's a list of deaths in 1995 and 1996 in the Children's Hospital generally and in paediatric intensive care. I would like you to identify -- these are not coded, this is the primary diagnosis.

A. Meningococcaemia, which -- certainly meningococcal septicaemia is a form of meningitis caused by a meningitis organism, Neisseria meningitidis, and there are three deaths out of 42 in 1995 and one death unspecified in 1996.

THE CHAIRMAN: Thank you.

MR STEWART: Would it assist, sir, to bring up the actual coding that was applied to Claire's case?

THE CHAIRMAN: Yes, perhaps.

MR STEWART: It's at 302-153-003. (Pause).

THE CHAIRMAN: We can come back to that, if we can.

MR STEWART: We'll come back to that.

THE CHAIRMAN: Sorry, do you have a reference there what the coding was?

MR STEWART: It's a detailed document with a considerable number of primary and subsidiary diagnoses. It might be easier to follow if everyone had a chance to look at it.

THE CHAIRMAN: Okay.

MR STEWART: So Dr Taylor, you say that now, with hindsight, you can see that Claire's case is one which probably should have been referred to the coroner. Of course, the next obvious question is: could you not have seen that at the time, given the content of the medical notes and records?

A. Well, clearly, I didn't see it at the time.

Q. All right.

A. But then I didn't participate in the decision to refer to the coroner or, nowadays, the medical adviser to the coroner, which I believe possibly would have been the way I would have perceived it being dealt with nowadays.

Q. Given the level of interest that you had achieved in

hyponatraemia following your researches and the finding of the inquest, why did you not take a closer interest in this case of hyponatraemia?

A. I don't know. I clearly had a duty, as I've said before, to manage Claire with my five other children in PICU that day, about her complex fluid management with diabetes insipidus, to prepare her in the best possible way for this second set of brainstem tests. That was my job with her. That appears to be what I set out to do and I can't explain or understand or even know why. I presume because that was my main job with her, that was my job with her that day.

Q. Would you have had a reluctance to get involved in another case going back to the coroner with hyponatraemia?

MR UBEROI: The question doesn't make sense on any logical or factual basis, in my submission. Given the limited role which Dr Taylor has just explained he had in the clinical care that was given to Claire Roberts, why would he have any reluctance? I think this matter's been pursued and it's been answered in various ways now.

THE CHAIRMAN: Okay. Let's look at it another way, if we actually look at the note, which gives the sodium. Let's look at Dr Taylor's note, which gives the sodium reading.

MR UBEROI: 090-022-061.
MR STEWART: Thank you very much.
We have it, the fifth line down:
"Sodium 129 from 121."
At that stage you note:
"Appears brainstem dead informally."
And it's 7 hours post arrest, so that gives you a timing for your entry.
A. Yes.
Q. That's a case of hyponatraemia.
A. Well, hyponatraemia is present in the diagnosis of other severe infection.
THE CHAIRMAN: What has happened is that the sodium level, Claire's sodium level, has risen from 121. Where do you get the 121 from? Do you get it from the earlier notes?
A. Yes, presumably.
THE CHAIRMAN: If you go back into the earlier notes to get the 121 --
MR STEWART: At 090-022-059, is, I think, the immediate reference closest to Dr Taylor's entry. It's there down at the end of the first paragraph:
"Serum Na also noted to be low, down to 121, presumably on the basis of SIADH."
THE CHAIRMAN: So you have the 121, you assume, from Dr McKaigue's note?

A. Well, I could have got it from several sources. Presumably it would have been written on the PICU blood results record, which is part of the clinical record of the nursing obs. So I'd certainly have been looking at that during a ward round as well as the fluid balance, the blood gases, the blood pressure, the heart rate and the urinary output. That would all be probably -- well, that would definitely have been part of the clinical records that I would have examined during my time on the ward round with Claire.
MR STEWART: There's also, further down, a reference to:
"CT scan shows severe cerebral oedema."
That's about ten lines down.
THE CHAIRMAN: The point is, doctor, that's bringing in the records, and when you go into the records and look through the records from which you are gathering some of this information, that brings you back closer to Dr Webb -- never mind Dr Stewart for the moment -- at 11.30, but that brings you back to Dr Webb, who's recording hyponatraemia. I'm just curious as to why this was missed. Not half as curious as Mr and Mrs Roberts, I suspect. I understand your role was limited, I understand that you were looking after intensive care that day, children who probably did survive thanks to your treatment. I don't doubt any of

that at all. But I am curious as to the entries about hyponatraemia apparently being missed by you and no flag being waved.
A. Sir, I believe in those days, certainly before the other later deaths, that we, in hospital medicine, did see hyponatraemia on occasion in patients, not fatal. It was sometimes -- it was not infrequently recorded with any type of fluid. Obviously, Solution No. 18 was a very commonly used fluid at that time. I don't believe Adam and Claire were the only patients prior to 1996 that did have hyponatraemia present during their hospital stay; they did not die from it or get cerebral oedema from it, and I don't think doctors at that time, including myself, put -- the knowledge now is different and trying to look back with the knowledge we have now into this time of the mid-1990s, I honestly don't believe myself or other doctors believed that sodiums of 121 on their own would cause fatal cerebral oedema. That's just a reflection of what I remember at the time. It is different now and it's hard now with the knowledge we have, and certainly what this inquiry is going through, to understand that doctors might have had that knowledge. But that was the knowledge at the time.
THE CHAIRMAN: Let me ask you something slightly different, but a variation. As it happens, it was Dr McKaigue who

was in PICU when Claire came in.
A. Yes, he attended Claire before me.
THE CHAIRMAN: And as it happens, this is a 9 year-old girl -- sorry, were you here earlier this morning?
A. Yes.
THE CHAIRMAN: So you'll have heard me going through this sequence of events with Dr Hicks.
A. Yes.
THE CHAIRMAN: Right. Doctors Webb and Steen finished their duty at 5.30, 6-ish on Tuesday evening. Their understanding, as relayed to the inquiry, is neither of them had a concern that there was any immediate risk to Claire's life. Dr Webb said -- and he knew the position best because he'd be treating her all afternoon -- had he apprehended a risk to her life, he wouldn't have left, and I don't have any doubt about that because Dr Webb came back a number of times to see Claire and to see what more he could do and to see if what he had done was working. They're both called into the hospital in the early hours of the morning to find, to all intents and purposes, Claire is dead, she's in an irreversible condition, and they decide -- either Dr Steen on her own or with Dr Webb -- that they're sufficiently clear about the cause of death that they're able to tell Mr and Mrs Roberts, when they arrive in the

hospital, that they recommend a brain-only autopsy, which indicates a striking degree of confidence in their understanding of the reason for Claire's death and no need to refer to the coroner.

Even without the benefit of hindsight and even without knowing that in the intervening years the bar has been lowered for referrals to the coroner, does that not strike you as very surprising?

A. Well, I wasn't there at the time so I don't know what was said or how it was said. But certainly it's one of the great difficulties in paediatric practice, the rapidity of which a reasonably well child can suddenly deteriorate in general practice and in hospital medicine, much more so than in adult medicine. Children do go from being at school, playing, to moribund within minutes and hours. Unfortunately, if we could get a crystal ball and see which ones were going to have a runny nose and a cough and which would develop life-threatening illnesses, then one would be a very good doctor, but unfortunately children continue up to the present day to suffer overwhelming infectious diseases and succumb very rapidly, whether care is good or less than good. But certainly in those days, by today's standards, the care was not as good as what I would have expected by today's standards and possibly

even by those standards.

THE CHAIRMAN: The plus side for children is that they recover quicker and the downside is that they may deteriorate more quickly?

A. Well, anybody who's practised acute paediatrics will certainly testify to that, sir.

THE CHAIRMAN: But Claire was a girl who had been in hospital from Monday evening, was being treated with drugs for both status epilepticus and for encephalitis.

A. Yes. Either of which can be a rapidly fatal condition.

THE CHAIRMAN: She was being treated by Dr Webb, she was given drugs for both of those conditions.

A. Yes.

THE CHAIRMAN: So does that not make the prospect of her being overwhelmed within the space of a few hours lower? The risk is lower because she's actually being treated with drugs for those conditions?

A. I can't give you a percentage, 90 per cent. I would say most children with seizures are managed outside the paediatric intensive care unit. There are currently eight beds for every child in Northern Ireland who could become critically ill and often we go over those eight beds. We're trying to go up at the moment to 12 beds because of the need, and if I were on the wards, I would admit every child to intensive care because of my

knowledge of what I see being the tip of the iceberg with very sick children. But I don't think any doctor or nurse has the skills to definitively say which child is going to get through the seizures and through the encephalopathy without referral to intensive care. It's one of the difficulties that I have when a doctor asks me to go and visit a ward in casualty or on the ward and assess the child for intensive care treatment.

THE CHAIRMAN: What I'm asking you really is a slight variation on that. I understand from a lot of the evidence which has been given over the last few weeks here that encephalitis and status epilepticus are comparatively unusual, but they're very, very dangerous, and that --

A. Yes.

THE CHAIRMAN: -- each of them can cause a comparatively quick death in their worst forms; right?

A. I'd agree with that, yes.

THE CHAIRMAN: That explains, I think at least in part, why Dr Webb was so conscientious on that Tuesday afternoon by repeatedly coming back.

A. Yes.

THE CHAIRMAN: But once he starts, as he did, to treat Claire for both of those conditions and as he steps up, for instance, the anticonvulsant and as he starts the

acyclovir, don't those treatments reduce the prospect that Claire is going to be overwhelmed because she's actually been treated for these conditions, which can have such a disastrous effect on a child's health?

A. If you want me to comment, it's outside my clinical area of expertise to comment on neurological conditions.

THE CHAIRMAN: The point I'm getting to is: surely in that scenario, Claire is less likely to be overcome in a very short time by those conditions, since she has already been treated for them, as compared to a child in whom the set in more quickly and has not been treated for them. The point of giving her the drugs is to prevent this disastrous effect.

A. I understand.

THE CHAIRMAN: If she is being treated for those conditions and still deteriorates, as she did, then it should raise question marks about whether in fact that diagnosis was the correct one, at least to the point where you want to verify it.

A. I don't think it necessarily follows, with respect, sir, that a child who has got a chronic condition lasting several hours can still deteriorate as a child with an acute rapidly deteriorating condition.

THE CHAIRMAN: Okay.

A. And as an intensivist, you're asking the wrong person

because I would go to the ward and pick up lots of children who are at risk of sudden death and fill five intensive care units, but the clinicians who have more knowledge about which children can get through certain illnesses will make the decision whether they want to phone the intensivist to make an assessment of their child.

THE CHAIRMAN: Okay, thank you.

MR QUINN: Mr Chairman, if I can come in on this point while this point is being aired. At page 92 of the [draft] transcript today, lines 8 and 9, the question that the Roberts family are concerned about is what you led up to, Mr Chairman:

"Does that not strike you as surprising?"

It's page 92, lines 6, 7, 8, and 9 is the lead into it. It's about lowering the bar for referral to the coroner:

"Does that not strike you as very surprising?"

Meaning: does it not strike you as surprising that this case was not referred to the coroner? That question wasn't really answered because he then discussed the difficulties with treating children on a paediatric ward and how they go down quickly and come up again quickly, but he didn't really answer that question, with respect, and that was the question that

the Roberts were very concerned about.

THE CHAIRMAN: Yes. Can I take you back to that, Dr Taylor? It is the decision -- and I do understand from what we have heard that the bar is now set lower for referrals to the coroner, the coroner has more cases referred to him now than he did in the mid-1990s.

A. Yes.

THE CHAIRMAN: Even allowing for the bar being somewhat higher then than it is now, do you not find it surprising that Claire's case was not referred to the coroner in 1996? Sorry, let me add one more point. There was no resistance from Mr and Mrs Roberts. They weren't resisting post-mortems or a referral to the coroner. This was all led from within the Royal.

A. With respect, the parents wouldn't be part of the decision to refer to the coroner.

THE CHAIRMAN: Yes.

A. That's between the doctors and --

THE CHAIRMAN: Right. So the decision not to refer Claire's death to the coroner is taken entirely independently of the parents?

A. It has to be.

THE CHAIRMAN: Let's go back to the question. Knowing what you now know about Claire's case, isn't it still surprising that, in 1996, her death was not referred to

the coroner?

A. Knowing what we now know in retrospect, it should have been. I would have expected it to be discussed with the medical adviser, who wasn't present in 1996.

THE CHAIRMAN: That's not what I'm asking you. I'm asking you something different. I'm not asking you about what would happen today. For you to contact the medical adviser at all, that means you're considering referring it to the coroner, doesn't it?

A. Yes. You're having difficulty writing a death certificate.

THE CHAIRMAN: Yes.

A. So you would obviously want to discuss it.

THE CHAIRMAN: You see, when I asked Dr Hicks about this earlier today, she really could give no explanation for the decision not to refer Claire's death to the coroner.

A. I have to add another difficulty that we have in the clinical circumstance, even today, sir, which is contacting the coroner out of hours.

THE CHAIRMAN: But again, that's a problem which only arises once you decide you're going to contact the coroner.

A. That's correct.

THE CHAIRMAN: The point here is there was no contact with the coroner. There was no attempt at contact with the coroner. A decision was taken in the early hours of

Wednesday morning, before any brainstem testing, that Claire's death would not be referred to the coroner and that there would be a brain-only autopsy. And that's a feature of what happened to Claire, which I have great difficulty in understanding.

A. I understand.

THE CHAIRMAN: I'm not asking you to repeat what you have said before, but can you help me understand that beyond anything that you have said before?

A. No.

MR QUINN: Does that mean he is saying that he does find it surprising that it wasn't reported to the coroner?

THE CHAIRMAN: Dr Hicks says it was surprising.

MR QUINN: But does this witness say it is surprising? He still hasn't answered the question.

THE CHAIRMAN: Do you find it surprising that Claire's death was not referred to the coroner?

A. From retrospect, from what I believe now -- [OVERSPEAKING].

MR QUINN: Sorry for overspeaking, but this --

THE CHAIRMAN: Not with hindsight --

MR QUINN: Not with hindsight --

THE CHAIRMAN: Knowing --

MR UBEROI: The witness has attempted to answer and there's confusion over when knowledge occurs. He said that

knowing now what he knows about the facts of Claire Roberts, he was surprised that the case wasn't referred, as I understood his answer.

THE CHAIRMAN: But knowing now what we know includes what was learnt at the coroner's inquest, which eventually took place. So knowing what we now know doesn't answer the question. Saying "with the benefit of hindsight" doesn't answer the question because some of what we know now -- some of it -- came out at the inquest, so we can't say: because there was an inquest, I now think there should have been an inquest earlier. What I'm really saying -- and Dr Hicks really didn't have much difficulty dealing with this this morning, Mr Uberoi.

I'm trying to clarify with Dr Taylor what his position is. At that time, given the apparently sudden deterioration in Claire's condition, consultants who had limited concern about her health -- and I don't mean that in any pejorative sense -- I mean limited concern in that they were not immediately worried that her condition was going to deteriorate with the result that she would die. They both expected to come back into hospital on Wednesday morning and to find Claire still there on Allen Ward. Instead, the decision is taken at that time before any brainstem testing not to refer to the coroner. And that's what I'm asking Dr Taylor, does

that surprise him by the standards of 1996 and what was available on these notes and records in 1996.

MR UBEROI: I understand the question, sir. I would simply raise -- I may have misunderstood, but I was under the impression he had answered it; he may not have done. I do understand the difference between today and 1996.

THE CHAIRMAN: Can I ask you one more time on this, Dr Taylor.

A. I'm certainly not trying to avoid the question, I'm just having difficulty trying to remember what the practice was in 1996. I believe the practice in 1996 ...

MR UBEROI: Sorry, the witness was distracted there by some comments. I think the witness needs to be asked the question and then he needs to answer it and then we need to move on, would be my suggestion.

A. I'm trying to answer why I would have referred the case in 1996 or been involved in that decision. To answer that, it's hard to remember back to what the practice was in 1996 because it has changed so much with medical advisers and, as you said, the bar being lowered. If the bar's being lowered now to what we report to the coroner, the bar was theoretically higher by definition to where it was in 1996. The key element in referring or not, referring a case to the coroner, is: can the clinicians write with confidence a death certificate?

If the clinicians can write a death certificate and have a known cause of death and, on the back of the death certificate, there's a box to tick to say if further information is found, for instance at post-mortem, the death certificate can be amended. That's on every death certificate.

THE CHAIRMAN: But doctor, my question is how could they be confident?

A. I don't know.

THE CHAIRMAN: How could they have been confident at 3 or 4 in the morning?

A. I don't know. I'm trying to picture the practice in 1996. If the clinicians are confident about writing a cause of death on a death certificate, they wouldn't refer it to the coroner.

THE CHAIRMAN: To have that necessary information, either one or both clinicians who went home at about 6 o'clock on Tuesday evening, expecting to see Claire in hospital on Wednesday morning and not having warned her parents that she was in serious jeopardy of dying, then have to come back in at 3 or 4 in the morning and say, "Oh well, we know what happened here, it's perfectly clear to us, therefore we can complete a death certificate without referral to the coroner". That's what has to happen, doesn't it? They have to have that degree of confidence

in order to do that?

A. That's correct, and there's an element of subjectivity rather than objectivity involved in that decision.

MR STEWART: Would you be surprised to hear that the death certificate was completed without reference to encephalitis?

A. It's hard to use the word "surprised" in that. I'm trying to reflect on what the practice was, and the requirement to phone the coroner in 1996. It's different.

THE CHAIRMAN: No, that's not the point, I think, with respect. You have said that in 1995 and 1996 there were a number of deaths which no longer occur now because of things like encephalitis, and that can explain a sudden dreadful deterioration in a child's health, which causes her death.

A. Yes.

THE CHAIRMAN: Right. So if that is a putative explanation for not referring Claire's death to the coroner, one would then expect to find encephalitis on the death certificate.

A. Yes.

THE CHAIRMAN: But it's not. It's not on the death certificate.

A. I understand.

THE CHAIRMAN: So they didn't decide not to refer Claire's death to the coroner because of encephalitis. You agree?
A. I didn't know what was on the death certificate.
THE CHAIRMAN: Yes. So you can't say, "She died of encephalitis, that's why we're not going to refer it to the coroner" if you then don't put encephalitis on the death certificate.
A. Yes.
MR STEWART: Just one more thing. Can I ask for document WS012/2, page 26, to be shown? This is an autopsy request form filled out in respect of the patient Adam Strain. Is that your handwriting?
A. I believe so, yes.
Q. This was in Adam Strain's case. And over the page, please, to 28. If those pages could be placed side by side, you'll see that you started to request a hospital autopsy for Adam Strain, but you decided better; is that right? Why did you stop completing this form?
A. Sorry, which terms? I don't understand the question, sorry.
Q. The question is: that is your handwriting?
A. Yes.
Q. And the form is not completed?
A. Yes.

Q. You stopped the process of completion of the form.
A. I was unable to complete the death certificate element because it says if a death certificate has already been prepared ... So obviously it hadn't been prepared because it was a coroner's case, so I didn't complete that part. That's an optional part on the second page.
Q. "If a death certificate has already been prepared, copy below".
A. Yes.
Q. And you were not prepared to issue the death certificate --
A. You can't write a death certificate in advance of a coroner's case. It would be ridiculous.
Q. You can issue a medical certificate of cause of death. Why were you filling this out if there was a referral to the coroner?
A. Because this is an autopsy request form, this is the same form we use for forensic post-mortems or hospital post-mortems.
Q. I thought that a coroner directed his own autopsy and that this is a request for the hospital to perform an autopsy.
A. Under the direction of the coroner. I think Dr Armour explained, if I can remember, that the clinician has to complete as much clinical information as possible to

enable her to conduct the autopsy, whether it's a coroner's autopsy or a hospital post-mortem.
Q. Why did you not then complete the form anyway, if you were providing information, and sign it, if that was the basis on which this form was filled in?
A. I --
Q. Why didn't you sign it?
A. I completed it --
MR UBEROI: I'm very puzzled and slightly concerned, on the question of fairness, why we're going back to questions of Adam Strain in governance. This witness has been cross-examined on matters to do with Adam Strain's governance. He has answered the question as best he can already. As I say, I'm puzzled as to why a cross-examination on the basis of a matter pertaining to Adam Strain governance is being raised now at this point.
MR STEWART: Because, on the face of it, it would appear as though Dr Taylor was wrestling with the question about whether or not an autopsy should be requested in hospital or, perhaps not, and allow the coroner to pursue an autopsy.
MR UBEROI: Wrestling with the question in relation to Adam Strain? This is the Claire Roberts governance hearings and this witness has already been

cross-examined on governance in relation to Adam Strain. I don't follow where this can take us at this stage.
MR STEWART: The relevance is that this is an issue he's talked about before.
MR UBEROI: That's my point.
THE CHAIRMAN: You're contrasting it to Claire's case?
MR STEWART: Yes. I'm saying that if Dr Taylor had considered the issues before in a hyponatraemia case and had thought about them, then perhaps it should have been at the forefront of his mind when it came to this case and that he ought to intervene and suggest that a referral to the coroner --
THE CHAIRMAN: So I think that's getting to the point about why, although Dr Taylor had such a limited role in relation to Claire, he didn't proactively intervene and suggest a referral to the coroner.
MR STEWART: Yes.
THE CHAIRMAN: I think that question is appropriate, Mr Uberoi.
MR UBEROI: It is, and if that's the question, I'd be grateful if that's the question that's put.
THE CHAIRMAN: Do you understand, Dr Taylor? The question is: knowing what you did about Adam's case and knowing what you must have picked up about Claire's case, despite your limited involvement, why did you not

proactively intervene and say that Claire's was a case which should be referred to the coroner?
A. I think I've answered the question before. I was in PICU on the day Claire died. I looked after her amongst my other PICU patients. My involvement with her, clinically, was to prepare her from the first set of brainstem tests to the second set of brainstem tests. I don't recall any conversation I had with the other clinicians involved and it was only after my duties finished around 5.30 that day that the other doctors convened and performed the brainstem tests and made the decision about death certification. I do not believe I was involved or ... I was not cognizant with her underlying diagnosis, that was a neurological paediatric diagnosis. I'm not a trained paediatrician, nor a neurologist. I'm an anaesthetist by training and that's a decision I would have left to the more appropriate authorities.
THE CHAIRMAN: Okay. It's 1.10. You have some other issues to cover.
MR STEWART: Indeed, sir.
THE CHAIRMAN: Let's take a break until 2 o'clock, ladies and gentlemen.
Have you managed to make contact yet at all with Professor Young or Dr Webb about your privilege?

MR McALINDEN: They have been informed of the situation. We're just waiting for their responses. Hopefully we should be able to inform you at 2 pm.
THE CHAIRMAN: Thank you very much.
(1.13 pm)
(The Short Adjournment)
(2.00 pm)
THE CHAIRMAN: Mr McAlinden, any word?
MR McALINDEN: I'm still waiting for my instructing solicitor to ascertain the position.
THE CHAIRMAN: Okay, thank you. Mr Stewart?
MR STEWART: Thank you, sir.
Dr Taylor, following on from what we were discussing before lunch and if you didn't pick up in PICU that hyponatraemia was involved in Claire Roberts' death, I wonder, did you pick it up at the audit stage? You were, from December 1996, the coordinator of the audit programme in the Children's Hospital --
A. Yes.
Q. -- and you were something of an enthusiast for audit.
A. Clinical audit, yes.
Q. And indeed, an expert on it: you had published on audit.
A. Well, I sent some audit projects to the audit committee.
Q. If we look at your CV at page 306-019-012. In fact, at 10 there, we see that there is a submission by you of

"Audit in paediatric intensive care deaths" in February of that year. Was that a publication or what was that?
A. Well, if you read on, it says, "Submitted to the medical audit department".
Q. Yes. Describe what that work was.
A. Well, that was related to a paper that I'd read in the Journal of Medical Ethics from a PICU in England, and they actually looked at the deaths of an intensive care unit over a period of a year, and they looked at the number of patients who had died despite full intensive care, despite everything, and then looked at the patients who had died having treatment withheld or withdrawn. So I repeated a similar design for Belfast really to look at our practice to see if we were in keeping with a similar UK paediatric intensive care unit, and I believe the results were very similar: about 50 per cent of the children who died, unfortunately died despite full intensive care management. So all the ventilation, the drugs, the antibiotics, everything that could be given was given, and despite that, about half the children died. That was similar to the other intensive care unit that had published in the Journal of Medical Ethics.
And the other 50 per cent of children who died had treatment either withdrawn or withheld and, again, that

was similar to our experience in Belfast. And the children who were brainstem dead with treatment withdrawn and some children who, after discussion with the parents, didn't wish their child to be -- didn't wish any further aggressive treatment to be given to their child. So they agreed to withholding certain medical treatments. We managed those children in, obviously, a very sensitive manner, but they died in that manner.
That was an audit to compare our standards to the UK standards, to what was really the only publication in that area that I could find.
Q. So that's really a benchmarking exercise, is it?
A. That's what audit is.
Q. Yes.
A. Audit is comparing your outcomes to a guideline or a publication or some sort of standard that one can find.
Q. Yes, and so all these pieces of work listed here on this page and the preceding page, they're all examples of your work in this area of audit?
A. Of clinical audit, yes.
Q. Would it be correct to describe you as something of an evangelist for audit at that time?
A. No, I wouldn't dare describe myself as an evangelist.

Q. What term would you have used?
A. I was a person who was keen on audit.
THE CHAIRMAN: On the basis that it's important to learn lessons and it's important to know how we compare with other parts of the UK?
A. Yes. I think working in a provincial area -- if you can call Belfast a provincial area -- I attended every Paediatric Intensive Care Society meeting in the UK -- it visits different cities; this year it was in Dublin -- and talking to colleagues and networking with various ... presenting some papers. If you read my CV, I presented some at the PICS meeting.
I was very concerned that Belfast had the resources and the outcomes, really. I mean, that's what it boils down to. That we were not -- for our patients and for our staff to ensure that we weren't slipping behind what might be expected in the UK, if not Europe.
MR STEWART: So when you became audit coordinator in succession to Dr Shields in December 1996, what did that role entail?
A. That role entailed many elements. Of course, it was a voluntary appointment, it wasn't a job. I was continued in a full-time, quite busy specialty. But it involved chairing the audit half-days, according to a rolling calendar that was published by the Eastern

Health & Social Care Board. It involved facilitating other projects from other clinicians. It ensured coordinating -- so as audit coordinator, audit facilitator and audit chairman -- to ensure one doctor wasn't repeating the work of another doctor, that they could get together to make sure that the clinical audit department of the Royal Trust, at that stage, wasn't overwhelmed with requests for chart reviews and pulling charts and the secretarial and clerical duties that that audit department ... I believe Dr O'Connor had said -- and I agree with him -- it was a little bit under-resourced, to put it mildly, in those days. So we had to make sure that the projects were coordinated to make sure we didn't completely overwhelm the Trust's ability to meet the demand.
Q. And in terms of auditing the mortality cases, how were those cases selected for audit?
A. Number one, they weren't audited. Clinical audit is, as I've already described, you pick a national standard, whatever that may be, Caesarean sections, whatever your area is, and you compare your own practice to the practice that's in publication. Obviously, you want to get a good guideline, the NICE guidelines, or some other important standard that you would pick. You would audit through a series of statistical analyses, you would look

at your own practice, and if your own practice didn't meet the standard that was set by some authority, then you had an action plan, you implemented an action plan that would re-audit and bring you up to those national standards. So that's what I understood and that's what I practised with clinical audit.
Q. All right.
A. You are talking about mortality review.
Q. Lest there be no misunderstanding: were you responsible for the mortality meetings?
A. I was chairing the audit half-day. For the first hour-ish of that audit half-day, each and every case of death in the Children's Hospital was presented by the consultant and I chaired that meeting.
Q. Was Claire Roberts' death discussed at a mortality meeting?
A. I have no recollection of her death being discussed, but it would have been practice for her death to be discussed because every child's death -- certainly when I took over as audit facilitator, audit lead person in the children's directorate, I -- my secretary -- sorry, the PICU secretary who I asked to undertake the coordinating role for mortality, she was very fastidious at her job and she would ensure that each and every case was given a date for presentation.

Q. You would know quite quickly if a death had not been reviewed at a mortality meeting, wouldn't you, because there are only so many deaths per year and so many deaths considered?
A. The PICU secretary took on that role and responsibility for me.
Q. Is it possible that her death was not discussed at a mortality meeting?
A. Well, anything's possible.
Q. All right --
A. But it was my and her particular business to ensure that each and every death was discussed in a systematic way.
THE CHAIRMAN: Is that every death in PICU or every death of a child?
A. Most deaths will occur in PICU, some deaths occur in A&E, and very rarely would a death occur on the wards. Mostly, the children would be brought, however briefly, to intensive care before they died.
MR STEWART: Is there any way of establishing whether or not her case was discussed at a mortality meeting?
A. The PICU secretary would keep a record of every case that was presented.
Q. Because the inquiry has been keen to find out and has entered into correspondence and has asked people, and first of all, with the exception of Dr McKaigue, who

believes he recalls being present at a mortality meeting where her case was discussed, Doctors Steen, Webb, Herron, Sands, Bartholome, can't recall, and nor can you. Have you yourself made any attempt to find the PICU secretary?

A. My PICU secretary retired this summer and she -- I believe the Trust asked her to look into her records to see if the death of Claire was discussed at the audit, and I don't believe she was able to find that. But then, you'll have to remember the context. I took over as clinical audit lead, as you already know, in December 1996. I quickly realised that I was going to be very busy coordinating and facilitating the audits, so at some stage after December 1996 I asked the PICU secretary to undertake -- I don't know who did it before, the previous audit facilitator. But she at some stage then, in 1997, started maintaining a record and coordinating the actual mortality reviews.

So if a presentation was in late 1996 or very early 1997, then it may be that she hadn't really got up to speed in that role. For instance, she would, I believe, have asked her line manager before -- a doctor can ask a secretary to take on a different role or an increased role, but the secretary may well, not very politely, say that she is not able to take on that extra role without

her line manager authorising the increased duties and whatever goes along with that.

Q. Would it be fair to assume that a mortality meeting would not occur until after the autopsy report was available?

A. I believe it was the practice of the PICU secretary to wait for all the reports to be finalised. It's very embarrassing for the clinician and for others to be present at a meeting when the final outcome is -- particularly if you remember the mortality was a review of the death, it wasn't an investigation into the death. It was a review of the finality or the final statements, reports.

Q. The autopsy report in Claire Roberts' case became available towards the middle of February of 1997.

A. Yes.

Q. And if the mortality meeting awaited the receipt of that report, the meeting would presumably have been towards the end of February or into March 1997. Therefore, the PICU secretary would have recorded her death being reviewed.

A. Well, as I said a few moments ago, the PICU secretary, I asked to take over that role -- I believe there was a period before she took on that role where she had to sort out some administrative niceties with her line

manager to ensure that she wasn't taking on a role that wasn't supported by the Trust.

THE CHAIRMAN: Doctor --

A. I don't know when she actually started recording.

THE CHAIRMAN: Let's assume for the moment that Claire's death was reviewed at one of these meetings. What would that review entail?

A. The review in generic terms?

THE CHAIRMAN: If you can explain what would have been reviewed -- would the presentation have been by Dr Steen?

A. The presentation was by the person who knew the patient best or the person present at the time of the patient's death.

THE CHAIRMAN: That immediately begs the question -- because Dr Steen was the named consultant, but did not see Claire until she was in PICU. On the other hand, Dr Webb, who was not the named consultant, had actively intervened and had seen Claire a number of times.

A. Yes.

THE CHAIRMAN: Who would that lead to do the presentation?

A. Well, as I say, she wasn't the only case where there may have been one or more -- more than one consultant involved and even the lead consultant ... If I am on tonight, my name goes on the chart as the admitting

consultant, but I may not have much clinical responsibility for that patient next week when the patient may die, but I will be nominated as the admitting consultant.

THE CHAIRMAN: Who does the presentation?

A. The first thing my secretary, I believe, would have done would be to go through the chart and find all the names of the consultants and then track down to see -- and I believe -- I remember there being times when she would come to me and say -- I'm not talking about Claire because I can't remember, but I do remember other cases where there were a multitude of consultants involved in a patient's care and I would work through her and the different consultants to work out which one of them would take on the responsibility of presenting and it was usually done very amicably.

THE CHAIRMAN: So the presentation would either be done, in all probability, by either Dr Webb or Dr Steen?

A. Yes.

THE CHAIRMAN: Okay. And what does that presentation go into?

A. The presentation, in generic terms, usually would follow the pattern of the -- a chronological discourse of the patient's past medical history, reason for presentation for the final illness, as it were, and then the issues

around the death and the cause of death, any X-rays, CT scans, blood results and investigations and autopsy reports or coroners' inquests reports would all be presented in order. That's the usual --

THE CHAIRMAN: Right. If in the course of that it emerges that for instance Dr Bartholome was called to see Claire, couldn't see her because she was so busy and there was a gap of about three hours or so, is that the sort of thing that would come out at a review?

A. It may well come out, but remember the review is really following the investigation, it's an element of postgraduate learning that is done to a mixed audience of cardiologists, neurologists, nephrologists, anaesthetists, whoever is present then. So it's a mishmash of 20 or 30 --

THE CHAIRMAN: Pathologists?

A. Pathologists. My PICU secretary would invite the pathologist if there was an autopsy report.

THE CHAIRMAN: So if Dr Steen or Dr Webb was under the impression that encephalitis was a contributory cause of Claire's death then Dr Herron as the pathologist would be able to say, "That's not right because the evidence of encephalitis which we found on the autopsy report shows that it wasn't nearly at the level which would be required for it to be a contributory cause".

A. Right.

THE CHAIRMAN: That's the sort of thing that would be discussed? Except the problem is that nobody can remember any such discussion at all.

A. Yes.

THE CHAIRMAN: Is that the sort of exchange which we've been told can sometimes spark a fairly lively and fairly blunt debate between the various people who were or were not involved in the treatment of the child?

A. Well, I worked in Toronto for two years in the late 80s, and the grand rounds and the mortality presentations were, as you describe, a bear pit. They were very open and very occasionally led to clinical disagreement and a heated exchange of views. My role as the audit facilitator and chairman of this particular meeting was to ensure that a reasoned set of discussions did take place. I wouldn't say they were heated, but there was certainly an exchange of views and it was my job to make sure that everybody didn't speak at once and also to keep time. It would be usual to have two to three presentations in that first hour of the audit half-day.

THE CHAIRMAN: Do I understand it correctly that the discussions are deliberately not minuted in order to encourage free expression?

A. Well, when I took over as audit coordinator, that was

one of the things that was passed on to me, was to say that there should be no minute kept of the meeting, of each case.

THE CHAIRMAN: Is that still the position?

A. There's currently guidance coming through from the Trust. We had a presentation at the last audit meeting but one, where a doctor presented the guidelines that are under consultation at the moment to minute the mortality aspect of the meetings.

THE CHAIRMAN: Thank you.

MR UBEROI: Sir, may I just say at this point, if you're establishing a clearer picture of these mortality meetings, I don't know whether you wish to establish with this witness where the notes would have been during the presentation, how many copies of the notes there were in the presentation? I don't know if that's the sort of factual evidence which you're interested in.

THE CHAIRMAN: Clinical notes and records?

MR UBEROI: Yes.

THE CHAIRMAN: Presumably whoever did the presentation would have worked their way through the clinical notes and records.

A. Yes, as I said my secretary was particularly fastidious. She didn't want to get any complaint that some of the notes weren't present. So she would wait until all the

notes were filed in chronological order, all the investigations were all collated, and she worked hard to make sure -- and it was hard work to make sure that the relevant clinicians, including the pathologist, was there on that particular day. Everybody had different duties that day. As I say, I was the chairman and lead of the audit, but it may be I was on for PICU that audit day so I would have had clinical responsibilities and I wouldn't have been able to chair either the start of the meeting or the end of the meeting.

THE CHAIRMAN: Right, but the presentation can only make sense if the person who does the presentation has worked his or her way through the reports and records so that the presentation is as full and complete as it needs to be.

A. That was the way the PICU secretary organised it and that was the way the clinicians wanted it to be organised.

THE CHAIRMAN: When you get to the meeting -- and let's suppose here it is Dr Steen; it doesn't matter whether it was Dr Steen or Dr Webb -- that person will have the records to hand, will they?

A. The PICU secretary ensured that the records were there for the consultant.

THE CHAIRMAN: Will anybody have copies of them?

A. No. It was very -- I don't remember any cases presented where copies were handed out to the clinicians present.
THE CHAIRMAN: Okay.
A. Very often an acetate was made of a summary of the patient. In those days, we didn't all have Powerpoint back in the mid-1990s. It was a teaching, education centre that we used in the hospital, the function room, and, at some stage in the 1990s, a Powerpoint projector was purchased and doctors usually summarised slides, a slide show of their case.
THE CHAIRMAN: Mr Fortune?
MR FORTUNE: Sir, Dr Taylor's just referred to the last-but-one audit meeting when a set of guidelines in draft was presented. It may be interesting for you to find out when that last-but-one audit meeting was and whether it has any connection in time to the fact that you've been sitting for many weeks now.
THE CHAIRMAN: Can you help on that, doctor?
A. I believe the Trust is being proactive to ensure that things are being documented in a way that perhaps pre-empts the inquiry.
THE CHAIRMAN: Does that come out -- is that within the Belfast Trust --
A. I'm not -- I don't know that for certain. That's my presumption.

THE CHAIRMAN: That could come from -- if they're pre-empting anything here, great. They don't need to wait for a report from me. That's one option. The other possibility is that it is coming from either the department centrally, the Department of Health, or alternatively from any one of the Royal Colleges or the GMC.
A. I can't illuminate you any further. I just know I was present at an audit meeting and a doctor presented the draft guidelines to suggest that -- and there was a range of debate again; the consultants don't sit quietly. There was a range of debate about keeping the status quo, not recording the minutes. Because this is -- I have to state quite clearly to you, sir, that the mortality section of audit is not an audit of the clinical records, it is not an investigation of the death; it is a review following the completion of any investigation that has been undertaken and the finality is presented to the consultants for the purposes of learning from that death.
MR UBEROI: Our LiveNote has frozen. I don't know if I might send out a plea for some assistance.
MR STEWART: If there is a misunderstanding between the terms "mortality meeting" and "audit", is it because mortality meetings are conducted under the heading of

"medical audit meeting"?
A. Sorry?
MR UBEROI: Can we see the document that's being referred to in fairness to the witness?
MR STEWART: All right. I will come to that in just a second. If I may ask you two questions first. If, at the mortality meeting, only the person presenting the case has the notes and records, how can other people examine the case in any meaningful way?
A. Because sir, with great respect, it's not an examination of the death; it's a review of the cause of the death in the Children's Hospital so that the doctors may learn that the case has been concluded and this is the final outcome of the cause of death. That helps to educate the doctors present that a child with diabetes or hyponatraemia has died within the hospital.
Q. The reason I ask is that a proper examination of the notes in this case would have revealed two potentially serious medication overdoses. What is the point of having a mortality meeting when people don't have the opportunity to look for the causes of death from the notes?
A. Well, sir, there are other methods of investigating death in a hospital. They were being very -- evolved and formative and, obviously, inadequate back in 1996,

but a serious adverse incident will now be triggered by such a case, I believe, as Claire and Adam. That would involve an investigation of those notes. Following that investigation internally, they will go on to be reviewed externally.
Q. May we confine ourselves to 1996?
A. Yes, sir.
Q. What review of Claire's notes would have been conducted in 1996 to see if everything was all right or lessons could be learned?
A. Well, it wasn't during the mortality meeting --
Q. Right.
A. -- because that was not convened. The people coming to the audit half-day were not the people who were trained and experienced and given up to exploring such matters.
THE CHAIRMAN: Sorry --
A. It was a review of the death.
THE CHAIRMAN: I'm a bit lost then because I can't understand. If it's not an investigation, it's a review, as bald as that, how anybody gets excited at these meetings. If I understand you correctly, you're not challenging what was done or not done, it's simply a report to a meeting that a child has died and this is the cause of death.
A. That's correct.

THE CHAIRMAN: So what's to get excited about?
A. I can give you some examples of things that did change because of these mortality meetings, and there are several that I remember during my short time as the audit lead. One was -- and it has already been referred to I think in a private witness statement from Dr Shields.

Several cases came through, if you like, to say as a cluster of deaths around meningococcal disease, meningitis. These were reported during that and the cause of death was known. When we frequently have to phone the coroner following the tragic death of a child with meningitis -- and it's very rarely in my experience that the coroner requests that there is a coroner's case involved. Nearly always the advice, in my experience, is to complete a death certificate and not go down the coronial system. Those cases are brought for review at the mortality meeting outside the coronial system. Any adverse event that occurred during that is clarified by the clinicians involved in that case. The paediatrician would review what antibiotics were given, what treatment was given. We, in intensive care, would look to make sure that the patient was adequately treated in intensive care. Then they would be presented at the mortality review.

During a discourse of that review, people would perhaps say, "I remember previous deaths similar to this", and maybe putting the system together, doctors in community practice would say, "I'm meeting mummies who are concerned about their child developing a rash and developing neck stiffness". So they would want to know what they could tell their parents.
THE CHAIRMAN: That's --
A. And together -- we got together and made a Northern Ireland guideline.
THE CHAIRMAN: On meningococcal disease?
A. On meningococcal disease. That was part of my sick child liaison group, which you've asked about. Not long after those cases were brought to the mortality review, not having undergone serious adverse incident reviews, but clearly where practice was -- deaths occurred and perhaps practice -- whether in primary care, whether in recognition of the illness or whether in the hospital care -- did the patient move smoothly through the A&E, and the theatre and the intensive care, those were reviewed, put through as a guideline and subjected, as you can see, to a clinical audit project where we looked at the standards to see if the guideline was actually making any difference. And I believe we did reduce our mortality with a very serious paediatric condition.

THE CHAIRMAN: Okay, thank you.
A. There are other cases such as children who were born with congenital abnormalities and I arranged for the neonatologists and the obstetricians to meet with us in a joint meeting so that we could work together to make sure that mummies were told that their child had a potentially fatal birth defect and so that the obstetrician would work with the neonatologist, who would be initially resuscitating that baby and then the baby would come to us for, perhaps, surgery. For it all to work together, a joint audit review mortality meeting -- I facilitated to make sure that we were all making sure that these children got the best chance of survival.
THE CHAIRMAN: Is this an extended spin-off from a mortality review in the first place?
A. This is all related to mortality. The children that we present at mortality, people would say this child died with a 50 per cent mortality of a very serious congenital defect. Some doctor would say, "But the mummy was very upset, maybe the information she had been given during antenatal care by the midwife or by the obstetrician hadn't prepared her adequately", and that would be brought through from people attending the meeting, and to make things better, even if we couldn't

impact or improve survival of the babies, at least we could better inform the clinicians and the parents of future infants.

So I believe that the mortality review did make big differences to the quality of care and perhaps even survival of children, not only in the paediatric hospital, but also in the regional maternity hospital. That was during my time as tenure.
THE CHAIRMAN: Right. Mr Fortune?
MR FORTUNE: Sir, do forgive me. You said a few moments ago that you were lost. I thought I was the only one who was lost. If I look at Dr McKaigue's witness statement, about which we will hear tomorrow when he gives evidence, WS156/2, at page 6. At the top in the second paragraph, Dr McKaigue refers to Dr Steen presenting Claire's death at the audit meeting at which he, Dr McKaigue, was present. And if you go down to question 24:

"I cannot recall if the pathologist was present at the audit meeting when Claire's death was presented."

At 26, Dr McKaigue says:

"When Dr Taylor was audit coordinator in the Royal, his role at audit meetings was as a facilitator. This did not exclude him from contributing to discussions."

My question to you, sir, and ultimately to

Dr Taylor, is: is Dr McKaigue talking about the mortality meeting or something completely different, or is the meeting known by more than one name, and if so, is it minuted? To that extent, I'm totally lost.

MR STEWART: May I assist perhaps? 305-011-591.

MR UBEROI: [Inaudible: no microphone] interject as well? I'm not really sure anyone is lost. The witness has offered his evidence, which is effectively that there were the clinical audit meetings and the mortality meetings were a sub-section of that. He has been very clear on that and he has just offered you some examples of some of the things that came from them. I'm lost as to why Mr Fortune is lost.

MR FORTUNE: Before the blind leads the blind, what was discussed at a clinical audit meeting that wasn't discussed at a mortality meeting, or vice versa, and were there records provided to all the clinicians at one or other?

MR UBEROI: Dr Taylor has offered his evidence on precisely that point, his definition of what the clinical audit aspect of things was, and he has very been clear on the fact that the clinical audit was not the same as the investigation into a death. He has talked about the benchmarking process and how clinical audit involves the recognition and benchmarking of trends. That's the

evidence.

MR STEWART: This document is the minute of the first meeting you chaired as audit coordinator on 10 December 1996. This was shared with us by the DLS on the basis that this may well have been the meeting at which Claire's case was discussed, although it seems unlikely.

THE CHAIRMAN: Even if it's not, it's a minute of an audit meeting.

MR STEWART: Yes, indeed, and it's useful because it starts off with Dr Shields handing over the role of audit coordinator to Dr Taylor. And following that, a discussion ensued about the future running of the audit programme, with it being noted that the audit meetings should start as usual with the mortality meeting:

"Each case presentation should have a time limit and the consultant supervising the case should have the opportunity to express problem areas in the management of the case in a non-hostile environment and those presenting cases should indicate to Dr Taylor how long they will require."

So that's the type of format of a meeting. You've had the mortality discussions first.

A. Yes.

Q. How long would they have lasted?

A. Approximately an hour, depending on the amount of cases.

Q. Each?

A. No, the whole element of mortality would last an hour.

Q. So that would be no matter whether there was one death to discuss or four? It would last an hour?

A. I don't think there was ever just one.

Q. Okay. How many would be on average?

A. Two to three is my memory.

Q. And that would all be done in the space of an hour?

A. I wouldn't put on any more than about three, certainly. But one would look at them in advance and if there was no -- if the child had died after a complex illness and there was no controversy or difficulties that one would expect to be ... I don't know how to put this, but if they were going to be short cases presented, one would have some anticipatory knowledge of what would be a quick case and what would tend to take a lot longer. And as I said, perhaps babies born in the neonatal nursery with major congenital defects who were known to be unlikely to survive, then perhaps the meeting wouldn't take very, very long. Having said that, we did get some surprises and perhaps areas did open up many times that -- although this baby was expected to die, some doctor or nurse would say, "But that's not what mummy was told", and that would lead us to then

investigate a better way of educating not only the paediatricians because we don't come in contact with pregnant women very often, but very often then ... I got a feeling from those present that to take this any further forward -- and that certainly Dr Hicks was very supportive of a joint audit with the Royal Maternity Hospital consultants, which would include obstetricians, midwives and neonatologists, because without putting them all together, the messages do not get back.

THE CHAIRMAN: Does that lead on to point 2 then:

"The directorate should continue doing three or four multi-professional audits each year and would encourage the team approach to audit."

A. Every audit was multi-professional. Medical audit changed to clinical audit before my taking over as the clinical audit lead. So during and before my time it was very open for all to attend the nursing -- I remember specialist nurses coming for pain, doing an audit on our pain management to ensure that our quality of pain management, post-operative pain, was as good as the national standards, which were published at the time. I remember other specialist nurses in diabetic care and asthmatic care coming and being welcomed. I remember pinning the audit agenda on the noticeboard, the education noticeboard, well in advance of each

audit, putting it on the door of the education room in advance -- two or three days, a week, in advance of the audit meeting. I went round personally contacting individuals outside the medical fraternity to make sure that it was open to all.

Having said that, nursing very often used the audit half-day in my perception, my experience, to conduct their own in-service training, so theatres would obviously not work unless there was an emergency during an audit half-day, and that gave theatre managers the opportunity to get nurses trained on new diathermy machines, fire training, moving and handling training. So the nursing established -- undertook their own form of in-service education and review of their practices outside the clinical audit meeting and I had no control over that.

THE CHAIRMAN: Okay, thank you.

MR STEWART: What about the final section of paragraph 2?

"In addition, it is important that each unit continues to do the case note review audit."

A. Yes.

Q. What case notes were reviewed?

A. Well, this was again started by Professor Shields before I took over as audit coordinator, and Professor Shields had very kindly given me the template from the Royal

College of Paediatrics and Child Health template for case note review. It was a couple of A4 pages where doctors in that ward would undertake a random selection so that we weren't picking on any particular doctor or nurse. And they would sit down in a group and I actually timetabled an event once or twice a year for each unit to sit down and we did it in anaesthesia where we got the Royal College of Anaesthetists template for anaesthetic record review and that a random selection of case notes or anaesthetic records were reviewed by the clinicians encountering that case note or that medical record. Then the results of that were handed to me and I sent them on over to the clinical audit department. That was a continuous process. I have to say that after each case note review audit was undertaken, the quality of case notes did improve for the next few months, and then they tended to slip perhaps back again into not so good. So it was a good way of improving the clinical record note-keeping in my view.

Q. Would a death case have had the case notes reviewed in that way?

A. No, the case notes review -- you're talking about a serious adverse incident review?

Q. I'm talking about Claire Roberts' case.

A. That should have triggered -- but in those days the

system was not as mature as it is now -- a serious adverse incident review of her case notes.

Q. Is there any evidence that Claire Roberts' case was subjected to a case note review, an adverse incident review, a clinical audit or any other form of review, investigation or appraisal to your knowledge?

MR UBEROI: Can I interrupt [inaudible: no microphone] concern at this point? Dr Taylor is here offering factual evidence and I'm sure, he hopes, helpful evidence on the system as it was. There's a danger of him being cross-examined in a fashion which would suggest he is responsible for the system. He's not. He's working within it. He has placed his hand up in order to be the chair of the paediatric audit committee, which is what he is here offering evidence about. But I would express that note of caution if that line of cross-examination is going to be pursued in response to his answers about what the system was.

THE CHAIRMAN: But he's part of that system.

MR UBEROI: He is.

THE CHAIRMAN: And I think it's legitimate to ask -- because, sorry, let me put it this way as a variation on what Mr Stewart said. I don't think anyone will doubt -- and I don't think even Mr and Mrs Roberts will doubt, despite their experience -- that there is an

awful lot of good work done in the Children's Hospital. And if you develop guidelines about meningococcal disease, that's great, that will help treat children and save lives in the future. This inquiry will not conclude a report that everything goes wrong in the Children's Hospital. It clearly doesn't, doctor, and I don't want that message, misunderstanding or misrepresentation of the inquiry to get out.

What we're looking at, in very crude terms -- and I'm sure this is too simplistic -- is: what went wrong in the cases of Adam and Claire and Raychel, as a start. And, secondly, what happened afterwards.

We are going into this because it helps us to understand what is supposed to happen afterwards and how lessons are learnt and how mistakes are spotted and how practices improve. We've got out of this inquiry over the last number of weeks a lot of evidence about what went wrong in Claire's treatment, which did not even come out at the inquest and which certainly did not come out in 1996. But the second aspect about what happened afterwards is almost a vacuum. And the parents have said this repeatedly -- not just the Roberts, but other parents as well have said this -- when things go wrong they can understand, we're all imperfect, we all make mistakes, but what reassurance do they have or do other

parents have that the same things will not happen again?

So when Mr Stewart was asking you since you were part of the system from late 1996 -- part of the system anyway, but you took on the role of audit coordinator and when that system develops and continues and improves, where is the evidence that anything positive happened after Claire died to make it less likely that another child would die in the same or similar circumstances?

A. Well, there's no evidence.

THE CHAIRMAN: There isn't any evidence, is there? And that's really the problem. The problem isn't that there weren't systems in place, the problem isn't that there was nothing which could have been done. Nobody can ever say in Claire's case, "Look, that's just one of those things that happens and we couldn't have done any more or any better", because I'm afraid from the weeks of evidence we've heard, Claire's case is full of mistakes.

A. Yes.

THE CHAIRMAN: And I suspect the real tragedy is that, as was put in Adam as case, as you may have heard, that sometimes you just get the rather inelegant comparison to a piece of cheese and sometimes the skewer goes right through all the holes. And that's a disastrous result where in other circumstances where people make mistakes,

as they inevitably will, those mistakes are picked up somewhere along the way, hopefully before the child dies or at least after the child dies to make sure it doesn't happen again. That's the governance issue. Where is the evidence that anything was picked up at all? And there doesn't seem to be any. Or where is the reassurance that something like this won't happen again? And I'm afraid it's not there either.

A. Well, I believe there has been changes made. I believe, after the Kennedy report in Bristol, that we did change the culture significantly. I remember presenting the Kennedy -- not the 1997 recommendations. I remember photocopying the recommendations that were pertinent. Sentinel cases -- reporting of sentinel cases was a key aspect, and I recollect photocopying them, putting them on to acetates and presenting it during the audit meting that serious cases had to be reviewed a la -- post-Bristol. The governance term wasn't even known. I did not know about governance until after Bristol.

Then we come into an era where serious adverse incident reporting was part of the systems in place in the Royal Trust in 1996, but it wasn't always utilised. What's happening now is that serious cases are reviewed, not only mortality, but the numbers of near misses, which is a term that the risk managers

don't like, but we know what they mean.

THE CHAIRMAN: Something short of death.

A. I would rather 100 near misses be picked up than one mortality. The pharmacists now, in every third or fourth clinical meeting, present the outcomes of the serious adverse incident reviews. So they're presented during clinical audit; they're not part of mortality, they are administration of drug errors, they are prescription errors. So you say the drug errors that were present in Claire's chart weren't reviewed, and I see no evidence that they were reviewed. But today, and for the last few years, a group consisting of a consultant anaesthetist, a pharmacist and a nurse sit down and they get every single adverse -- IR1 is what they're called -- report. It's just changed to an online system rather than a paper system in the Trust and that was updated at the last audit meeting as well.

So every adverse incident is collated, they are put into a tabular form so that prescription errors -- which are usually caused by a doctor -- and administration errors -- which are usually caused by nursing -- are all collated. They may or may not have led to patient harm, they may have been very minor rather than a drug dosage being wrong, but perhaps it was mixed up in salt water instead of pure water, if you know what I mean, sterile

water. So those are recorded as adverse incidents. They may be near misses. The number of mortality cases is obviously very small in relation to the number of total adverse incidents that are reported. And I believe the system still is not perfect, but it is much better now -- and I believe that Claire's drug errors would have been picked up in 2010 and beyond that weren't picked up in 1996. And to me it's a source of great regret that I didn't preside over a better system, that pharmacists were present on the ward rounds, pharmacists were present on the wards, and they are very helpful to me and my colleagues when it comes to prescribing drugs that we're not familiar with. That has changed.

Audit is not really a benefit in terms of mortality review. Audit is a system, as I've explained, of looking at the macro -- looking at the larger numbers of patients coming through the service and comparing that to national standards. CEMACH is also present now -- the Confidentiality Enquiry into Maternal and Child Health deaths, CEMACH -- and those are presented online.

PICANet, which paediatric intensive care funds, records all the deaths -- records every patient coming into PICU. You can go online to PICANet.org.uk and you can download the latest report which gives you the

paediatric mortality of PICU, which is the main mortality of the Children's Hospital in Northern Ireland, and compare our results against a standardised mortality rate. So in other words, a risk-adjusted score is given for every PICU in the country. We're coded as ZB. It's available to the lay public, you can check to see what is our observed mortality, so the numbers of death we observe, no greater than the deaths that would be expected according to the degree of severity. And we are hovering around the 1 mark, which means that our observed mortality is no greater than the observed. And that gives me great confidence in dealing with the public and with my patients to say: when your child is looked after in our hospital, particularly PICU, the risk of death in this hospital is no greater or less than if that child was treated in Sheffield or Birmingham or one of the London teaching hospitals. That detail is available online and it took a big effort for our trust to move from our home-grown computerised coding system into a truly nationwide system where the mortality of each case is plotted on a curve and we're well on the mark.

Paediatric cardiac babies are reviewed and you'll have heard recently that there was a few outliers on the deaths from that and that triggered an external review.

And that concluded that Belfast was safe to provide paediatric cardiac surgery, but not sustainable.

THE CHAIRMAN: Because of numbers?

A. That was -- well, you can read the report. I don't want to go into that. But the external review was triggered because of two deaths, which made Belfast just outside the curve, which triggered an automatic external review. So what I'm trying to say -- it's a very long answer to a very short question -- is I believe the systems were inadequate back in 1995 and 1996. I believe a lot has changed and a lot of hard work has gone into trying to prevent such cases.

THE CHAIRMAN: Okay, thank you.

A. I believe we're nearly there, but I don't think --

THE CHAIRMAN: The reality is you won't ever quite be there. It's impossible to get there.

A. It's impossible, it's a continuing process of quality improvement.

THE CHAIRMAN: Thank you very much, doctor. That's very helpful.

MR STEWART: Just one more audit point, if I may, and that is: when the minutes of the paediatric directorate clinical audit meeting with the mortality meetings were produced, did they ever make reference to the lessons learned from the mortality discussions?

A. I believe I produced a few audit minutes, mortality minutes were part of that, where I did write down lessons that had been learned.

Q. I've come across an example from before your time as well.

A. It may well have happened during Professor Shields' time as well.

Q. 305-011-574. This is from March 1995. It's the paediatric medical audit meeting, "Topic: mortality". Points of note:

"Three cases were presented. Decisions. Action."

And there's a neat distillation of a point:

"If a child presents dead on arrival, the senior house officer on duty must complete the appropriate protocol form ..."

Efforts were made in relation to 1995, earlier, to distil it, yet it's still not been possible to trace anything that might relate to Claire.

A. No.

Q. Can I ask you, moving on from audit, about your subsequent work a number of years later with the working party in relation to hyponatraemia in children, the Department of Health working party. That's in your CV as part of your national work and you're on the committee from September 2001 to January 2002. Why were

you put forward or chosen or why did you volunteer for membership of that working party?

A. I can't remember who asked me to sit on it, but I didn't volunteer for it; I was asked to sit on it. It might have been Dr Carson, but I can't remember. I wouldn't like to put him on the spot if he doesn't agree with me.

Q. Did you produce and did you prepare to present a Powerpoint presentation to the Department of Health hyponatraemia working party on hyponatraemia in the Royal Belfast Hospital for Sick Children, a teaching aid?

A. Yes, I remember that.

Q. I believe that you did not, in fact, present it.

A. No. I was a bit disappointed in that. I thought I could get some -- I think that was sent to Paul Darragh, by email, a week before the first meeting, 18 September, and it was compiled over the summer months, July and August. Raychel obviously died in June. So over July and August, I attempted to get as much information as I could possibly get to try and illuminate the hyponatraemia working party about the incidents of hyponatraemia within our intensive care unit. And that's what the first draft was. I was a little bit disappointed that some of my work, albeit an early draft stage, wasn't taken up.

Q. Let's go to that inquiry. It's 007-051-100. There you are e-mailing Paul Darragh at the Department of Health on 18 September saying:

"Here are some draft documents for your consideration in advance of the meeting on 26 September." That's the week following.

A. Yes.

Q. Then you attach to it, 101 -- this is the Powerpoint presentation teaching aid:

"Hyponatraemia working party, Department of Health 2001."

On the next page, 102:

"Background. Dilutional hyponatraemia has been documented in otherwise healthy children following routine elective surgery. If unrecognised, it can lead to seizures, cerebral oedema and death."

It's quoting Arieff there.

The next, 103:

"Incidence of hyponatraemia in the Royal Belfast Hospital for Sick Children."

And we've got the deaths represented by bars in all of the years, 1991 to 2001, excepting 1995, the year that Adam Strain died, and 1996, the year that Claire Roberts died. How do you explain your omission of these two cases from your incidences of

hyponatraemia?

A. I've explained it in my written evidence. I don't know if you've got the reference to that to help ...

Q. You based, as I understand your witness statement, this graph on evidence gleaned from a PICU computer database.

A. Yes.

Q. And you chose not to use the hospital computer database; is that correct?

A. What do you mean? I think I've explained it in my written evidence. There's --

MR UBEROI: What the witness is alluding to is witness statement 157/2, page 2. Beginning at 4(a). Perhaps one might ask if the next page could be put up in split screen so the full answer is there.

THE CHAIRMAN: Sure.

MR UBEROI: Thank you.

MR STEWART: Perhaps you just tell us rather than reading out your witness statement.

A. I would have known of three different ways of interrogating computer data. In the time I had available, I obviously couldn't pull hundreds of charts from PICU. There's the PAS, Patient Administration System, which is --

Q. That's the hospital system?

A. It's one of the hospital systems, if you let me

continue. The PAS is basically administrative. It allows every patient who is admitted to be entered by the admissions secretary on their arrival in the hospital: their name, age, date of birth, hospital number. Sticky labels are then printed from that to be held in the patient's chart and a new chart is produced or the old chart is found and brought to the ward.

The PAS allows every patient to be tracked through the system, multiple admissions, discharges from outpatient clinics, discharges from hospital, and death. But unfortunately, the PAS does not contain important data such as blood test results, sodiums or clinical codes; it's purely an administrative system. So that's not really of much use to me, although you can get sometimes rough statistics about the number of admissions in a hospital over a month or a year coming to casualty or coming to outpatients. But that's that first -- and that's been around for years. But it's not really integrated into the clinical management of the patient, if you know what I'm trying to say.

The second system is the clinical coding system, which is the one I think you're alluding to. Clinical coding, to me, was a system run by, I think it was a company called CHKS. It was administered by a senior coding manager -- to my knowledge, at that time, his

name was Danny McWilliams -- and a paediatric clinical coder called Margaret Newell. They entered sets of clinical codes on to a huge computer in the main hospital and it included paediatric adult --

Q. May I interrupt you to show you what they coded for Claire? That's at 302-153-003. This is what was coded on the hospital PAS computer system in relation to Claire. If you run down there, you'll see the words "hypoosmolality" and "hyponatraemia" occur. So there she is, and hyponatraemia is correctly coded alongside her.

A. Well, you said that was the Patient Administration System.

Q. Yes.

A. I didn't understand the Patient Administration System to be useful for that. I believed that was the clinical coding system that did that. They're two separate systems.

MR UBEROI: May I rise at this point to really raise a procedural point? If Dr Taylor's being cross-examined on the mechanism by which the data was sourced, certainly it was my understanding that we've submitted some of the documentation which, effectively, the PICU secretary produced. And I stand to be corrected, but I don't believe it's yet been circulated. It's a fairly

major redaction process to do so. So there's a slight conflict in my mind if the witness is being cross-examined on this point, the fact that relevant documentation has been submitted by him, which has yet to be circulated.

THE CHAIRMAN: But I think the problem about the documentation is that it has to be virtually completely redacted, doesn't it? Because as provided to us, it had the names of many, many other children.

MR UBEROI: I think that's right, sir, but it does exist, and if you're able to see things from my point of view --

THE CHAIRMAN: I think maybe there's just a fairly direct point that can be raised about this.

MR STEWART: The most direct point is this: given your involvement with Adam Strain in 1995 and going through the inquest in 1996 and being told in 1997 that the medical negligence suit against the hospital in relation to your care of this patient had now settled, how could you forget that there was a death in 1995 of a patient in the Royal Belfast Hospital for Sick Children from hyponatraemia?

A. Well, the system I used for collating the draft form of the bar chart was provided by the PICU secretary. I've sent the original records that she collated from her

computerised database in PICU. In that search that she kindly did for me in August to prepare that chart, there were no hypokalaemic -- hyponatraemic deaths coded for 1995 or 1996.

MR STEWART: Answer the question: how could you forget?

A. Because the --

MR UBEROI: He must be allowed to finish, please.

THE CHAIRMAN: Well, did you forget, doctor?

A. I collated the data for that bar chart from the data the secretary had collated for me from the PICU database.

THE CHAIRMAN: Let me ask it in another way: as you were part of the working party which produced very widely praised guidelines, did it not strike you in your preparatory work for this that there was one particular death missing from the record which you were presenting for this talk and that was the death of Adam Strain?

A. I don't know why I excluded that. As I said, the reason -- the bar chart was prepared from data provided by the PICU secretary in her haste to produce a chart.

THE CHAIRMAN: I understand, doctor, how in some circumstances you get -- you use an assistant or a secretary who will give you the information and you bring that forward. But this is not a typical scenario of you bringing the information forward. This is a scenario in which you know yourself, just by looking

at that chart, that it's wrong.

A. I went by the data that was given to me at that time.

THE CHAIRMAN: Okay, thank you.

MR STEWART: Thank you.

MR FORTUNE: Sir, can I ask my learned friend to bring up 007-051-102? It's the Powerpoint presentation.

THE CHAIRMAN: It's the first page.

MR FORTUNE: Yes. I'm a little concerned about the references to Arieff in 1998 and the BMJ in 2001, which may seem to suggest that dilutional hyponatraemia came to be the subject of comment in those years when, of course, we all know that the Arieff paper was published in the British Medical Journal in May 1992. It may not be a good point, but it's a curious point.

THE CHAIRMAN: Yes, I understand.

MR UBEROI: Well, this is a presentation put together in 2001 and it's citing different and more recent articles. There's no mystery to that at all.

THE CHAIRMAN: Okay.

Before you finish, doctor, I asked you before lunch about the confidence that Doctors Steen and Webb might have had in the early hours of 23 October 1996 about the cause of Claire's death. And you told me that in the mid-1990s there had been an unhappy number of deaths arising out of encephalitis.

A. You might have misinterpreted what I meant, sir, which was to say that children could die and change condition very quickly and it was my recollection that children with meningitis and, potentially, encephalitis could go from a situation of being relatively well to being moribund --

THE CHAIRMAN: Right.

A. -- and even dying.

THE CHAIRMAN: Then I asked you about the figures which were contained in a letter, which I showed you and which is now -- I don't know if it's available.

A. I remember reading it.

THE CHAIRMAN: It has now been distributed to everybody, I think. It's 302-174-001. If you bring up 002 as well, please. When I asked you about this -- do you have it yet? It's 302-174-001. I think the parties have it. Okay. We'll get it put up on the screen subsequently. This gives the total number of deaths by primary diagnosis in the Children's Hospital in 1995 and 1996. When I asked you about this earlier, doctor, before everybody else had seen it, I think you took me to the second page, which is "meningococcal septicaemia".

A. Yes.

THE CHAIRMAN: And then "meningococcaemia unspecified". But

septicaemia is something quite different from what Claire had, isn't it?

A. Well, yes. Again, I apologise for that. Perhaps what you're misinterpreting was that children with suspected sepsis or infective processes could move from a relatively stable -- I was talking more generically, I believe, than specifically about Claire.

THE CHAIRMAN: I was looking to see where in 1995 and 1996 children with encephalitis or some meningitis featured in these records of deaths, of the primary diagnosis of deaths, and what we have in fact is septicaemia, three septicaemia cases in 1995 and one unspecified in 1996; is that right?

A. Yes. Of course, meningococcaemia is an organism that affects both the meninges of the brain and the blood systems. So the primary diagnosis may well have been septicaemia, but there may well have been meningitis co-existing.

THE CHAIRMAN: Just for the record, there are no encephalitis meningitis deaths in 1995 or 1996.

A. No, sir, not as a primary diagnosis.

THE CHAIRMAN: What about status epilepticus?

A. Not listed as a primary diagnosis on this page.

THE CHAIRMAN: In any death for two years? Okay. No more questions?

MR STEWART: No, sir.

THE CHAIRMAN: Are there any more questions for Dr Taylor?

MR McCREA: Yes. The first question really was: were you aware that Claire's original sodium level on 21 October was 132 and that it had fallen to 121?

A. I'm not sure if I was aware of that. I can't remember.

MR McCREA: Okay. Did anyone draw to your attention or did you examine Claire's notes and records to see what medication she had in fact been given on the 22nd?

A. I can't remember those details.

MR McCREA: In particular, can you remember examining the prescription notes themselves?

A. I can't remember examining them.

MR McCREA: You can't remember? Would you have had to --

A. -- examine the PICU records that were available.

MR McCREA: I'm talking about the midazolam, phenytoin and sodium valproate.

A. I can't remember.

MR McCREA: Would you normally have looked at those while in PICU to see what anaesthetics or what drugs you can provide and what you can't provide where there's any conflict between what medication you wish to give and what the child has been given?

A. Well, yes, that would be important, but in fact she wasn't receiving any medication for sedation that day

because she was being prepared for her second set of brainstem tests, so I wouldn't have been giving any drugs that could have made me look at previous drugs from that point of view. I believe the only drug I gave her was DDAVP, which was to slow down her urinary output.

MR McCREA: Does that mean you don't recall looking at the notes in relation to the prescription?

A. I don't recall. But I'm not trying to give you a picture of my normal practice.

MR McCREA: During the course of the day of 23 October 1996, did you speak with either Dr Webb or Dr Steen as to what had happened to Claire while she was on the ward, why she was in PICU?

A. I can't remember.

MR McCREA: Well, did you meet with Dr Webb and Dr Steen during the course of that day?

A. I don't remember. I didn't make a note of it and I can't remember.

MR McCREA: Do you even recall her being there in PICU?

A. No.

THE CHAIRMAN: I think, just before you sit down, Mr McCrea, you helpfully passed a message to Mr Stewart earlier suggesting I was probably wrong -- in fact I was certainly wrong -- this morning by suggesting that the

discussion about "no reference to coroner and a brain only post-mortem was before either of the brainstem tests".

MR McCREA: That's right, it was after the second brainstem test.

THE CHAIRMAN: So that would be in keeping with the normal practice that you were aware of?

A. That would be very unusual to try to speak to the coroner. He won't let you speak to him until [OVERSPEAKING].

THE CHAIRMAN: I was entirely wrong and I apologise to everyone for that. That came after the second brainstem test, but at that stage, you would expect the consultant from PICU to be involved in the discussion.

A. If we were doing the other set of brainstem tests, the PICU consultant and the paediatrician or the neurologist would take part in it. So if you were intimately involved in the decision-making process, yes.

THE CHAIRMAN: Thank you. Mr McAlinden?

MR McALINDEN: Mr Chairman, just in relation to that point, I have consulted with Dr McKaigue in relation to this issue, and he will be giving evidence tomorrow, but just to alert the inquiry at this stage.

His evidence was that after the CT scan report came back, he initiated a discussion with Dr Webb and

Dr Steen in relation to the issue of a referral to the coroner.

THE CHAIRMAN: Thank you very much.

Before Mr Uberoi, are there any questions from anybody else? Mr Uberoi?

MR UBEROI: No questions from me, thank you.

THE CHAIRMAN: Dr Taylor, thank you again for coming back to help the inquiry.

(The witness withdrew)

Ladies and gentlemen, we'll take a break now. We'll start Mr Walby at about 3.35.

(3.23 pm)

(A short break)

(3.47 pm)

MR PETER WALBY (called)

Questions from MR STEWART

THE CHAIRMAN: If you can live with this, I wanted to sit until about 4.45 today, and then we'll pick up your evidence tomorrow morning.

A. That's all right.

THE CHAIRMAN: Thank you very much.

MR STEWART: Mr Walby, you have provided the inquiry with three witness statements: WS176/1, 2 and 3. Are you content that they should be adopted by the inquiry as your formal evidence?

A. I am.

Q. Thank you. You have also provided us with a copy of your CV, which starts at page 311-009-001.

A. May I highlight an error, which I --

Q. Yes, please.

A. I prepared this CV with my first witness statement and, over the weekend, just in preparing to come, on page 2, could I ask you -- where it says the period "1 January 1983 to 31 December 2009", that should be 2008. Then three lines up from the bottom, where it says "2007 to 2009" that then should be 2008. That means I started my part-time job on 1 January 2009, rather than 2010.

THE CHAIRMAN: Thank you.

MR STEWART: So I see that from 1999 to 2007, indeed at the time when Claire Roberts was admitted to hospital, 1990 to 1996, you were at that time serving as clinical director yourself --

A. Yes.

Q. -- in the otolaryngology directorate.

A. That's correct.

Q. Did you gain clinical governance experience there, such as it was, at that time?

A. Yes.

Q. Then you went to work as associate medical director in

the litigation management office. Was in that in succession to Dr George Murnaghan?

A. When he left to go to Dublin, his job was not replaced by one person, and many of the different jobs that he had were split into different posts.

Q. Yes.

A. So they created a post, which had part of his work, and I applied for that.

Q. And what part of his work was that?

A. It was the -- his directorate had been initially called "risk and litigation management" and risk was peeled off that, and I was not involved in that. I was involved in primarily dealing with employers' and occupiers' liability cases, clinical negligence cases and liaison with the coroner for inquests and preparation of witness statements.

Q. Did Dr Murnaghan train you, did you learn the ropes under him?

A. No, there was a gap. He left in the summer of 1998 and the medical director, Dr Carson, acted as caretaker until they decided what to do, and I was interviewed in November 1998 and appointed to start work on 1 January 1999. So I arrived without anybody in post.

Q. I see. And what were the circumstances of Dr Murnaghan's resignation?

A. He applied to become registrar of the College of Physicians of Ireland in Dublin. So he left to do that.

Q. You said that really you were then involved in litigation for the occupiers' liability and employers' liability --

A. Yes.

Q. -- and in relation to clinical negligence claims?

A. Yes.

Q. So your work was all focused on the defence side of litigation as opposed to bringing cases on behalf of the Trust?

A. Yes.

Q. And we have a copy of your job description, which is at WS176/1, page 13. There you are responsible to the chief executive directly, but you also reported to the medical director. So you have close lines of communication with the very highest levels of clinical governance in the Trust. And your main duties were set out at 1 to 10. Number 1:

"To be a member of the Trust's clinical governance steering group, ensuring that the Trust's clinical governance duties and responsibilities are promoted and implemented."

What did that encompass?

A. Well, I recollect that that was primarily to bring the

statistics from the three areas that I was talking about earlier to this group, to give listings of numbers of cases of various varieties, and how they'd been dealt with.

Q. Were you bringing information to them about lessons learned from them or simply statistics about cases handled, processed, won, lost, settled?

A. At the start, in my first year, it was literally process, but you'll see elsewhere in my first witness statement, where you ask me, within the first year in the post I realised that there was a gap and that lessons learned from clinical negligence cases were not disseminated. So it was my practice from 2000 to write a clinical summary of every clinical negligence case where payment of damages was made, which indicated we were at fault, and that summary was then circulated to the clinical directorates and later what was called the governance managers in the Trust, but they weren't called that in 2000.

Q. Did you adopt the same practice in relation to inquests?

A. Inquests were slightly different in that the cases often -- learning had taken place before an inquest was held. I would know from having been part of the process of running up to an inquest what had been occurring. But just prior to inquests, it became my practice to

send a short synopsis to both corporate affairs and the medical director to alert the Trust that this inquest was up and coming. And after the inquest, I would report in a similar way to those two people to say what had happened and what was the outcome and if there were concerns that had been expressed by the coroner as to learning that needed to take place from what had happened during an inquest.

Q. But was there a more detailed, more medical, more clinical synopsis of lessons learned than just what you might circulate to the press officer or up the line to the medical director?

A. It could be quite detailed in that -- the press officer sounds as if it's going rather outside the medical, but it was a route to the chief executive's office in that the director of corporate affairs liaised closely with the chief executive's office. And therefore -- but it gave a lot of information to the medical director about the case, but not in great detail.

Q. Did you, after the inquest in Claire Roberts' case, prepare such a synopsis for the medical director?

A. No, I didn't.

Q. I was racking my brains and couldn't remember seeing one. Why was that?

A. It was so widely known. You'll see that there were

people asking me for -- e-mails asking for information in the days -- at the time the inquest was being heard. The medical director received the verdict and he knew about it and you've read where he talks about how he wishes he had arranged a root-cause analysis and he gives the reasons why he didn't. The department were sitting at the inquest, the police were sitting at the inquest, so my routine didn't occur in Claire Roberts' case because of that scenario. And it was also then -- not complicated, but in addition, because at the end of the inquest, counsel for the Roberts family had raised a number of issues which the coroner did not think were appropriate to be dealt with during his inquest, and he suggested that they were more in the realms of the hospital's complaints department.

So I, at the end of the inquest, went and had a not very long, but a brief conversation with Mr and Mrs Roberts and I invited them to take that up at the chief executive's office, the areas that they wanted to go into further. So that was as far as I went.

Q. Forgive me, but I would have thought that, given the level of public interest, the fact that this inquiry was being established and the fact that the coroner might have made or forbidden questions that might have touched upon medical negligence, that you might have thought

this was an ideal opportunity to inform the medical director of what you had seen at the inquest.

A. No. You have used the words "medical negligence". I didn't use the word -- I said "complaints". And herein lies a difficulty in that you have heard how Dr Murnaghan was planning to settle the Adam Strain case without going near the clinicians. I had it in my mind at the end of the inquest that we had not handled it well and should the Roberts bring a clinical negligence case, the Trust would be settling it. I have to say that the damages are awarded for the death of a child are statutory and they're a small amount and it's embarrassing that that's the situation. It adds insult to injury, the fact that parents lose a child and, when they bring a case, there normally will be no discussion of it because the case will be settled out of court -- because in this case I would have felt that we were in the wrong. And worse still, if you bring a clinical negligence claim, if you have previously initiated a complaint through the Health Service, the rules state that the complaint investigation stops once a clinical negligence case is embarked upon.

So the Roberts family were in some difficulty that if they brought a negligence claim, they weren't going to able to make a complaint, it wouldn't be dealt with.

Q. But conversely, had they made a complaint formally under your system, you'd have been obligated, by virtue of the rules of good clinical governance, to mount an immediate, full and thorough investigation, wouldn't you?
A. And you'll see from my file that I e-mailed Pauline Webb, who's in charge of the complaints department, saying: expect to be hearing from the Roberts family. In that e-mail, I counselled her to be aware that she should probably only be dealing with the Roberts family case, but that indeed I was aware, from counsel for the family, that they would have a lot of questions about the Adam Strain case, and I just set down a warning to her that it was maybe -- you need to be careful to deal with the Claire Roberts complaint and that there was a distinct possibility that Mr O'Hara would be taking the case under his umbrella and therefore the wider envelope would be dealt soon enough with in another form.
THE CHAIRMAN: Can I just go back one bit? This might help to short circuit some issues for me, and also for you, Mr Walby. You said a few moments ago that:
"After the inquest, we had it in mind that we hadn't handled it well and would be settling any claim brought by the Roberts family."

What --
A. If a claim had come in --
THE CHAIRMAN: What I want to ask you is: can you summarise succinctly what it was that you believed that the Royal had not handled well and would therefore be settling a claim for --
A. The failure to do a blood test on Tuesday morning.
THE CHAIRMAN: Thank you.
MR STEWART: Anything else?
A. No, that's why I would have settled the claim. I think the claim would have been settled on that point alone.
Q. Just to revert to your contact with Pauline Webb at that stage, why didn't you, given that you expected a claim to be made, likely to be made, warn somebody to start an investigation process?
A. Well, the medical director dealt with that. I would not have embarked on an investigation myself at all. In any inquest, I would not have done that; that would have been dealt with by the area of the Trust where the patient episode occurred. And the medical director was well on top of this case, the Trust was acutely alert to what was happening. Therefore, as the medical director, Dr McBride, in his statement has been saying, he thought of these things, but decided that he wouldn't take it further forward.

Q. I see. Just to go down to paragraph 3, your duty to:
"Assist the medical director, the director of nursing and clinical directors in ensuring that all aspects of clinical governance are embraced by management and membership of clinical directorates."
How did you go about assisting the medical director in ensuring that all aspects of clinical governance were embraced?
A. This is a job description, which I probably put aside once I had got into the post and, as you'll see, all the things that I told you that I thought about the job I was taking on are on the second page. So these are listed and I suspect this was a catch-all, this was to cover a number of general areas. It really falls into number 1 as well, I think it's to ... The clinical governance throughout the Trust. So it was making sure that I couldn't exclude myself from any particular area, but I don't -- it didn't mean anything particular.
Q. So the first six main duties are really more honoured in the breach than the observance, are they?
A. No, that wouldn't quite be right in that 5 and 6 were ones which it later became clear that the work involved in that was just -- just couldn't possibly be undertaken in the post. I was a full-time consultant ENT surgeon and I was doing this in extra sessions.

Q. Right.
A. Whereas in number 6, I did --
THE CHAIRMAN: Can I ask you how many extra sessions?
A. Three initially.
THE CHAIRMAN: That's effectively a day and a half, is it?
A. Yes.
THE CHAIRMAN: Right, thank you.
A. Number 6. Initially, number 6 just involved reporting the figures to the department of where we were with junior doctors and trying to get junior doctors' hours reduced. At early stages, there was not great impetus to get them reduced, but when the junior doctors' hours issue started to come up and the junior doctors' hours -- it could be seen in numbers of years ahead, the numbers of hours would have to be reduced drastically because of the hours that they worked. It meant that very radical solutions were going to be required by the Trust to get the hours down to the number required. And therefore, number 6 and number 5, which was to a process that was coming in to do with regulation, self-regulation of consultants mainly, those two were hived off and another consultant in the Trust took on board 5 and 6.
MR STEWART: The effective process of professional self-regulation referred to in paragraph 5, does that

mean doctors reporting adverse clinical incidents with which they've been personally involved?

A. Yes. I think it would do in that I know, when I retired as a consultant ENT surgeon, by that stage I was having an annual appraisal with my clinical director and certainly to that would be brought any complaints that had been made about you or any adverse incidents or anything. So there was a form for the clinical director to discuss with you any areas about your practice that maybe could be improved.

Q. Is there an implication from the wording of number 5 that the process that preceded was somehow ineffective?

A. Yes.

Q. Number 7 over the page, page 14, is:

"To provide a claims investigation and management service on behalf of the Trust in relation to claims of litigation ..."

We've discussed that. Number 8:

"To assist Her Majesty's Coroner with enquiries and the preparation of statements prior to inquests."

Can you describe a little about how much of your time that took up?

A. It took up quite a lot of time. When I started on 1 January 1999, Dr Carson, who had been dealing with this over the six or seven months before, after

Dr Murnaghan had left, I think there had been a particular backlog that had developed in dealing with the coroner, and therefore I was asked for the first three months to concentrate purely on the coroner's work. That's all I did in the office at that stage to do with inquests and the run-up to them.

Q. Dr Murnaghan described himself as a link or a facilitator between the Trust and the coroner; did you see yourself in the same role?

A. Yes, absolutely. I heard the word "agent" used this morning, "an agent of the coroner", and of course that's not correct. I was doing things at the coroner's direction, but not as his agent.

Q. Yes. But your duty was to assist him?

A. Yes.

Q. And also to assist with complaints management where appropriate. Can I ask you: did you only deem a matter a complaint if it was initiated under the complaints procedure?

A. Yes. I would get occasionally asked to vet a letter, or -- it was very peripheral. There would be a circumstance where I might be asked to get peripherally involved at a late stage. And, I would have to say, the comments that I made on the letter to the Roberts in January 2005, they really would almost

fall under that in that they weren't part of my mainstream job at all, but occasionally I would be asked to do that, normally by the medical director, if something had come up.

Q. And so although such correspondence came to your attention not because a formal complaint had been triggered, you nonetheless dealt with it as if it were a formal complaint, did you?

A. It could come from various parts of the hospital, but certainly if the complaints department asked for my input, I would give it. I can't think of any occasion where I refused.

Q. I suppose really my question is: would you deal with that contact under the complaints procedure rules of engagement, as it were?

A. As I said, the only time that I would get involved in this would be way down the -- I was never part of initiating or developing a complaints investigation. It would really be being asked to scan, as an independent person who hadn't been involved in the building up of things -- as you can see, there's been talk about a number of people viewing drafts of papers and making changes to them. If a number of people make changes to drafts, sometimes if you come afresh and look at it, there are non sequiturs, things are left out,

things have been dropped, and therefore I think I was often used as a proof reader, to tell you the truth.

Q. Paragraph 10. A duty was:

"To liaise with Trust solicitors, to give advice and support to staff involved in litigation, coroner's cases or the complaint process."

What type of support are we talking about?

A. This was support -- you've heard over the last couple of days -- and it has brought it home to me -- that all the clinicians, all the four doctors who gave evidence at the Claire Roberts inquest, all consultants by that stage, none of them had ever given evidence at an inquest before. I know Dr Webb had made one inquest statement in the Adam Strain case, but it demonstrates to you how rare it is in a doctor's career that he actually gets caught up in the coronial process. There may be some, and there are some specialties -- I suspect A&E and intensive care anaesthetists will be used to making witness statements for the coroner, but most other doctors don't. And therefore, there's a certain amount of naivety in how they would prepare them. Therefore, I became experienced in guiding them and supporting them because often they were anxious about what was up and coming.

And it wasn't just doctors, it was nurses.

Occasionally, it could be technicians if something had gone wrong with equipment. Basically, an inquest statement could be demanded from any hospital employee. Therefore, I was there to provide support and explain what the process was about.

Q. So would you have seen yourself as providing a service to those staff members who needed a bit of support when going to the inquest?

A. Yes. Yes, indeed, it did.

Q. Would they have relied upon you?

A. I hope they looked upon it -- they were relying on me. That's what I was trying to do.

Q. They were a bit out of their depth and you were a practised campaigner and you were able to shepherd them in the right direction.

A. Yes.

Q. Did you see any conflict or tension between the support you gave to staff, your duty to support staff, and your duty to assist the coroner in the preparation of statements?

A. Clearly, you could get that wrong, and therefore I was indeed conscious, not of a tension, but I was there to assist the coroner and if some flat stones needed to be upturned and something unpleasant was underneath them, I was there to do that and I did do that.

THE CHAIRMAN: It's a question of where you draw the line between supporting staff and providing the coroner with the relevant assistance.

A. That's why I'm hoping you're going to give me enough time to go through in detail every amendment I made to each of the seven statements which we've got in total here.

THE CHAIRMAN: We'll go through as many as we need to, Mr Walby.

A. Thank you.

MR STEWART: You counted rather more than I have. Even though you may not have perceived a tension or a conflict, do you think others might have perceived a difficulty there for you between acquitting your duty to the coroner to get those statements and supporting the staff when they are out of their depth? Do you think other people might have seen that there was a difficulty there?

A. Well, if they knew me, they would know that the way I would be performing the duty that I had to do what was required as regarding witness statements for the coroner and they knew me -- I had been around the hospital for a long time and therefore I was well experienced at all levels in most parts of the hospital and I was well-known. So I was in a good position to be providing

support. I'm not sure -- maybe I haven't answered the question.

Q. Can I ask to look at page 139-151-001? This is an e-mail that you, I think, sent to Michael McBride, 16 December 2004. This is in relation to the letter that Mr McBride is going to send to Mr and Mrs Roberts. And you report that you've in fact reported the death to the coroner and so forth. In the second paragraph:

"I think the letter to Mr and Mrs Roberts should come from your office rather than mine, given its adversarial name."

So can I suggest that that at least shows you were alive to the responsibility that out there, amongst those who perhaps don't know you, there is a perception that, on the one hand, the litigation management office might be defensive of the Trust whereas the medical director might be more straightforward?

A. I was well aware that -- the litigation management office name covered all the work I was doing for the coroner as well. And of course there's no litigation involved in coroners' work. So it was a catch-all title for the office, but it didn't sit well with the coroner's work. You'd have had to have created a rather more complicated title for the office. When Dr McBride had written his letter, I can't just remember

the mechanics of it, but I remember there was an issue of it being printed out and he would sign it, and I suggested that really a letter coming from him on paper that was headed "Litigation management office" did not give the right measure of tone to the parents of Claire.

Q. Tone? They might not trust it. The "litigation management office" sounds like a defensive litigation type thing. It might be better, is what you mean, if it came from the medical director.

A. Well, it was going to be coming from the medical director anyway. It literally was the paper it's printed on. That's what this was about. I had no part in the drafting of that letter. So it literally was a presentational comment that I was making.

Q. It's a question about presentation I put to you.

A. It was to do with presentation.

Q. Yes. Because your duties were not only to the Trust, but they also were, of course, to the coroner himself. I'm referring to the duty imposed upon you as all other doctors by the GMC and the 2001 edition of Good Medical Practice. I would ask that that be brought up at 314-014-014. At paragraph 32, just to place in context the various duties by which you were bound at that time:

"Similarly, you must assist the coroner by

responding to enquiries and by offering all relevant information to an inquest or inquiry into a patient's death. Only where your evidence may lead to criminal proceedings being taken against you are you entitled to remain silent."

So do you accept that you did have duties at that time both to the Trust and to the coroner?

A. Yes.

Q. Can I ask about the time that UTV broadcast its documentary programme on hyponatraemia? Do you remember that time?

A. I do.

Q. Did you watch the programme when it was broadcast?

A. I did.

Q. What sort of stir did it cause? Did it cause a stir in the hospital?

THE CHAIRMAN: Sorry, Mr Walby, you'd have known about it in advance, wouldn't you?

A. I did, yes.

MR STEWART: I was going to ask you about the preparatory --

A. Well, there appears -- what I didn't know was that there was correspondence between the Trust solicitors and the Trust about the programme and whether it should be broadcast in the form it was. I only was sent that correspondence around about the time of the broadcast

itself, within a day or two before it, whereas there had been ongoing communications, which I was not involved in at all.

Q. This was a letter from Mr George Brangam, Trust solicitor, to the producers, I think, of the programme. For the sake of completeness, we can bring it up at 137-005-001. 7 October -- that's about a fortnight, I think, before the date of broadcast. There's debate about the perceived unacceptable behaviour from Mr Trevor Birney, and then:

"Mr George Brangam, the Trust solicitor, requires an [in the third paragraph] an unqualified retraction of an allegation that the Trust had perhaps misled the coroner."

Then it goes on to indicate that:

"If you do so, the Trust reserves the right to take legal action against you unless an unqualified retraction is made [and so forth]."

Would you not have normally been liaising with the Trust solicitor yourself?

A. I was only one area of the Trust that liaised with the Trust solicitors. The personnel department had a lot of dealings with the Trust solicitors to do with personnel and disciplinary matters. There was a lot of dealing with the Trust solicitors by the estates department to

do with contracts and things. The chief executive's office will have had direct dealings with the Trust solicitors. So there were a number of different areas -- and in fact the complaints department would have also liaised with the Trust solicitors. So although the office that I was associate medical director of at that stage has that title, in fact it was a small proportion or only a portion of the work.

THE CHAIRMAN: It's only one route from the Trust to the solicitors?

A. Yes.

THE CHAIRMAN: Right.

MR STEWART: So your work then really was just inquests and defence work?

A. Yes. That's why I'm saying this came out of sight of me. This came as copy correspondence.

THE CHAIRMAN: So there's a whole lot of other issues like employment issues, family cases, for instance, that won't go through you at all? There's a whole lot of areas that you literally have nothing to do with?

A. Nothing to do with, yes.

MR STEWART: So we know that in the immediate aftermath of the broadcast, considerable disquiet was expressed, and the department wrote a letter to Mr McBride asking that all documents relating to the other cases, the other

three deaths, be secured and kept safe.

A. Yes, I think that was a letter to the chairman --

Q. The chairman, yes.

A. -- I think.

Q. It appears at 137-002-001. You're quite right, the it was addressed to the chair. This is in relation to Lucy Crawford, Raychel Ferguson and Adam Strain. It says:

"The department is currently considering how it should respond to the allegations made in the programme. Without prejudice to that, there is a need to ensure that all relevant records and documents are secured so that, if necessary, they can be made available for independent examination. To that end, I am writing to you to take whatever steps are necessary to ensure and keep safe all documentation within the custody or control of the Trust, its employees, servants or agents, including drafts and information in electronic format."

This includes practically everything they can think of, even legal advice received by the Trust in connection to the cases. Was this sort of information sent down to you?

A. A copy came to me, yes.

Q. Did it come to you before you heard about the case of Claire Roberts?

A. Yes.

Q. So as soon as you heard about the case of Claire Roberts, you thought "that links in with this"? Did you then think that you should secure all documentation relating to Claire Roberts?
A. Well, if you remember, Claire Roberts' notes came to me in December 2004, and I held on to those notes until I left in March, by and large. So they came to the office. So the documentation in relation to Claire Roberts was secured.
Q. Did you seek out computer records?
A. No.
Q. Coding records?
A. No.
Q. Did you make a search for audit records, mortality records?
A. No.
Q. Neuroscience grand round records?
A. No.
Q. So did you take any steps to locate and secure documentation apart from the file you were given?
A. No, but I have to say you would need to run down the list again, but I didn't do that in terms of Lucy Crawford, Raychel Ferguson or Adam Strain, the list of things you have just listed. A lot of those came later, looking for those.

THE CHAIRMAN: Let's take the third bullet point under "this should include":
"All notes of meetings or discussions concerning each case."
If Adam's case or Lucy's or Raychel's was discussed at a grand round or at an audit meeting of any sort, then that would be a meeting which concerned the case, wouldn't it?
A. You're absolutely right. You know what I did with this letter, I sent it immediately to the Trust solicitor and said, "What do we do here?". The Trust solicitor then arranged to meet the medical director to discuss how this would be dealt with and I attended that meeting. At that stage in relation to Claire Roberts, of course, there was no inquest file.
THE CHAIRMAN: Yes.
A. But there was developing what was called a "media file" because of the UTV programme. So it was a discussion of what do we need to keep, and it was in terms of those three children. Not "keep", we were keeping everything but securing.
MR STEWART: Were you given a direction by the medical director to locate and secure documentation?
A. Yes.
Q. And what steps did you take to comply with that

direction?
A. I have to say that I only made sure that I had the medical records. There are lots of subsidiary departments of the hospital of which records I now know I did not recover, such as neuropathology file notes.
Q. At the time there was -- correct me if I'm wrong -- considerable advice in how you should go about an investigation into an adverse clinical incident, and that advice encompassed the sort of documentation you should locate and secure as part of an investigation; isn't that correct?
A. Yes.
Q. I could take you to some of the directives if you wanted, but it's clear that in 2004 there was readily available advice as to how to go about an investigation. Even though you were directed to get the documentation, you say you didn't. Can you say how that squares with your duties in relation to clinical governance?
A. Well, this instruction from the department was to hold it all -- the bottom line of that -- and retain it. So I only obtained, as I say -- in the case of Adam Strain there were clinical notes and a medical negligence file and an inquest file. In Raychel Ferguson, there were the notes and inquest file and a medical negligence file. But if I'm right, we didn't have all three in all

three cases. We had an inquest file and notes on Lucy Crawford. I don't think a clinical negligence case involved the Belfast Trust in Lucy Crawford. There was one, but it didn't involve the Belfast Trust. So those are the materials that I had secured.
Q. Yes. I was going to suggest to you that it's hard to conceive of a more formal and a more forthright departmental requirement than:
"Now requires you to take whatever steps are necessary to secure and keep safe all documentation".
That is really about as strong as it gets, isn't it?
A. Well, yes.
Q. And indeed, you had, as you said, your media file. I think you called it the Insight file; is that right?
A. No, we tended to call it the media file, and I tended to use -- I have notes, "I put it in the Insight file", but in fact the file in the office remained labelled the "media file", but it's the same file.
Q. WS177/1, page 54.
MR FORTUNE: Is this file 141?
MR STEWART: This comes from Dr Rooney's witness statement. I wonder if it's the same one. You can see, top right-hand corner, it looks like your initials, "APW"?
A. This is a page from my file, my media file, I suspect.
Q. You're 176, though. It has been circularised to

Nichola Rooney, we can see at the top, there, and Dympna Curley.

A. The writing on the top right-hand corner is mine, so that's a copy that came to me.

Q. Yes:

"This is about a query fourth hyponatraemia case. Place in the Insight file, please."

A. Yes. And that's the media file.

Q. So in November, after the letter requiring the documentation to be secured, you knew this was a fourth case and you were filing them together.

A. No. Well, I put it in the Insight file because I had -- if we read at the bottom, this is the e-mail from Dr McBride to Heather Steen, number 2. That is indicating -- and I think at a hospital meeting I must have heard, "It looks like there may be another case of hyponatraemia", and therefore no names were mentioned and I just heard the -- and then when this e-mail came to me, I had no file to put it in because I didn't have a name. That's a note -- the blanked out is the secretary's name -- asking the secretary:

"This is a about a query fourth hyponatraemia case. Please place in the Insight file."

Because we had nowhere else to put it at the time.

Q. Yes.

A. And you'll see in what eventually becomes the Claire Roberts coroner's file, there's another reference to the first time it becomes clear that the name is Claire Roberts. There's -- somewhere I have a margin note saying, "This is the fourth case". And by that stage it goes -- that page gets put into what becomes the Claire Roberts inquest file because we now know the name of the patient to attach it to. That page really could have been moved into the inquest file.

Q. At that time in 2004, were you aware of the responsibility of the Trust to report an adverse clinical incident such as Claire's to the department?

A. Incident reporting to the department was not -- I would have known that that is something that the Trust should be doing, but you know, I didn't report an incident to the department in my career, so I had no knowledge of the detailed pathway as to how one did that. So it wasn't part of my role, but I did know that incidents would be reported to the department.

Q. I asked because subsequently it was you who suggested to Dr McBride that it should be reported. That is at 139-052-001.

A. Yes. Isn't this interesting? This circular HSS(PPM) 2/2006 was issued two weeks before, so it clearly had just arrived on Dr McBride's desk, so he was clearly

alert to it. But I haven't seen that. I think there had been an earlier one in 2004, but this one arrives from the department two weeks before and he realises on reading that, that if a matter of serious public concern is coming up, and this indeed was Claire Roberts' inquest, that for that reason it should be reported to the department.

Q. Okay. Just to correct you, the circular that we're talking about here, 2006, is dated 20 March 2006.

A. Yes, eight days before. Did I say 14?

Q. In fact, it was not a fresh instruction in this regard but it merely repeats the content of circular HSS(PPM) of June 2004.

A. I think I said that.

Q. Yes. So what I'm asking you is: did you not think in 2004 that you should report it to the department then?

A. As I said, I have never reported anything to the department. Dr McBride, I think in his witness statement, has said: yes, indeed he thinks it should have been reported to the department then.

Q. Because the criteria for reporting under the 2006 circular is identical to the criteria under the 2004 circular.

A. Yes.

Q. And if you reckoned in 2006 it should be reported, why

didn't you do so -- were you aware of the 2004 circular?

A. I knew that there was the need to report incidents to the department. As I say, never having initiated the procedure or been involved in it, I can't say that I would have kept that circular to hand because it would have been something that would have been dealt with by the medical director's office.

Q. So it wasn't your responsibility, is that what you're saying?

A. That sounds as if I'm ducking it, but on the other hand, if a serious incident happened, I would make sure the medical director's office knew about it and they would then take it further. So it's not as if I'm making light of it. It was a very important document.

THE CHAIRMAN: Don't worry about that, Mr Walby. I understand the position. If a serious adverse incident is reported to Dr McBride's office then, in essence, you're entitled to assume that he will report that to the department.

A. Yes.

THE CHAIRMAN: It's not ducking it. If ten people in the Trust know that there's a serious adverse incident, then it's ridiculous to have ten reports going to the department. But it is important to have one report going to the department.

A. Yes, it is.
MR STEWART: So the next question is: if you could have or did appreciate in 2004 that no report had been sent by the medical director, would you not then have suggested that perhaps it should be sent?
A. Well, if you remember, in 2004, we've got the Roberts family reporting the death of their daughter and the coroner is being advised that this is a death that he might want to investigate. So we're at an early stage of matters. But certainly, as 2005 progresses, and the Trust becomes more aware of the problems that had occurred in that case -- Professor Young has highlighted them for the Trust -- but the fact is sometime around that stage it indeed could have been and should have been reported to the department.
Q. Indeed because the department makes the point in the circular that it's important that action be taken. It expects:
"... urgent action to be taken to investigate and manage the adverse incident."
It goes on to say that in fact:
"The department may, in independent reviews, provide guidance in relation to determining specialist input into such reviews."
So there would have been a real reason why the

department should have been notified.
A. I agree.
Q. Can I ask --
THE CHAIRMAN: Sorry, can you just give me that reference, Mr Stewart, that you were quoting from?
MR STEWART: WS061/2, page 422. That is --
THE CHAIRMAN: Mr McKee, is it?
MR STEWART: Yes. That is the 2004 circular. In 2005, a further circular is sent out, reiterating the need to comply. That appears at WS068/1, page 251. And then the circular is sent out in its final -- in this case, essentially unchanged -- version in 2006. And that appears at, as does this document, 139-045-002.
Can we go back to that last page we were looking at? This is the account, is it, dated 28 March 2006, from you to McGinley. McGinley was the press office; is that right?
A. It is, and it contains a serious mistake.
Q. Could you perhaps highlight that for us?
A. Yes. I have written there, why I know not:
"She had severe learning disability."
We know that's not the case. I haven't written it anywhere else, but in that -- fortunately -- and I don't know how it came to light, but I only quite recently saw the SAI that had been submitted to the department

because -- why we didn't have it. Unfortunately, someone has had the wit to remove that "severe" from the version that went to the department. This was modified by Mrs Champion, as it seemed to have been her role at that stage to have been forwarding that. So I apologise for having made that mistake. It was quite wrong. But it has been corrected before ... A lot of my very -- almost identical wording goes to the department.
Q. I was going to draw your attention to something in the middle paragraph, the paragraph commencing:
"Following the UTV Insight programme in October 2004 into paediatric deaths from hyponatraemia, Claire Roberts' parents contacted the hospital and, after a review of the notes, it was considered in retrospect that the known hyponatraemia, which was treated, may have had a part to play in the medical condition leading to death, and after a meeting with the family, the death was reported to the coroner."
"In retrospect, it was considered that the known hyponatraemia, which was treated, may have had a part to play in the medical condition."
Was it not known at the time and was it not recorded in the notes at the time?
A. I don't think that the -- you are drawing me into clinical matters, but I don't think that the clinicians

at the time did feel that the hyponatraemia was ... Where is it?
Q. It says here:
"After a review of the notes --
A. "Played a part in the medical condition."
I think they felt that the cause of death that was written on the death certificate did not lead you to believe that that's what they were considering and that the SIADH, which causes hyponatraemia, was a consequence of these.
Q. This was a conclusion of the review of the notes?
A. Yes. Whose review -- is this my review of the notes?
Q. It's written by you.
A. Yes, okay.
THE CHAIRMAN: The information which you have to write this note is what, the collected statements which are going to the inquest, which is due to be heard reasonably soon?
A. Yes.
THE CHAIRMAN: Okay.
A. This is a month or two in advance of the inquest.
THE CHAIRMAN: Yes. And just before Mr Stewart continues his line of questioning, when you say:
"The known hyponatraemia, which was treated ..."
Is that a reference to Dr Stewart and his

intervention between 11 and 11.30 on the Tuesday night?
A. Yes.
THE CHAIRMAN: Thank you.
MR STEWART: Because what you had at that time, if you were basing your view on the notes, and they contained references to hyponatraemia in the discharge, in PICU, in Allen Ward, and it's also clinically coded with hyponatraemia being a condition, you also had Dr Webb's witness statement that you had obtained from him for the coroner.
A. Yes.
Q. And you had that at 091-008-053. In the middle of the page is the paragraph:
"Claire's hyponatraemia led to her developing cerebral oedema (swelling) and then brain herniation. The swollen brain will herniate down, resulting in brainstem compression and cardiorespiratory arrest."
If your information is based upon the case notes and what the clinicians are telling you, I would suggest to you that it would not be correct to say that in retrospect it's only apparent that hyponatraemia played a part in her death, but that it must have been apparent at the time too.
A. Yes, that is right, but I think my sense there is that the hyponatraemia is as a consequence of SIADH and not

as a consequence of overloading with fifth-normal saline.
Q. Let's just go back to the page and have a look at your wording again. Back one page:
"After a review of the notes, it was considered in retrospect that the known hyponatraemia, which was treated, may have had a part to play in the medical condition leading to death."
I suggest to you that that misleads.
A. I've written too long a sentence. I'm having some difficulty dissecting it here.
THE CHAIRMAN: Let's break it up:
"Following the UTV programme, Claire Roberts' parents contacted the hospital."
Let's put a full stop there:
"After a review of the notes, it was considered in retrospect that the known hyponatraemia, which was treated, may have had a part to play in the medical condition leading to death."
Full stop. So it's that middle segment of that four-line paragraph that Mr Stewart is asking you about.
A. I think that's correct.
THE CHAIRMAN: And the question is: is that correct? Mr McAlinden?
MR McALINDEN: I'm reluctant to interfere at this stage, but

I do think that it's rather inappropriate for a statement to be made to a witness that he is trying to mislead the department or his medical director in relation to the serious matter of submitting an SAI. The statement, when analysed properly and carefully, is clearly consistent with what actually occurred in this case.
There was a review of the records by Professor Young. At the time Professor Young reviewed the records, he formed the opinion that hyponatraemia may well have played a part in the death of the deceased and, as a result of that, the case was referred to the coroner. In essence, that's what that statement in this letter says and, in essence, there is no actual misleading content in that statement.
THE CHAIRMAN: Okay.
MR STEWART: The suggestion from this is that it was only in retrospect that this was known and that it was somehow not known at the time.
MR McALINDEN: It is quite clear. It really is "in retrospect" because the review by Professor Young occurred in retrospect. It was that that triggered the investigation.
THE CHAIRMAN: That is undoubtedly correct. It is correct to say:

"After a review of the notes by Professor Young, it was considered in retrospect ..."
That's entirely accurate.
MR McALINDEN: Yes. And also my learned friend then raised an issue in relation to Dr Webb's statement. Dr Webb's statement was obviously obtained after the referral to the coroner because the statement was a statement obtained for the purpose of the inquest. So it could not be the case that Dr Webb's statement was in some way contemporaneous with the events.
THE CHAIRMAN: Sorry, there are two separate issues. One is if that is referring only to what has happened from 2004, then it's undoubtedly correct that it was considered in retrospect and that the known hyponatraemia may have had a part to play in Claire's death; okay?
MR McALINDEN: Yes.
THE CHAIRMAN: Let's go back to 1996, which I think was the gist of Mr Stewart's question. He was querying the inclusion of the words "in retrospect".
The question is: was it known at the time or was it considered at the time that hyponatraemia may have had a part to play in the medical condition leading to death? And I think the gist of Mr Stewart's question is that when you go through a series of entries in the

medical notes and records and the documentation from that time, that wasn't just known in retrospect from the work of Professor Young and others from 2004 onwards, but it was also recognised at different points in the notes in 1996.

I accept the first part is that, if I read your sentence as, "after a review of the notes by Professor Young", that's correct.

A. That's what I'm meaning.

THE CHAIRMAN: Let me ask you to take it one step further. If we go back to the 1996 notes, October 1996, is it not also apparent that there was, to put it at a minimum, some recognition by some of those involved that hyponatraemia was present in Claire and that this may have had a part to play in the condition which led to her death?

A. That's correct. What causes the hyponatraemia is an additional matter.

THE CHAIRMAN: Yes. Okay. I've got that point.

MR STEWART: Why put in the two words "in retrospect"? Because if you hadn't put those in, it would have read:

"After a review of the notes, it was considered that the known hyponatraemia, which was treated, may have had a part to play in the medical condition."

THE CHAIRMAN: I think the answer to that, to be fair to the

witness, is that that's a reference to the review of the notes by Professor Young in 2006. But there's perhaps two separate issues.

In any event, it's 4.50, Mr Stewart. If you're in the middle of something, we'll finish it, if we can do it briefly. Otherwise, we'll adjourn until tomorrow morning.

MR STEWART: Just a couple more questions, if I may, on this particular area.

When the notification of the serious adverse incident was made then to the department, and that appears at 302-164-003, and as you've already told us, the wording of that is essentially taken from that last document we looked at, which was your briefing to the press office.

A. Yes.

Q. Was this a conventional way of drafting a serious adverse incident report for the Department of Health, to work it out first in a press release?

A. Well, the email went, I think, to both parties. I think it went to the medical director as well. I can't remember the circumstances on why I would have aimed at ... You'll need to take me back as to ... Was the email to McGinley and copied to McBride?

Q. It went to June Champion.

A. The medical director then forwarded to June Champion and instructed her to deal with it as an SAI.

THE CHAIRMAN: Can we go back to the previous page for one second, please? It goes to McGinley with a cc Michael McBride. And then it goes from Dr McBride to Ms Champion.

A. That is just serendipity. I could have put both those names on the heading line -- I just never did that. I sent it to one person and copied it to another. It could have been -- it needed to go of equal importance to both.

THE CHAIRMAN: But it has the effect of going to both, so that's not an issue.

A. And the medical director then did indeed think that an SAI was needed and he chose to use my e-mail as the source of a lot of the information. But that was outside my knowledge. It wasn't my plan. I was happy with it, but it wasn't my plan.

THE CHAIRMAN: And that shows, in a sense, what we have talked about a few minutes ago: that if you report something like this to Dr McBride, he takes the responsibility of reporting to the department?

A. Yes.

MR STEWART: And he does that, and can we go please, finally, to 139-046-001? This is Michael McBride giving

information to all:

"The department has been informed as per the circular of 2006 and has requested a further background briefing which I will provide."

Did you provide that?

A. No, I ... This is Michael McBride saying he is going to provide something.

Q. Yes. Did you ever see it?

A. No, I didn't see his --

Q. Did it exist? Did he provide a further background briefing?

A. I don't know.

THE CHAIRMAN: I don't want the name that's redacted in the recipients of that email, but can I take it that the redaction is --

A. My secretary.

THE CHAIRMAN: So in fact that goes to you?

A. Yes.

THE CHAIRMAN: Thank you.

MR STEWART: Indeed, we know it goes to you because your initials are at the top and there's a line that you have drawn from the reference to the circular of 2006, that's the circular about informing the department, and you've entered a comment there. Can you read it out, please?

A. Yes. This circular, you see, is dated February 2006 and

I didn't think that I had seen it and I asked my secretary to get me a copy of it. You'll see that there is a copy, a blank copy, of the SAI and this circular in the coroner's file, which I obtained after I knew that this is what Dr McBride was doing. I got the circular and made this note to myself, which reads:

"Having seen this circular, it seems a bit heavy-handed for this case."

Q. "For this case"?

A. "For this case." But this was, in my innocence, not being aware that the reason for reporting this was basically so that the department and the minister would know what's going on. It was being done a bit above my pay station and really I now see that indeed the department does need to know about things which will have public interest. That's why I made that note.

Q. This is a case of a child's death from hyponatraemia, of a care management problem, of an inquest, of a public inquiry, of politicians being involved, and you're saying: it's a bit heavy-handed for this case.

A. What I thought was heavy-handed was submitting an SAI just before the inquest. It was basically saying it could have been submitted much earlier, once I had read it. So it's a throwaway line in my e-mail, but you wanted to know my thinking and that was my thinking when

I read that, that I thought submitting an SAI for the public aspect of it, to the department, was maybe inappropriate, that it should have been done earlier.

MR STEWART: Sir, thank you.

THE CHAIRMAN: Thank you. Mr Walby, can you convenience us tomorrow morning?

A. Yes, indeed.

THE CHAIRMAN: Thank you very much. I'll leave you to discuss timetabling tomorrow. I'm content to pick up with Mr Walby if that suits. We've got Dr Murnaghan and Dr McKaigue. Maybe you could have some discussions and work out some sort of prospective timetable between you.

Okay, thank you very much. Tomorrow morning at 10 o'clock.

(4.57 pm)

(The hearing adjourned until 10.00 the following day)

I N D E X